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No-Suicide Contracts with Suicidal Youth: Utah Mental Health Professionals' Perceptions and Current Practice

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ABSTRACT

No-Suicide Contracts with Suicidal Youth: Utah Mental Health Professionals' Perceptions and Current Practice

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Suicide is the third leading cause of death among youth and young adults ages 10–24. In 2001 the U.S. Surgeon General laid out a national strategic plan to more effectively address suicide prevention (United States Public Health Service, 2001). In 2008, Gene Cash, then president of The National Association of School Psychologists, made a "call to action" to prevent suicide. Although suicide prevention has been repeatedly identified as a priority in mental health care, the vast majority of interventions with suicidal youth are not evidence based due to a lack of research utilizing controlled studies (Daniel & Goldston, 2009). Unfortunately this leaves mental health professionals (MHPs) to routinely implement interventions that are not research based and not proven effective in deterring suicidal thoughts and actions.

No-suicide contracts (NSCs), commonly used in clinical and medical settings, solicit a commitment from a suicidal individual, a promise *not* to complete suicide. The prevalence of school-based MHPs' use of NSCs with suicidal youth (SY) is unknown. Additionally, minimal feedback is available regarding MHPs' percpetions of and current practice regarding implementation of NSCs. Likewise, school policy directing MHPs' intervention when working with SY is neither well described nor understood. A brief survey was created to access these percpetions and practices. Of 326 MHPs attending a Utah Youth Suicide Prevention Conference, 243 completed a survey (74.5% participation rate). Half of participants intervening with SY reported using NSCs. Only 27 of the 243 participants indicated that their school's policy encouraged or required a NSC. Only 8 participants reported knowledge of a formal written school policy that specifically guided their intervention with SY.

Reasoning underlying decisions to use or not to use NSCs were explored. Common explanations included attending to individual student needs, following perceived guidelines, building trust with SY and adapting contracts to fit student needs, and opening discussion about suicide. Several participants expressed a need for additional training with no-suicide contracting. A few participants called for either renaming NSCs or implementing a similar, but more positive, "commitment to treatment" strategy. Participants did not mention a need for additional research to explore the efficacy of NSCs. In fact, research was not mentioned. This reflects the gap between research and practice and the dependency on personal experience and going along with the status quo versus depending on research findings to dictate improvement and change in practice.

Keywords: no-suicide contract, mental health professionals, school-based intervention, suicide prevention

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Greg Hudnall and Cathy Bledsoe also deserve much credit for their contributions in helping with both the design and implementation of this study. I would also like to thank the participants of this study who took the time to offer their opinions and perspectives.

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DESCRIPTION OF THESIS STRUCTURE

Following the introductory pages (title page, acknowledgments, abstract, table of contents, and list of tables), this thesis is segmented into two major sections: (a) the article ready for submission to a journal (pp. 1–30) and (b) the review of the literature (pp. 31–45).

This thesis contains two reference lists. The first reference list (p. 23) contains the references included in the journal-ready article. The second reference list (p. 46) includes all citations used in both the journal-ready article and the section titled “Review of the Literature” (p. 31).

This thesis is prepared in a “submission ready” journal format. A more extensive literature review is included in Appendix A. The Questionnaire that was utilized in this study is included in Appendix B.

Background

Worldwide, approximately 3,000 individuals complete suicide daily, and approximately 20 times this number of individuals survive failed suicide attempts (World Health Organization [WHO], 2011). Annual deaths resulting from suicide exceed the number of deaths from homicides and wars combined (WHO, 2004).

Prevalence of Youth Suicide

For U.S. youth ages 10–24, suicide is the third leading cause of death, each year accounting for approximately 4,400 deaths and 149,000 emergency room visits for attempted suicide (Centers for Disease Control and Prevention [CDC], 2009). Additionally, the prevalence of completed and attempted suicides are underestimated because the cause of injury or death was erroneously documented as *accidental* or subsequent to high-risk activity (e.g., automobile accidents, accidental drug overdoses, falls, drownings). Based on data from the 2009 U.S. *Youth Risk Behavior Survey*, 13.8% of 9th- through 12th-grade students seriously considered attempting suicide in the previous 12 months; 10.9% made a plan to complete suicide; and 6.3% attempted suicide (CDC, 2010, p. 9). From a teacher's perspective—considering these numbers in a high school classroom of 30 students—over the past 12 months, 4 students seriously considered attempting suicide, 3 made a plan to complete suicide, and 2 students attempted suicide.

These numbers reflect the current prevalence of suicidal ideation and planning among youth. On a more personal note, these numbers represent desperate youth contemplating and taking action to escape physical and emotional pain. Voicing medical and mental health professionals' sentiment, Weiss (2001) stated, "The management of the suicidal patient is one of the greatest clinical challenges facing mental health professionals" (p. 414).

An indication of difficulties preceding suicide, over 90% of individuals who completed suicide struggled with depression and/or other forms of mental illness and substance-abuse disorders (National Institute of Mental Health, 2010). Another indication of society failing to effectively intervene with troubled youth, in Utah, 63% of all youth suicides were completed by males registered in the juvenile justice system (Moskos, Halbern, Alder, Kim, & Gray, 2007).

Suicide Prevention

Noting the prevalence and impact of youth suicide, medical and mental health professionals identify youth suicide as a major public health problem (Gould, Shaffer, Fisher, Kleinman & Morishaima, 1992; National Institute of Mental Health, 2010; U.S. Department of Health and Human Services [DHHS], Public Health Service, 2001). In 1999, the U.S. Surgeon General proposed a national strategic plan to address suicide prevention, including youth suicide prevention (U.S. DHHS, Public Health Service, 2001). More specifically targeting school settings, in 2008, Gene Cash, then president of The National Association of School Psychologists (NASP), made a *call to action* to prevent youth suicide.

Described as a preventable cause of death, a permanent solution to a temporary problem, suicide leaves survivors feeling guilt and wondering how they might have more effectively intervened to prevent such tragic loss. Suicide's far-reaching grasp forever alters lives of surviving family members, friends, teachers, schools, and communities. Furthermore, the massive weight of disenfranchised grief following a youth's suicide adds to survivors' difficulty in healing and moving forward (Balk, Zaengle, & Corr, 2011).

The desire to prevent youth suicide is keenly felt among mental health professionals (MHPs) who work with youth in school and community settings (Greydanus, Bacopoulou, & Tsalamanios 2009; Miller & Eckert, 2009). In particular, prevention efforts are critical in

secondary schools because, in comparison to younger children, adolescents are at a much greater risk for attempting and completing suicide (Daniel & Goldston, 2009).

Facing the challenge of intervening with Suicidal Youth (SY), school-based MHPs repeatedly indicate insufficient graduate pre-service training to adequately and confidently intervene during crisis situations (Allen, Jerome, et al., 2002; Allen, Burt, et al., 2002; Debski, Spadafore, Jacob, Poole, & Hixson, 2007; King, Price, Telljohann, & Wahl, 1999). Additionally, the vast majority of interventions with suicidal youth are not considered evidence-based due to a lack of research utilizing controlled studies (Daniel & Goldston, 2009). Daniel and Goldstein noted, "There are insufficient data from controlled trials to recommend one intervention over another for the treatment of suicidal youth." (2009, p. 252). Unfortunately, this leaves MHPs to routinely implement interventions that are neither data-based nor proven effective in deterring suicidal thoughts and actions. Although currently considered controversial, one such commonly promoted intervention is the use of *no-suicide contracts* (Miller & Eckert, 2009).

No-Suicide Contracts (NSCs)

The use of NSCs originated in an adult clinical out-patient study by Drye, Goulding, and Goulding (1973). They recommended evaluators ask suicidal patients to make the statement: "No matter what happens, I will not kill myself, accidently or on purpose, at anytime" (Drye et al., 1973, p. 172). These researchers professed that patients' verbal commitment or refusal to commit helped assess level of suicide risk, reflecting the seriousness of patients' intention to complete suicide. They also noted benefits of shifting responsibility to patients, lessening the emotional burden previously shouldered by MHPs. Although this study was later criticized on numerous points, Drye et al. initiated verbal NSCs, forging a new way of conceptualizing

patients' responsibility for self-harm. Their original verbal intervention eventually morphed into current-day written NSCs.

Though NSCs' content and wording may vary depending on client's age and situation, NSCs commonly rely on bilateral agreement between a client and MHP or adult in position of authority (Buelow & Range, 2000; Drew, 1999; Farrow & O'Brien, 2003; Kelly & Knudson, 2000; Weiss, 2001). The client commits not to act or follow through on self-destructive impulses. Typically, NSCs explicitly state the identified individual agrees *not* to attempt suicide or direct harm toward him- or herself in any way. After this statement, a specific time frame is designated for abstaining from self-harm. Contact numbers are listed for the individual to call in the event of increased suicidal ideation, self-harm, and suicidal behavior. Additionally, the individual and MHP outline a plan of action, and the MHP offers guidance and supportive strategies to further protect the individual from self-harm. Concluding the contract, the individual and MHP sign the document, formally agreeing to previous statements. The contract is then copied; one copy is given to the individual and one copy to the MHP (Buelow & Range, 2000; Poland & Lieberman, 2002).

Evidence base for NSCs. No-suicide contracts have been looked at across various professional areas for many years to explore their usefulness and effectiveness. After searching and finding *no* solid empirical evidence supporting the effectiveness of NSCs, Kelly and Knudson (2000) countered the use of this commonly used intervention. Across time, similar complaints have been voiced against NSCs (Farrow & O'Brien, 2003; Garvey, Penn, Campbell, Esposito-Smythers, & Spirito, 2009; McMyler & Pryjmachuk, 2008; Miller, 1999). After conducting a literature review of empirical studies and legal cases related to NSCs, Garvey et al. (2009) concluded: "Overall, empirically based evidence to support the use of the contract for

safety in any population is very limited, particularly in adolescent populations" (p. 363). They also warned, "A contract should never replace a thorough assessment of a patient's suicide risk factors" (p. 363).

McMyler and Pryjmachuk (2008) reviewed 23 publications investigating the effectiveness of NSCs. The publications McMyler and Pryjmachuk reviewed were investigated by researches across various domains, such as: hospital staff, psychiatric inpatients, registered crisis nurses, and psychiatrists. Ten articles described empirical research, and 13 described opinion-based support. Based on their review, they concluded that potential benefits associated with NSCs, such as ensuring check-ins with patients and facilitating exploration of suicidal thoughts, could be achieved by other means, such as interviews, observations, and assessments to detect suicidal ideation. They cautioned, NSCs were "at best, ineffective and, at worst, harmful" (McMyler & Pryjmachuk, 2008, p. 520). In particular, they warned that practitioners should not depend on NSCs to ensure clients' safety.

School psychologists' perceptions of NSCs. An article currently available on the NASP website, *Times of Tragedy: Preventing Suicide in Troubled Children and Youth, Part II* (NASP, 2002), offers eight tips for school personnel and crisis team members who work with SY. The fifth tip specifically refers to NSCs. Although the following quote identifies NSCs as *effective* in preventing youth suicide, NASP does not cite research supporting this claim.

> No-suicide contracts have been shown to be effective in preventing youth suicide. In cases where the suicide risk is judged to be low enough not to require an immediate treatment (e.g., there is only ideation and no suicide plan), a no-suicide contract is still recommended to provide the student with alternatives should their suicide risk level increase in the future. Such a contract is a personal agreement to postpone suicidal

> behaviors until help can be obtained. The contract can also serve as an effective assessment tool. If a student refuses to sign, they cannot guarantee they will not hurt themselves. The assessment immediately rises to high risk and the student should be supervised until parents can assume responsibility in taking the student for immediate psychiatric evaluation. (National Association of School Psychologists, 2002, "Tips for School Personnel," 5th tip)

Also published in NASP resources and publications, several applied researchers with extensive school-based experience refer to positive aspects of NSCs (Brock, Jimerson, Lieberman, & Sharp, 2004, p. S9-35; Lieberman, Poland, & Cassel, 2008; Lieberman, Poland, & Cowan, 2006). Speaking from personal experience, these authors identified benefits associated with assessment of suicidal risk, more specifically the benefits in using NSCs as one piece of a larger treatment intervention plan.

In regard to youth suicide, Miller and Eckert (2009, p. 160) identified controversies surrounding NSCs (verbal and written). They noted that although this practice is common, particularly in outpatient settings, there are opposing opinions regarding the efficacy of NSCs in preventing students from attempting or completing suicide. Opponents warn that when individuals sign NSCs, MHPs may assume a false sense of security and subsequently lower their guard, decreasing their vigilance in monitoring suicidal risk (Goin, 2003).

Purpose of Study

The purpose of the study was to look at NSCs from the viewpoints of MHPs working in schools because although suicide is the third leading cause of death among youth ages 10–24, it is preventable. The NSC is a tool that MHPs have used to prevent suicide among youth and this study set out to explore how often NSCs are used, who is using them, what policy guides the use,

and what reasoning underlies the decision to use them with SY. MHPs working with SY are challenged to identify the seriousness of a student's suicidal intent; determine the student's emotional stability and degree of hopelessness; assess whether or not the student has a plan to inflict self-harm; and decide if the student has plausible means to carry out plans of self-destruction. These judgments then set into action a host of preventive responses aligned with the student's level of risk and situational needs, most importantly keeping the student safe and emotionally supported. MHPs also coordinate and implement strategies to provide ongoing follow-through and follow-up with SY, parents, school staff, and outside agencies (if deemed necessary).

MHPs are commonly encouraged to use NSCs as an intervention and assessment tool to determine suicide risk. However, ongoing debate and research reviews have placed NSCs under a critical lens of inspection. Based on recent publications, researchers and practitioners question the efficacy of NSCs in preventing self-harm and suicide (Garvey et al., 2009; Miller & Berman, 2011). In particular, this debate over the effectiveness of NSCs has not been carefully considered and resolved in regard to responding to SY, particularly in clarifying school-based treatment protocol and aligning practice with current research findings and recommendations.

As a model for school districts, Utah is currently creating a state manual for youth suicide prevention, intervention, and postvention. In gathering information for this manual, the debate over how to use (or not use) NSCs prompted the authors to investigate the literature and to elicit feedback from Utah's MHPs who intervene with SY. Regarding NSCs, information gathered from this survey will assist the authors in more clearly identifying current practice and prevailing attitudes of MHPs.

Research Questions

To gather information from MHPs about the current practice and prevailing attitudes surrounding NSCs, the following questions were chosen to help identify and describe Utah's MHPs' perceptions and practices related to NSCs with SY.

1. Do Utah's MHPs report using NSCs with SY?
2. Are Utah's MHPs aware of existing policies regarding no-suicide contracts?
3. When working with SY, to what extent do Utah's MHPs agree or disagree with using NSCs?
4. What reasoning underlies Utah's MHPs' agreement or disagreement in regard to using NSCs?

Method

Procedures

A questionnaire was administered during Utah's annual statewide conference on youth suicide prevention, held December 3, 2010, in Provo, UT. This one-day conference provided training relevant to Utah's MHPs who work with school-age youth. A two-page questionnaire (one sheet of paper, front and back) and a pen were inserted into each attendee's conference packet. During the conference's opening session, attendees were invited to complete the enclosed questionnaire. Additionally, to promote a higher return rate, reminders were given during conference breakout sessions. Participants placed completed questionnaires in drop boxes located at the conference registration desk.

The paper-pencil questionnaire was prepared by the primary author and three members of the Provo (UT) suicide prevention conference planning committee. Prior to the conference, Brigham Young University's Institutional Review Board (IRB) committee approved this

questionnaire. The questionnaire consisted of three sections: (a) demographic information, (b) items considered for inclusion in Utah's proposed *State Suicide Prevention Manual*, and (c) working with suicidal students. Time to complete the survey ranged from 10 to 20 minutes.

This study focused on the first and third sections of the questionnaire. For the demographic portion, participants were asked to either select from a provided list of optional responses (circling selected responses) or write a short response (fill in the blank). Participants circled response options to the following demographic descriptors: (a) participant's gender (*male* or *female*); (b) age group or groups of youth the participant worked with (*preschool*; *K–6 grades*; *7–8 grades*; *9–12 grades*; or *NA, I do not work with youth*); (c) assisted in developing youth suicide prevention strategies or policies (*yes* or *no*); and (d) experience working with SY (*yes or no*). The demographic section also requested participants to write in responses describing (a) age, (b) job title, (c) school district, (d) number of years providing mental health services, (e) number of years working in school settings, and (f) number of years working with youth (including both in and outside school settings).

Participants' responses to five questions contained in the questionnaire's third section, *Working with Suicidal Students,* were the main focus of this study.. Table 1 describes these five questions, response options associated with each question, and how each question aligned with specified research questions. Four of these five questions required participants to circle or check provided response options. One question (open-ended) asked participants to describe their reasoning underlying agreement or disagreement in regard to using NSCs.

Participants

Of the 326 MHPs attending Utah's annual Suicide Prevention Conference, 243 completed conference questionnaires (74.5% participation rate). Of the completed questionnaires, 229 were

completed by MHPs. Data from these questionnaires were analyzed for this study. The 14 questionnaires that were not included were completed by individuals who reported no prior experience working as an MHP (e.g., principal, teacher, or unemployed). These surveys were excluded from the study because this study focused on MHP's perceptions.

Of the 193 participants who reported their gender, 73.1% indicated they were females and 26.9% indicated they were males. Ages of participants ranged from 22–74 years of age (M = 43.35; SD = 11.61).

Of the 229 participants, 187 (81.7%) reported working in school settings and 42 reported not working in schools (18.3%). Those not working in school settings reported working in community agencies such as detention centers, foster care, youth treatment centers, etc. Of the 229 participants, 212 (92.6%) reported working with youth; 15 participants (6.6%) reported not currently working with youth and 2 (.9%) did not respond to this question.

For those working in school settings, the average number of years employed in school settings was approximately 12 years (M = 12.43, SD = 9.87 years). Participants who reported working with youth both in school settings and in community agencies reported working an average of 16 years (M = 16.10, SD = 10.59). Combined, all participants reported providing mental health services for an average of 10 years (M = 10.82, SD = 8.78).

Of the 229 participants, 222 reported a job title. These included the following titles: school counselor (n = 127, 57.2%); community-based counselor (n = 22, 9.9%); school psychologist (n = 21, 9.5%); administrator (n = 17, 7.7%); social worker (n = 16, 7.2%); *other* (n = 10, 4.5%); student (n = 6, 2.7%); teacher (n = 2, .9%); and psychologist (n = 1, .5%). Those listed as "counselors" indicated they worked with adjudicated youth, substance abuse programs, and community agencies serving youth in combined school and community settings. Those who

indicated “other” described themselves as professionals who provided youth support services in school and community agencies for adjudicated youth, foster care, substance abuse centers, and alternative education settings.

Table 2 summarizes the number and percentage of participants who worked with specific grade-levels of students. Numbers in this chart surpass 229 because some participants worked with several age groups. As indicated in Table 2, the majority of participants reported working with junior high and high schools students.

Additionally, participants were asked to identify the school district in which they worked. Of the 229 participants, 148 (64.6%) reported working in urban areas along the Wasatch Front; 44 (19.2%) reported working in rural areas; and 37 (16.2%) did not clearly specify where they worked, indicating counties rather than school districts or cities.

More than one-third (n = 86, 37.6%) of participants reported previously assisting in developing youth suicide prevention strategies or policies. On an individual basis, the majority of participants indicated previously working with suicidal youth (n = 196, 85.6%). The remaining participants either reported not working with SY (n = 23, 10.0%) or did not indicate a response (n = 10, 4.4%).

Coding MHPs’ Responses to Open-Ended Question

After indicating their level of agreement or disagreement with using NSCs when intervening with suicidal students, participants were asked to explain (in writing) their reasoning for agreeing/disagreeing with the use of NSCs. This open-ended question required participants to write a response. These handwritten responses were analyzed using content analysis (Gall, Gall, & Borg, 2007). The two primary authors, Hansen and Heath, took responsibility for coding participants’ comments. After initially reading and examining the written comments, initial

themes were further defined into six overarching categories. Each participant's comment was coded in at least one category. Comments were coded under multiple categories when multiple topics were addressed; therefore the number of comments exceeds the total number of respondents.

After comments were coded independently, inter-rater reliability was established using Cohen's *Kappa* statistic. A target level of inter-rater reliability was set at a .80 level of reliability, identified by Gall et al. (2007) as a minimum level of inter-rater reliability sufficient for most research purposes (p. 254). The inter-rater reliability was calculated using the cross tabs method from the Statistical Package for the Social Sciences (SPSS). When discrepancies in coding were noted between the two raters, consensus was reached following discussion. Prior to discussing discrepancies, inter-rater reliability for each category exceeded .84.

Results

Use of NSCs

Of the total sample ($N = 229$), 196 participants indicated previously working with SY. This means that the majority of MHPs (85.6%) intervened with suicidal youth. Of participants who intervened with suicidal youth, 99 (50.5%) made an NSC; 92 (46.9%) indicated not contracting with SY; and 5 (2.6%) did not respond. These data provide the basis for answering the first research question, *Do Utah's MHPs report using no-suicide contracts with youth who are suicidal?* In response, half of participating MHPs who intervened with SY utilized NSCs.

Awareness of Policy Regarding NSCs

Participants responded to two survey questions that aligned with the second research question: *Are Utah's Mental Health Professionals aware of existing policies regarding no-suicide contracts?* Regarding policies guiding the use of NSCs, participants were asked if their

school or district suggested or required using an NSC. If yes, the participants were asked to further identify the type of policy—whether it was formally written, generally assumed/unwritten, or if they were not sure. Of the 229 participants, 25 (10.9%) reported that their school or district suggested or required using NSCs; 58 (25.3%) reported that their school or district did *not* suggest or require using a NSC; a majority, 131 (57.2%) reported they were *not sure*; and 15 (6.6%) did not respond. Of the 25 participants who indicated their school suggested or required NSCs, eight reported having a formal written policy, 14 reported having a generally assumed/unwritten policy, and three were unsure as to the nature of the policy. Based on these data, in response to the second research question, over 80% of participating MHPs reported either being unaware of or not having a district policy that specified guidelines for implementing NSCs with SY. Only 3.5% (n = 8) of all participating MHPs indicated their district had a written policy regarding use of NSCs.

Opinions Regarding NSCs

Of 229 participants, 201 (87.8%) responded to the following question: *Do you agree/disagree with using no-suicide agreements/contracts when working with students who are suicidal?* Response options included numbers 1 through 5, anchored on the extreme ends with 1 indicating *strongly disagree* and 5 indicating *strongly agree*. Of the 201 participants who responded, 26 (12.9%) indicated disagreement with using NSCs, responding with a 1 or 2. In contrast, 103 (51.2% of 201 participants) indicated agreement with using NSCs, responding with 4 or 5: Half of respondents agreed with using NSCs when working with SY. Of the 201 respondents, 72 (35.8%) responded with a 3 on the Likert scale, reflecting uncertainty regarding agreement or disagreement with using NSCs.

These data provide the basis for answering the third research question, *When working with SY, to what extent do Utah's MHPs agree or disagree with using NSCs?* Participants' responses indicate that when intervening with SY, participating MHPs were more likely to agree with using NSCs ($M = 3.54$, $SD = 1.09$).

Reasons for Agreeing or Disagreeing with the Use of NSCs

Participants explained (in writing) their reasoning for agreeing/disagreeing with the use of NSCs. Of 229 participants, 177 (77.3%) offered explanations. The six overarching coding categories to describe participants' responses included: (a) trusting NSCs to keep students safe and students benefiting from structured guidelines of contracting; (b) following guidelines and previous practice that encouraged or discouraged the use of contracting; (c) building rapport and opening discussion regarding the student's suicidal thoughts and plans; (d) expressing the need for additional training and additional intervention options to more effectively respond to suicidal youth; (e) emphasizing individual student needs and evaluating benefits and drawbacks of contracting with each student; and (f) renaming the NSC to reflect positive action, rather than focusing on *not* completing suicide.

Trust in NSCs and benefits of structure. Participants often explained their agreement or disagreement by referring to personal perceptions of various aspects of contracting, with 75 of the 177 (43.3%) who offered explanations referring to this. In this category, participants shared positive perceptions of placing trust in contracts, increasing or placing responsibility on students for accountability, and committing to keeping agreements specified in NSCs. Participants expressed the benefits of contracts offering structure and a sense of direction to SY who lacked and desperately needed a sense of direction. More specifically, 61 participants referred to the benefits contracting offered SY, including increased trust, commitment, and accountability.

Beyond the structure provided for students, 21 participants explained that NSCs also offered structure and step-by-step directions for adults interacting with SY. When faced with the challenging situation of intervening with SY, several participants indicated that contracting clearly outlined what needed to be done.

Utilization of guidelines, policy, and practice. When explaining their agreement or disagreement with contracting, several participants referred to specific policy/guidelines (including legal implications), past research, best practice, and reliance on previous personal experience or inexperience with NSCs (n = 44, 24.9% of 177 who offered explanations). However, of these 44 participants, only 3 referred to a specific policy guiding their decision (school district policy and mental health professional guidelines); seven participants explained their reasoning for using or not using NSCs was based on legal implications; 17 participants referred to past research and guidelines supporting *best practice*. Additionally, as part of their explanation for supporting or not supporting NSCs, 20 participants included personal experience or inexperience with NSCs. Most evident in supporting NSCs was participants' perceptions of prior success with NSCs. Likewise, most evident in *not* supporting NSCs was participants' perceptions of prior difficulties and perceived lack of success when implementing NSCs.

Rapport and open communication. Another common theme related to the openness and quality of communication with SY. Of the 177 who offered explanations, 32 (18.1%) noted that NCSs offer a way to develop rapport and open communication with SY. Participants commented that NSCs helped facilitate open discussion about suicide, leading to students' perceptions of increased support and hope. Twenty-one participants explained either using or not using NSCs based on the potential to increase support for the SY. Six participants referred to the contract's potential to increase students' hope by identifying specific goals, and focusing on

the future. Six participants referred to the contract's potential for opening an honest discussion of suicide.

Additional training and increased options for intervention. Thirty-five of the 177 participants who offered explanations (19.8%) expressed a need for additional training and increased options for intervention with SY. Participants explained their ambivalence or disagreement with using NSCs by indicating a need for more information and training (n = 15). In addition to the NSC, participants expressed a need to expand intervention strategies to include more options (n = 20). Expressing a perceived lack of knowledge and training, participants' responses emphasized the need for increased training and a broader repertoire of treatment options to intervene more effectively with SY.

Student-centered approach. Participants explained their agreement or disagreement with using NSCs by emphasizing the importance of a student-centered approach (n = 21, of 177 who offered explanations, 11.9%). When deciding whether to implement an NSC, these participants explained the importance of taking into account the individual's uniqueness. More specifically, 15 of the 21 comments referred to the importance of carefully attending to unique student's needs, including cultural sensitivity. Participants cautioned not to rigidly use generic and impersonal contracts. When weighing in on a decision of whether to use the NSC, eight participants referenced the importance of attending to student impressions of contracting. These participants indicated that some students might respond positively and others might not. To determine if the NSC was something MHPs should pursue with a particular student, participants suggested attending to nonverbal cues and closely monitoring student's "buy in" during the process.

Negative connotation associated with the name no-suicide contract. Three participants suggested renaming NSCs (n = 3, 1.7% of 177 who offered explanations). One participant expressed that SY needed positive strategies and a "plan to live," rather than the NSC's negative slant, telling SY what they should *not* do (complete suicide). Two participants suggested renaming the NSC, suggesting the title, "safety plan."

Discussion

When working with youth, suicide prevention is a high priority for educators, school-based MHPs, and those working with youth in community agencies and services for adjudicated youth (Cash, 2008; Miller, Eckert, & Mazza, 2009; Walsh & Eggert, 2008). Although professionals routinely use NSCs and many supervisors and professional groups encourage this intervention as standard practice (National Association of School Psychologists, 2002; Sandoval & Zadeh, 2008), few studies have investigated the effectiveness of NSCs (Reid, 1998; Rudd, Mandrusiak, & Joiner, 2006). In particular, the research basis for implementing NSCs with adolescents is particularly limited (Garvey et al., 2009).

The most striking finding, over 80% of participating MHPs reported either being unaware of or not having a district or agency policy that specified guidelines for implementing NSCs with SY. Less than 4% of all participating MHPs indicated their district or agency had a written policy regarding the use of NSCs. Although the vast majority of participants were unsure of the policy, they tended to agree with using NSCs.

Half of those responding to SY implemented contracts. This prevalence rate is comparable to previous research conducted with 267 Minnesota psychiatrists, of which half reported intervening with NSCs (Kroll, 2000).

Limitations

It is recognized that this study may be affected by several limitations. Rather than drawing from a large, randomized sample, this study was conducted with a convenience sample of Utah MHPs who attended an annual suicide prevention conference. With this in mind, caution should be taken when generalizing this study's findings to other populations. In order to determine the prevalence and use of NSCs, other states should conduct their own research. Although some findings may be similar across states, each state would benefit from the specific information relevant to their unique needs and practice.

Another limitation, participants may have misunderstood survey questions, or may have interpreted meanings other than were intended. Additionally, the questionnaire's reliability was not established to assure that participants' responses were consistent across time or within the questionnaire across similar questions.

This questionnaire was designed to be completed in less than 20 minutes. Demographic information was limited. Because previous training related to suicide prevention/intervention and level of college education (college degree) were not included, results were not examined based on demographic factors that may have influenced level of training, experience, and perceptions of NSCs.

Additionally, the questionnaire did not describe context and risk factors associated with suicidal threat. This may have confused participating MHPs because decisions to implement NSCs may hinge on the perceived degree of suicidal risk (Lieberman & Davis, 2002; Sandoval & Zadeh, 2008, pp. 56-57). An improved survey would include descriptors of suicidal intent and the likelihood of carrying out a plan to complete suicide. This would assist future researchers in

determining at what level of risk MHPs may or may not recommend specific types of intervention.

Implications for Practice

Some practical implications emerged from this study. The evaluation of MHPs perceptions about NSCs can inform administrators about the potential barriers NSCs bring about. It also helps to inform administrators about the need for additional training, as current MHPs feel they lack in this area. Policy regarding SY in schools should be established and publicized for administrators, teachers, and other MHPs in the school to be aware of and follow that derive from research.

Practitioners need additional training. Based on written comments, participants expressed a need for additional training regarding the use of NSCs. This aligns with previous research indicating MHPs express both a lack of preparation and a lack of confidence in effectively intervening during crises, including incidents of suicidal threat (Allen, Burt, et al., 2002; Allen, Jerome, et al., 2002; King et al., 1999; McAdams & Keener, 2008). On the topic of suicide awareness training, Gibbons and Studer (2008) offer suggestions for involving school staff. They emphasize the importance of including annual updates and ongoing training, including role-plays and scenarios to offer opportunities to practice and observe applied knowledge and skills. Miller and Berman (2011) published an excellent resource with the Guilford Practitioner Series: *Child and Adolescent Suicidal Behavior: School-Based Prevention, Assessment, and Intervention*. They recommend using *commitment to treatment plans* rather than NSCs. This book's information should be carefully reviewed and considered when updating school crisis plans, more specifically suicide prevention sections of crisis plans. Additionally, professionals with extensive experience working with SY offer excellent

guidelines to intervene and protect SY (Brock, Nickerson, Reeves, Jimerson, Lieberman, & Feinberg, 2009, pp. 74–77).

Research must guide policy. Interestingly, several participants reported implementing NSCs because they perceived longstanding research supported this intervention as *best practice*. Opposing this reasoning, other participants claimed existing research did *not* support NSCs. These participants reported opting *not* to use NSCs because they believed contracting was harmful and lacked an evidence base to support its use. When initially coding participants' comments, researchers anticipated input regarding the need for more research to investigate effectiveness of NSCs. However, this need was not mentioned. It appears that MHPs may be entrenched in the status quo of *always doing what they've always done*. Reflecting the gap between research and practice, practitioners may not be in step with nor in search of new research regarding NSCs. Acknowledging this challenge in the trenches, school and agency policy regarding youth suicide prevention *must* stay abreast of best practice and research. Additionally, school and agency leadership must require and provide ongoing training on this critical topic, keeping all MHPs aware of and familiar with policy guiding practice.

Clearly specified policy must guide practice. Understanding and aligning with school, district, and agency policies and protocols is important for fluency and consistency of prevention and intervention efforts. One school psychologist, Leu (2008), emphasized the importance of school districts providing specific guidelines on how to intervene with suicidal students: "The time to figure these details out is not in the middle of the event; 'winging it' is a dangerous policy. Training should include regular review of these policies and procedures and how they are to be implemented" (Leu, 2008, p. 47).

An unclear or undefined policy regarding NSCs and responding to SY detracts from the effectiveness of suicide prevention, leaving professionals in a state of ambiguity regarding how to operate without a specifically defined *best practice*. When intervening with SY, this critical juncture of assisting youth in choosing life over death must be based on clearly defined protocol, not leaving professionals with the task of relying on personal assumptions regarding what they believe might be effective support.

MHPs need to know what is expected of them and how they should respond to SY. Specific steps for intervening with SY must be clearly documented in school crisis plans. This written policy must be readily available to all MHPs. Additionally (referring back to the importance of training), MHPs need training to become familiar with policy and to develop requisite skills for intervening with SY.

Policy must be updated annually and revision dates clearly identified on both electronic and hard copies. Old policies must be shredded and replaced with new updated copies. Follow-through is more likely to occur when one person is responsible for ensuring suicide prevention and intervention policies are updated and distributed.

Implications for Future Research

Expanding this research beyond Utah to include MHPs working across the U.S. would provide critical information to national organizations associated with school-based youth mental health services (e.g., the National Association of School Psychologists [NASP], the American School Counselor Association [ASCA], and the School Social Work Association of America [SSWAA]). These organizations could then provide MHPs with up-to-date, clearly defined protocol related to youth suicide prevention.

Regarding NSCs and other interventions to deter youth from completing suicide, future research may investigate perceptions of MHPs, SY, and parents of SY. In particular, researching perspectives of SY who previously engaged in NSCs would enlighten practitioners' understanding of better meeting the needs of this vulnerable population. SY who previously participated in NSCs could describe their personal experience, including their impressions of NSCs, the pros and cons of implementing this type of intervention, and the effectiveness of NSCs in deterring suicidal thoughts and behaviors.

Conclusions

Several primary findings were highlighted in this research. Connotations associated with formal no-suicide contracting are considered negative and ambiguous. Rudd et al. (2006) suggested NSCs be replaced with "commitment to treatment statements." For example, recently a revised military protocol moved away from implementing NSCs and recommended focusing on commitment to treatment statements. This assisted individuals in focusing on life and positive choices that encourage healthy living (Britton, Patrick, Wenzel, & Williams, 2011). Rather than depending on written NSCs, Miller and Berman (2011) also encouraged the use of commitment to treatment statements (p.105). The current professional trend is to focus on supportive plans rather than contracting *not* to kill oneself. However, because schools shy away from clinical terms (e.g., treatment) and must consider age appropriate language, those who work with SY may consider the term, *safety plan*.

Youth suicide prevention is a serious undertaking for mental health professionals, one that requires solid preparation and sufficient skills to intervene effectively when faced with the challenge of supporting SY. Training aligned with best practice must start in university training programs and national professional organizations, then extend into the school districts and then

the schools themselves. Additionally, national organizations must clarify expectations for MHPs' response. National organizations' websites and materials must be updated to reflect policy change regarding NSCs: These websites must offer current guidelines and structure for professionals who depend on this guidance. Though the opinions regarding the effectiveness of NSCs were divided, the opinions regarding the need for training were not. The majority of those surveyed agreed that with more training, they would be more successful in utilizing NSCs and other resources with the youth they work with to help.

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Table 1

Working with Suicidal Students: Research Questions' Alignment with Survey Questions and Response Options

Research questions	Survey questions	Response options
Do Utah's MHPs report using no-suicide contracts with youth who are suicidal?	1. Have you made a "no-suicide agreement/contract" with a student? (Also referred to as safety plan, no-suicide agreement/contract, no-harm agreement/contract, etc.)	*Yes* or *No* (circle response)
Are Utah's MHPs aware of existing policies regarding "no-suicide" contracts?	2. Does your school or district suggest or require using a no-suicide agreement/contract?	*Yes, No, Not Sure* (circle response)
	3. If yes (to question #3), describe the policy:	*formally written; generally assumed/unwritten; not sure* (circle response)
When working with suicidal youth, to what extent do Utah's MHPs agree or disagree with using "no-suicide" contracts?	4. Do you agree/disagree with using no-suicide agreements/contracts when working with students who are suicidal?	5-point Likert scale anchored with *Strongly Disagree* (1) and *Strongly Agree* (5)
What reasoning underlies their agreement or disagreement in regard to using "no-suicide" contracts?	5. (referring to question #4) Explain your reason for agreeing/disagreeing.	Open-ended, write in response

Table 2
Number and Percent of Participants Working with Specific Grade Levels of Students

Grade level	Participants	
	n[a]	Percent of total group[a]
Preschool	13	5.7
K-6th grades	60	26.4
7th-8th grades	119	52.4
9th-12th grades	168	74.0
NA (did not work with youth)	15	6.6

Note. $N = 229$.
[a]Summed column of numbers exceeds 229 and percentages exceed 100% because several participants worked with multiple age groups.

APPENDIX A

Review of Literature

Voicing medical and mental health professionals' sentiment, Weiss (2001) stated, "The management of the suicidal patient is one of the greatest clinical challenges facing mental health professionals" (p. 414). The impact of youth suicide is far reaching, spreading beyond the immediate family, friends, teachers, and communities. All involved question what they might have done to prevent this tragic loss of life.

Youth Suicide Prevalence Rates

Suicide is the third leading cause of death for youth, 15 to 24 years of age (Centers for Disease Control and Prevention, 2011). The American Foundation of Suicide Prevention (AFSP, 2010) reported that each year more than 100,000 adolescents complete suicide. In the U.S., suicide ranks as the third leading cause of adolescent and young adult deaths (National Institute of Mental Health, 2011).

Tragically, youth suicide attempts and completions have increased drastically over the past 60 years, increasing over 300% (Berman, Jobes, & Silverman, 2006; Capuzzi, 2002). More specifically, in the U.S., 14 adolescents, aged 15 to 24, complete suicide each day—one adolescent suicide every 100 minutes (National Institute of Mental Health, 2011). In addition to those adolescents who complete suicide, based on a nationwide survey of youth in grades 9-12, the Centers for Disease Control and Prevention (CDC, 2011) reported that 15% of high school students reported seriously considering suicide, 11% created a plan for suicide, and 7% attempted suicide.

From an international perspective, 7.4 per 100,000 of youth aged 15-19 years old completed suicide each year (Wasserman, Cheng, & Jiang, 2005). Youth suicide is very critical

topic, described by medical and mental health professionals as a major public health problem (Gould, Shaffer, Fisher, Kleinman & Morishaima, 1992; National Institute of Mental Health, 2011). This description leads a call for action, placing a greater emphasis on preventing youth suicide. In particular, the call for action is felt among practicing school-based mental health workers. This call is especially urgent for those working in secondary schools because in comparison to younger children adolescents are at a greater risk for completing suicide.

Training for Suicide Prevention and Intervention

In 2008, the American School Counselor Association (ASCA) developed a suicide awareness training model for school counselors. ASCA leaders explained that because suicide was so prevalent among school-aged youth, school personnel have an obligation to take action, doing whatever possible to prevent suicide from occurring. Curriculum-based programs for students, faculty and staff in-service training, and school-wide screenings to identify students at risk are cited as ways to help prevent suicide (ASCA, n.d.; Gibbons & Studer, 2008). ASCA's website urges school counselors to take the lead in offering suicide prevention programs and assisting school faculty and teachers to more effectively address this important issue.

One such program to assist school personnel in identifying suicide risk factors is a warning sign-training program. To increase suicide awareness, common risk factors should be clearly identified and understood by school staff. In addition to school counselors increasing their own personal knowledge about suicide prevention, they are charged with the responsibility of educating their school's staff and administration.

The National Association of School Psychologists (NASP) currently supports a school-based suicide intervention (NASP, n.d.). The model first discusses the idea of assessment—identifying warning signs, determining if a student has thought about suicide, determining if the

students has a plan to carry out their intentions, and understanding the available support system surrounding the student. Next, they explain that it is the duty to warn parents when a child is at risk for suicide. After this action is taken, the next duty is to refer families to agencies that can further support the suicidal student. Finally, NASP explains that it is vital for school psychologists and counselors to follow up and support the family. NASP also supports the use of no-suicide contracts with students at risk for suicide (NASP, n.d; NASP, 2002).

No-Suicide Contracts

In professional literature, no-suicide contracts are referred to by a variety of terms. Most commonly we see these written contracts referred to as *no-suicide contracts* (Buelow & Range, 2000; Drew, 1999; Farrow & O'Brien, 2003; Kelly & Knudson, 2000; Weiss, 2001). They are also seen in the literature as *no-suicide agreements* (Davidson & Range, 2000; Davidson, Wagner, & Range, 1995; Myers & Range, 2002); *no-harm contracts* (Stanford, Goetz, & Bloom, 1994); *contracting for safety* (Egan, 1997); *suicide-prevention contracts* (Assey, 1985; Miller, 1999); and *no-suicide decisions* (Centre for Suicide Prevention, 2002; Drye, Goulding, & Goulding, 1973).

Throughout the remainder of this paper, the contract will be referred to as a no-suicide contract (NSC). A NSC bilaterally commits a client toward the avoidance of his or her self-destruction. The contract usually explicitly states that the client agrees not to kill or harm him or herself in any way. After this statement, a timeframe is usually decided upon between the client and therapist, counselor, or physician during which the client agrees to abstain from killing or harming him or herself in any way. Following these statement, phone numbers are typically listed for the client to call in the event of suicidal feelings or ideation. Additionally, the individual and therapist outline a plan of action, offering guidance and support to further protect

the individual from harming themselves. After the aforementioned ideas are discussed and written into the NSC, the client and clinician sign the document, agreeing to the previous statements. Following the initial signing of the NSC, the document is copied. Both clinician and client keep a copy (Buelow & Range, 2000).

Although NSCs may be verbal or written, Drew (2001) suggested that verbal contracts were less effective. One reasoning for this variance in perceived effectiveness is that verbal contracts may not be as consistent across situations. While written contracts are typically more consistent across situations, written contracts are still unique to the situation and setting. Because specific clients call for specific actions in the event of suicidal ideation, the wording of each contract is individual and unique, reflecting the client's needs.

Assey (1985) explained an important aspect of no-suicide contracting: Clients should make the contract. The contract is made **to** him or herself, **by** him or herself, and **for** him or herself. It is important for the client to take ownership and responsibility for his or her own suicide prevention. This ownership may help the client take the contract more seriously, and may help the client avoid suicide attempts or completion.

Alternatives to No-suicide Contracts

After reviewing literature on the use of NSCs, Rudd, Mandrusiak, and Joiner (2006) proposed, as a practice alternative, to encourage commitment to treatment statements. These statements are somewhat similar to NSCs, but more positive in that students are encouraged to commit to life (as opposed to stating they will not kill themselves). Although professionals report using NSCs and professionals encourage this intervention as a standard practice, few studies have investigated the contracts' effectiveness. Over the course of their research, Rudd et al. (2006) found no solid empirical evidence supporting the effectiveness of NSCs. They proposed

common terminology across professions and voiced concern regarding the use of the term *contract* in *no-suicide contract*.

Additionally, Rudd et al. (2006) proposed the use of *agreements* as part of the clinical intervention with suicidal youth, and that these agreements should be part of a broader treatment plan. To replace the term no-suicide contract, Rudd et al. suggested *commitment to treatment statement* (CTS; p. 247). The CTS would be an agreement between a patient and clinician, where the patient agreed to commit to a treatment process that included the choice to live. Basically, the client's focus was on living rather than dying. Furthermore, the CTS would include roles, obligations, and expectations of both clinician and patient. The plan was based on open and honest communication about all aspects of treatment and included a list of identified emergency services to access during times of crisis. The basic difference is that the CTS offers a more positive approach to working with an individual at risk for suicide. Instead of merely eliminating the option of suicide, the individual, instead, commits to living.

Medical Profession's Perceptions of No-Suicide Contracts

Psychiatrists. The American Psychiatric Association (APA) briefly discusses the use of NSCs in a 2003 article titled "Practice guideline for the assessment and treatment of patients with suicidal behavior." In this article, APA recommended the use of NSCs with clients who are suicidal and have an established ongoing therapeutic relationship with the therapist or doctor. No-suicide contracts are not recommended in emergency settings with unfamiliar clients. Further, the article explains that NSCs are a small part of an overall suicidal assessment and should never be used as the only tool for assessing suicidality and intervening with a suicidal client.

In a survey of 267 psychiatrists in Minnesota, half used NSCs and half had not used them in their work. Of this half who used NSCs, 41 percent of these psychiatrists had patients who completed suicide or who had made serious attempts to do so while under the NSC (Kroll, 2000). The study may have some sampling bias because data received came only from anonymous responders (Kroll, 2000).

Nurses. In hospitals that use NSCs, nurses are the staff members that typically negotiate the contract (Drew, 1999). Egan (1997) explains that using NSCs in the nursing field has become so commonly used that it is integral to all nursing assessments. Oftentimes nurses make a NSC with a patient rather than use their own assessments (Farrow, 2002). Farrow (2002) explains that NSCs are used because nurses believe them to be beneficial, but on many occasions they are used counter to clinical judgments of nurses. In the study conducted by Farrow, the most prevalent theme for why NSCs were used was that it was a way for nurses to protect themselves legally. Other reasons for using NSCs with patients, rather than use their own nursing assessments were to relieve the nurse's anxiety. When questioned if they had received any formal training in the use of NSCs, most often nurses answered that they did not receive any formal training, and assumed it was a procedure doctors came up with that would be effective with their patients (Farrow, 2002). A limitation of the 2002 study by Farrow are that the presented results are from a small-scale study in a single city in New Zealand, with transferability of results unknown.

Physicians. In a descriptive study from 1999, Drew found that NSCs were used by 79 percent of hospitals surveyed—66 out of the 84 hospitals. These contracts were typically completed after suicide ideation was expressed, after suicide attempts or self-harming behaviors. The results of this study suggest that NSCs are used widely in the physician settings.

Frighteningly, Miller, Jacobs, and Gutheil (1998) found through a survey of 112 psychiatrists and psychologists that most had not received any formal training in the use of NSCs, although they still make NSCs.

School Professionals' Perceptions of No-Suicide Contracts

National Association of School Psychologists. NASP refers to NSCs in a positive light. As seen in "Times of tragedy: Preventing suicide in troubled children and youth, Part II, NASP (n.d.) outlines eight tips for school personnel or crisis team members to refer to when working with a student who shows an increased risk of suicide. Tip number five, out of the eight, specifically refers to NSCs. NASP explains that NSCs have been shown to be effective in preventing youth suicide. However, this statement is not referenced or documented by empirically based studies or research. NASP, in no way, explains how or where NSCs have been shown to be effective in any way.

NASP further suggests that in cases with students whose suicide risk is assessed to be low, a NSC still be used with the student. They explain that this contract specify recommended alternatives for the student should their risk of suicide increase. NASP goes on to explain that these contracts can be used as an assessment tool to gauge students' suicidal levels. They explain, "If a student refuses to sign, they cannot guarantee they will not hurt themselves. The assessment immediately rises to high risk" (NASP, ¶XX). NASP then further supported NSCs by saying that these contracts have been shown to be effective and refers to usefulness, with no research base to substantiate their claims.

UASP. The Utah Association of School Psychologists (UASP) makes no mention either for or against no-suicide contracting. They do, however, aim to serve schools and the surrounding communities by promoting education, rights, welfare and the mental health of the

children and families they serve. UASP does this through supporting services related to prevention, collaborative consultation, assessment, intervention, advocacy and policy development (UASP, n.d.).

School Counselors (ASCA). The American School Counselors Association (ASCA) supports school counselors across the nation in their collective efforts to help students focus on academic, social and personal growth. Along with this, ASCA also aims to support school counselors and their efforts to encourage students' career development to achieve success in school and become responsible, caring members of society (ASCA, n.d.) ASCA explains that professional school counselors play an important role in emergency prevention and preparedness in schools, especially with suicide. They support the ideas of student suicide prevention and intervention and encourage this through suicide awareness trainings. ASCA makes no specific mention to using NSCs with students in high school.

Evidence Supporting Use of No-Suicide Contracts

Most authors would attribute the use of NSCs to a study by Drye, Goulding, and Goulding (1973) that states that the method of suicide contracting can be used by anyone to evaluate a person experiencing suicidal thoughts. The authors further explained that the method helps to make accurate plans with a suicidal patient as well as remove an emotional burden from the evaluator. An evaluator will ask the patient to make the statement: "No matter what happens, I will not kill myself, accidently or on purpose, at anytime" (Drye et al., 1973, pg. 172). If the patient can report this statement with confidence, the evaluator may dismiss suicide as a major problem. On the contrary, if a patient cannot or will not make the statement, they are deemed suicidal. The study associates NSCs with a decrease in suicide attempts and completions. Drye, Goulding and Goulding reported that out of the 600 patients that had made NSCs, there was not a

single suicide completion during the duration of the contracts. These results, and this study, cannot be generalized or duplicated because the study did not provide details about the study sample, methods, or specific criteria used.

Most often NSCs, when discussed in a positive light, refer to the benefits of contracts as assessment tools, and also as contracts as interventions. When assessing a client's suicide risk, Miller, Jacobs, and Gutheil (1998), explain that a client who refuses to agree to a NSC clearly has a high risk of suicide and the refusal is a clear warning sign for the clinician. This explanation that refusal to sign a NSC results in high-risk of suicide is not necessarily accurate. Many people may not wish to sign a NSC because they do not understand what the contract is or they may feel as if their clinician does not truly care for their well-being so signing a contract with them would do no good.

On an intervention standpoint, NSCs include specific steps that a client promises to take before attempting suicide. These outlined steps may be helpful with a suicidal client who feels too overwhelmed to think of proper alternatives by themselves (Myers & Range, 2002). From a legal standpoint, NSCs can be apart of documentation done to demonstrate a clinician's efforts to manage suicidal impulses (Myers & Range, 2002). The contracts however do not protect a clinician from malpractice in the event of a suicide.

Another potential benefit of NSCs is that the contract serves as a means to reduce anxiety of both the patient and the therapist (Davidson, Wagner & Range, 1995). NSCs allow for a therapist to openly talk about the sensitive subject of suicide with patients. This open conversation can ease many fears a patient and therapist had previously about discussing suicide.

Range et al. (2002) explain that "no-suicide contracts behaviorally help clients commit to positive action" (page 53). The contracts, behaviorally, help a client commit to specific actions

that are inconsistent with the actions associated with suicide. Range et al. (2002) goes on to explain that NSCs may allow for deeper communication and understanding to occur in a therapy setting. A possibility of initiating and developing the therapeutic relationship can be achieved through the use of NSCs (Drew, 1999; Range et al., 2002, Stanford et al., 1994). At-risk clients may believe that a therapist who would ask them to sign a NSC genuinely empathizes with their particular situation and is concerned about their safety (Range et al., 2002).

Evidence Against Use of No-Suicide Contracts

Clark and Kerkhof, in 1997, discuss NSC use comparing it to a soccer player that wears his jersey inside out, to every game, believing it helps the game. When asked why the soccer player was doing this, or why a counselor would use a NSC, the answer is the same: "Because my team-mate/therapy supervisor told me it would" (page 2). No-suicide contracting seems to be done out of tradition. Kelly and Knudson (2000) explain that *no* empirical evidence exists about NSCs and their effectiveness. No-suicide contracts, for the most part, are imagined to be effective, rather than basing the effectiveness on empirical data. In 2000, Davidson and Range studied the attitudes of 368 psychologists in using NSCs with children. From the study, NSCs were moderately to strongly indicated as an appropriate treatment intervention. The contracts, however, were only mildly to moderately indicated to be effective in preventing suicide. Important to note is that the study used vignettes to obtain information from the 368 psychologists, rather than actual clinical situations. Actual practice, Lewis (2007) says, is often played out differently than in hypothetical situations.

Kroll (2000) suggests that NSCs are often used to avoid legal issues regarding responsibility and suicide, rather than for genuine concern of patients. The therapeutic relationship that is developed and nurtured over the course of treatment can be stagnated by

pressuring a patient into agreeing to a NSC. A patient would be aware of the pressure and see that the concern was not genuine when working with a clinician who would pressure a client into signing a NSC. The therapeutic relationship is often referred to as the most important part of working with individuals in a therapy setting, so affecting this relationship negatively in anyway should be avoided. Often, administratively, NSCs are used to protect oneself against a malpractice lawsuit. These contracts, however, are not legally binding, since they are not a form of legal document (Miller, 1999; Stanford et al., 1994). When used to protect against malpractice, the individual receiving treatment may understand that the clinician does not genuinely have concern for him or herself and begin to withdraw from the relationship. No-suicide contracts should not be used as an obligatory risk management tool, so as to avoid harming the tender relationship between clinician and client.

A retrospective review of medical records, to example how no-suicide contracting affected likelihood of self-harm behavior in psychiatric inpatient settings, by Drew (2001) explains that there is a need for a thorough, and ongoing, assessment of suicide risk when a NSC has been signed. In the study, 31 patients had been engaging in self-harming behaviors with approximately half expressing suicidal intent. Twenty of these patients had signed a NSC. Drew (2001) suggests, then, that there is no evidence in the sample that NSC use prevented self-harm or suicidal behavior.

A potential limitation of NSCs is that they are used to reduce a therapists' anxiety, rather than benefit the patient (Davison, Wagner, & Range, 1995). Davidson, Wagner, and Range explain that these contracts are often used to quell the anxiety of a therapist in working with someone at risk for suicide. By making the contract, the therapist may feel as if they did something to help their patient. Sometimes, the NSC can even be used in substitute of actually

forming a positive therapeutic relationship (Davidson, Wagner, & Range, 1995). He warns that this behavior should be avoided, as it cannot only damage any relationship existing between therapist and patient, but also cause further harm to the patient. Range et al. (2002) explain that using NSCs can often convey the idea to clinicians that they have completed suicidal assessment with their client. However, Range et al. explain further that NSCs are not a substitute for thorough assessment and should not be used as such.

Another disadvantage of NSC use is that a client may believe the therapist is only concerned with safeguarding against liability, rather than used as a part of an overall treatment plan (Clark & Kerkhof, 1997; Miller, 1999; Range et al., 2002; Stanford, Goetz, & Bloom, 1994). Doubt in a therapists' concern about a client would lead to negative feelings between client and therapist. Clients may then become distant and reluctant to be honest in sessions with the therapist. Further, a client may feel pressure to sign a NSC in order to continue receiving any treatment services. Miller (1999) explains that clients, who have signed NSCs, may feel as if they have failed if they continue to have suicidal thoughts. This feeling of failure may lead to depression and an increase in suicide risk.

Along with the previously discussed cons to NSCs, the most compelling and poignant argument may be that there is no empirical evidence that demonstrates their effectiveness (Drew, 2001; Farrow & O'Brien, 2003; Miller, 1999). On the other end, there is some evidential documentation that demonstrates NSCs as being harmful. In 2001, Drew found that patients with signed NSCs were five times more likely to make suicide attempts, than those without the contracts. Miller, Jacobs, and Gutheil (1998) noted that the inclusion of signed NSCs were commonly included in the medical records of individuals who had completed suicide.

McMyler and Pryjmachuk (2008) aimed to answer the question: Do no-suicide contracts work? The pair studied 23 papers and articles—ten described empirical research, and thirteen were opinion-based papers. Based on the research and literature review conducted by McMyler and Pryjmachuk, they concluded that "any potential benefits associated with [no-suicide contracts], such as ensuring that inpatients are checked on, and facilitating the exploration of suicidal thoughts, can be achieved by other means, without resorting to using a tool that is, at best, ineffective and, at worst, harmful" (page 520). They expressed that any benefit from no-suicide contracting could be achieved through a more positive approach. They suggested that by avoiding potential harmful effects of no-suicide contracting, positive therapeutic relationships and genuine care for individuals would lead to more substantial benefits that those purported by no-suicide contracting.

No-suicide Contracts in Colleges and High Schools

Colleges. In a 2000 study, Buelow and Range evaluated the use of three NSCs with college students differing in length and specificity. The students surveyed preferred the most detailed version of a NSC, to simple or moderately detailed contracts (Buelow & Range, 2000). In this study, undergraduates with a background of having contemplated suicide in the past, and undergraduates without these contemplations reported similarly to the Likert-scaled questions. Further, no differences were seen between women and men, European Americans and African Americans, or between those who have had counseling and those who have not. On average, each of these groups reported that a more detailed NSC was more effective in stopping suicidal thoughts, feeling more cared for, lessening depression, giving hope and offering the individual more control (Buelow & Range, 2000). A limitation of this study would be that the study did not

offer an option for undergraduates to decide they would prefer not to use a NSC at all. The study focused on a decision between three given contracts, instead.

High Schools. Myers and Range (2002) surveyed high school students about a hypothetical situation involving a student with suicidal thoughts. Ninety-six Caucasian and African American students were randomly assigned to read one of two vignettes about a 15-year-old adolescent at risk for suicide. In one vignette Jamie met with a psychologist for therapy, and in the second vignette Jamie and the psychologist also completed a NSC together, along with therapy. The students rated their attitudes about the intervention done with Jamie, and students viewed the use of NSC with therapy more positively, than therapy without the NSC. While the high school students viewed the use of NSCs positively, their endorsement was lukewarm (Myers & Range, 2002).

Paucity of Research

While suicide is the third leading cause of suicide among adolescents, it is also the most preventable death. Mental health professionals working with youth in schools face the responsibility of preventing suicide completion from taking the lives of the students they work with. Through extensive research on the topic, an area where no-suicide contract use has not been discussed is in the realm of school psychologists, school counselors, and other mental health professionals working with suicidal youth, particularly in school settings.

The perspectives and perceptions that mental health professionals, who work with youth in schools, have has not yet been explored in the literature. This insight will expand knowledge about NSC use with youth in a school setting. The review of literature on the topic of no-suicide contracting with youth has led to the following relevant research questions.

Research Questions

1. Do Utah's Mental Health Professionals report using no-suicide contracts with youth who are suicidal?

2. Are Utah's Mental Health Professionals aware of existing policies regarding no-suicide contracts?

3. When working with youth who are suicidal, to what extent do Utah's Mental Health Professionals agree or disagree with using no-suicide contracts?

4. What reasoning underlies their agreement or disagreement in regard to using no-suicide contracts?

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APPENDIX B

SUICIDE PREVENTION SURVEY

Demographics:

Male Female **(circle one)**

Your age (in years) _____

Job title: _____ School District _____

_____ Total # years of service in mental health
_____ Total # years of service in school setting
_____ Total # years of service working with youth (in & outside school settings)

Circle all that apply Which age group/s do you currently work with?

Preschool K -6 grades 7 -8 grades 9 -12 grades NA, I do not work with youth

Circle answer
Yes No Have you assisted in developing suicide prevention strategies or policies for youth?
Yes No Have you worked with a suicidal youth?

What items should be included in Utah's State Suicide Prevention Manual?

Topic	Should the topics below be included in a manual? *Circle yes or no*		IMPORTANCE OF CONTENT *Circle one* *least important to most important*					
	YES	NO						
Suicide Information								
Prevalence of suicidal ideation	YES	NO	0	1	2	3	4	5
Suicide facts	YES	NO	0	1	2	3	4	5
Suicide myths	YES	NO	0	1	2	3	4	5
Suicide statistics	YES	NO	0	1	2	3	4	5
Suicide Prevention								
Causes and prevention strategies	YES	NO	0	1	2	3	4	5
Triggers	YES	NO	0	1	2	3	4	5
Risk factors	YES	NO	0	1	2	3	4	5
Warning signs	YES	NO	0	1	2	3	4	5
How to ask questions about suicide (with students)	YES	NO	0	1	2	3	4	5
Research-based best practices in school suicide prevention/intervention programs	YES	NO	0	1	2	3	4	5
Parent info: What parents need to know about preventing suicide	YES	NO	0	1	2	3	4	5
Teacher/staff info: What teachers/staff need to know about preventing suicide	YES	NO	0	1	2	3	4	5
Following a Suicide								
How to intervene after a suicide	YES	NO	0	1	2	3	4	5
Steps to dealing with a school suicide	YES	NO	0	1	2	3	4	5
What not to do after a suicide	YES	NO	0	1	2	3	4	5
Examples of school letters for school & home following a suicide	YES	NO	0	1	2	3	4	5
Info for parent: What to do following a suicide	YES	NO	0	1	2	3	4	5
Info for teacher/staff info: What to do following a suicide	YES	NO	0	1	2	3	4	5
Information and Support								
Resources – where to go for support/help (internet)	YES	NO	0	1	2	3	4	5

Where to get help in Utah: agencies, referrals, and support	YES	NO	0	1	2	3	4	5
Special Topics Related to Youth Suicide								
How to support GLBTQ youth	YES	NO	0	1	2	3	4	5
Bullying harassment	YES	NO	0	1	2	3	4	5
Drug and substance abuse	YES	NO	0	1	2	3	4	5
Male - female differences	YES	NO	0	1	2	3	4	5
Ethnic groups (e.g., Native American)	YES	NO	0	1	2	3	4	5

List other topics that you think should be included in Utah's State Suicide Prevention Manual?

Organizational Factors								
Developing/strengthening school's crisis team	YES	NO	0	1	2	3	4	5
Coordinating responsibilities with principal	YES	NO	0	1	2	3	4	5
Collaborating with community professionals	YES	NO	0	1	2	3	4	5

Working with Suicidal Students

1. When working with suicidal students, what are the things that you do/say? (write your response)

2. YES NO Have you made a "no-suicide agreement/contract" with a student? (Also referred to as safety plan, no-suicide agreement/contract, no-harm agreement/contract, etc.)

3. YES NO NOT SURE Does your school or district suggest or require using a no-suicide agreement/contract?

4. If yes (to question #3), describe the policy:
____(a) formally written; ____(b) generally assumed/unwritten; ____(c) not sure

	Strongly Agree				Strongly Disagree
5. Do you agree/disagree with using no-suicide agreements/contracts when working with students who are suicidal?	1	2	3	4	5

6. Explain your reason for agreeing/disagreeing.

If interested in sharing further comments, please list your current contact information:
Name: _____ E-mail _____

Phone number: (____)_____

THANK YOU! Primary contact: Melissa Allen Heath, Ph.D., Associate Professor <melissa_allen@byu.edu>
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