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

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ABSTRACT

Commonly used in clinical and medical settings, no-suicide contracts (NSCs) solicit commitment from suicidal individuals *not* to attempt suicide. The prevalence of Mental Health Professionals' (MHPs) use of NSCs with suicidal youth (SY) is unknown. Additionally, minimal feedback is available regarding MHPs' percpetions of and current practice implementing NSCs. Likewise, school policy directing intervention with SY is neither well described nor clearly understood. Of 326 individuals attending Utah's Youth Suicide Prevention Conference, 243 individuals completed questionnaires (74.5% participation rate) assessing perceptions and current practice related to NSCs. Of these questionnaires, 229 were completed by MHPs and included in data analysis. When intervening with SY, half of participants reported using NSCs. However, only 3.5% of participants (n = 8) reported knowledge of formal *written* school district policy that offered guidelines for implementing NSCs. Implications for clearly specifying policy to guide interventions with SY are discussed.

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

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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, the cause of injury or death 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 ninth 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 desperate 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 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, nonetheless 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 self in any way. After this statement, a specific timeframe 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, offering 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 given to the individual and one copy to the MHP (Buelow & Range, 2000; Poland & Lieberman, 2002).

Evidence base for NSCs. Similar to pulling the curtain and revealing the Wizard of Oz—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. 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

Although suicide is the third leading cause of death among youth ages 10-24, it is preventable. MHPs working with SY are challenged to identify the seriousness of a student's suicidal intent; determining the student's emotional stability and degree of hopelessness; assessing whether or not the student has a plan to inflict self-harm; and deciding 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

The following questions were identified to help identify and describe Utah's MHPs' perceptions and practices related to NSC's 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

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, this questionnaire was approved by Brigham Young University's Institutional Review Board (IRB) committee. 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).

This study focused on participants' responses to five questions contained in the questionnaire's third section, *Working with Suicidal Students.* 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 a 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.

Almost 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, Borg, & Gall, 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 a 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 a 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 Underlying 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 (*n* = 75, 43.4% of 177 who offered explanations). Participants often explained their agreement or disagreement by referring to personal perceptions of various aspects of contracting. In this category, participants shared positive perceptions of placing trust in contracts, increasing or placing responsibility on students for accountability and commitment 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.

Guidelines, policy, and practice (*n* = 44, 24.9% of 177 who offered explanations). When explaining their agreement or disagreement with contracting, several participants referred to specific policy/guidelines (including legal implications), past research, best practice, and relying on previous personal experience or inexperience with NSCs (*n* = 44). 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 (n = 32, 18.1% of 177 who offered explanations). Another common theme related to the openness and quality of 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 (n = 35, 19.8% of 177 who offered explanations). 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 (n = 21, 11.9% of 177 who offered explanations). Participants explained their agreement or disagreement with using NSCs by emphasizing the

importance of a student-centered approach (n = 21). When deciding whether to implement a 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.

Rename no-suicide contract (n = 3, 1.7% of 177 who offered explanations). Three participants suggested renaming NSCs. 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 which 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 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

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

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. 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).

Understanding and aligning with school, district, and agency policies and protocols is important for fluency and consistency of prevention and intervention efforts. 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. 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 when one person is responsible for ensuring suicide prevention/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 percpetions 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

In particular, 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." An example of this change, recently 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 trenches. 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.

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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.