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Suicide Prevention for High Risk Persons Who Refuse Treatment

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Introduction

A clinical dilemma is posed by persons who are recognized as a high risk for suicide and who refuse to accept a treatment program. A wide range of patterns is represented in this group, one common element being a desire for assistance but an inability to accept it due to the special implications it has for the individual involved.

In some instances involuntary procedures are used to resolve this dilemma, but it is often impractical, illegal or therapeutically undesireable to employ such measures. In an effort to develop an effective alternative, our focus has been on the following considerations:

1) The forces that bind us willingly to life are mostly those exerted by our relationships with other people, whether they be intimately involved in our lives or influence us by other psychological processes.

2) A suicidal person can be encouraged to retain an interest in continued living, by regular and long-term contact with another person who expresses caring and concern about the former's well being.

3) The contact must be initiated by the concerned person and must put no demands or expectations on the other, in order to be experienced as an expression of unconditional concern and to have potential for reducing feelings of isolation and helplessness.

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4) Such a program of continuing contact can exert a long term suicide prevention influence on high risk persons who cannot accept the established health care system.

Our goal has been to devise and test a suicide prevention program, based on these considerations, which effectively addresses the long term patterns of persons who decline traditional forms of treatment, can be applied to a large population, and requires minimal input of personnel, space and funds. Prior discussions of this effort (1,2) outlined the earlier phases of the project, which the present report recapitulates and brings up to date.

Method

During the period 1968 - 1974, 3,006 persons, admitted to nine psychiatric in-patient facilities in San Francisco because of a depressive or suicidal state, were identified as a high-risk population for subsequent suicide. Each person was interviewed at length for a detailed psychosocial evaluation by a project assistant with special training, experience and interest in suicide. The subjects were subsequently divided into a "treatment" group, comprised of those who continued their therapy program for at least one month after discharge from the hospital, and a "no treatment" group made up of those who declined post-discharge treatment or dropped out in less than a month.

"No treatment" subjects were then randomly divided into two subgroups, designated "contact" and "no contact". Subsequent procedures were directed to the "contact" subjects only, with no further active inquiry involving the "no contact" or the "treatment" subjects.

Contact subjects were started on a schedule of regular communications from the research staff member who interviewed them in the hospital. This was usually in the form of a short letter, or at times a telephone call. The

contact was simply an expression of concern that the person was getting along all right and inviting a response if they wished to send one. The letters were always individually typed and included responses to comments from the subjects if such were received. An example of a contact letter would be:

Dear _____,

It has been some time since you were here at the hospital, and we hope things are going well for you. If you wish to drop us a note we would be glad to hear from you.

Sincerely,

With this approach we believe it is important to avoid anything in the nature of gathering test data, or requesting information or action of any kind. By so doing we hope to emphasize that our interest is simply and entirely to let the person know that we remain aware of their existence and maintain positive feelings toward them. One such note is not expected to have much impact, but the cumulative effect of repeated contacts of this kind for months or years is postulated as having the potential for considerable psychological force.

The schedule for these contacts is monthly for four months, then every two months for eight months, and finally every three months for four years -- a total or five years and twenty-four contacts.

The extent to which a suicide prevention influence may be exerted by the program is most simply measured by the difference in suicide rates between the "contact" and "no contact" subjects, the latter serving as a control group. Data about mortality is obtained from the California State Department of Health, coroner's records, death certificates, clinical sources and information from family members and others. The influence on such self-destructive patterns as

suicide attempts and alcohol or drug abuse are not being considered at this time.

Results

In addition to the "treatment", "contact" and "no-contact" categories, several other subgroups emerged, as follows:

Undetermined - Treatment status one month after discharge not available after at least three inquiries and checking collateral sources. Letters not returned by the Postal Service.

Lost - Unable to locate subject; letters returned by the Postal Service.

Suicide before discharge from inpatient unit.

Suicide less than 30 days after discharge.

Non-suicidal death less than 30 days after discharge.

These circumstances precluded the determination of whether the person was a "treatment" or a "no treatment" subject by the project design, hence are listed separately. The overall distribution of subjects is indicated in Table 1.

Table 1 Here

The "contact" subjects also developed variants which require mention. As might be anticipated, a number of these subjects were lost before the five year period elapsed, the contact experience varying from zero to fifty-eight months duration. In order to simulate the results that would be obtained by a mental health facility as closely as possible, once randomly assigned to the "contact" group a subject

was retained in this category regardless of subsequent course. The distribution of these subjects is indicated in Table 2.

Table 2 Here

The question of non-suicidal deaths being affected by the contact procedure is considered in Figure 1, which indicates no evidence of any systematic influence ~~operating~~ as regards such deaths.

Figure 1 Here

In contrast, the rate of suicide in the "contact" and "no contact" populations shows a steadily diverging pattern, detailed in Figure 2. The treatment group is included for comparison. For greater precision, subjects were grouped in each category by "years at risk", starting with the date of their entry into the hospital, rather than the previously reported "mean duration of followup".

The differences are not now statistically significant, but if the curves continue to diverge at the same rate as the first four years of risk, that point will eventually be reached.

Figure 2 Here

Discussion

At the present stage of the study the data are consistent with our hypotheses, though we are aware that observed differences in suicide rates between the "contact" subjects and "no contact" controls may reflect influences other than the contact procedure. For example, a repeated observation is that contact

subjects use the project as a means of facilitating reentry into the health care system. They often indicate to us that without our being in touch with them they would have delayed such a move indefinitely, citing "embarrassment" or "not knowing what to do" as reasons. Similarly, family members have often called to say the subject was getting worse and refusing care, and asking for advice or assistance with appropriate action. Whatever feeling of relatedness is generated by our procedures may serve best by maintaining a channel for treatment-resistant persons to return to sources of professional help.

It is clear that the problem of short term risk is not addressed by our schedule, as evidenced by 25 suicides occurring before we were prepared to begin the contact procedure. It seems likely that the intensity of support required during at least the first 90 days after discharge necessitates a different -- but still specialized -- approach such as group therapy specifically for depressed and suicidal persons. Several studies of short-term contact based on differing theoretical grounds have been reported with somewhat guarded optimism. (3,4,5)

That the "treatment" group is consistently most vulnerable to suicide deserves attention. Day-treatment facilities were the treatment setting most involved in our sample, but a detailed review of this category has not been completed.

We continue to receive occasional responses from about one fifth of our "contact" subjects. These are often matter-of-fact acknowledgements or brief "thank-you-for-your-interest"notes, sometimes very warm expressions of how much the continuing letters have meant.

The importance of persisting in expressions of concern without indicating any expectation of some form of response remains a primary theoretical issue, especially with persons vulnerable to depressive states. We are concerned

with the need for a kind of institutional equivalent to the steadfast "significant other", described so well in the recent personalized account of "a woman struggling to live". (6) Having rejected the person wanting to help her, she eventually is moved to say,"I saw that his strength was of a variety not often found. He was like a rock that could not be ground down. During all the months of my illness, the weeks of hospitalization, the repeated suicide attempts, the inability to function, and my obvious loss of faith in him, he remained solid, always there, his very immobility an asset."

Whether such an influence, even to a small degree, can be built into the health care system, is a central question in the formulation of long term suicide prevention programs.

Conclusions

We continue to find encouraging evidence that a large high risk population for suicide can be identified and a systematic approach to reducing that risk can be applied for a prolonged period. It can be done with a small input of time, space, personnel and funds. Though statistical verification of effectiveness remains only potential, clinical significance can be demonstrated in a number of ways. This is especially evident as regards use of health care resources by persons who tend to avoid the established system.

References

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TABLE 1

DISTRIBUTION OF SUBJECTS: OVERALL

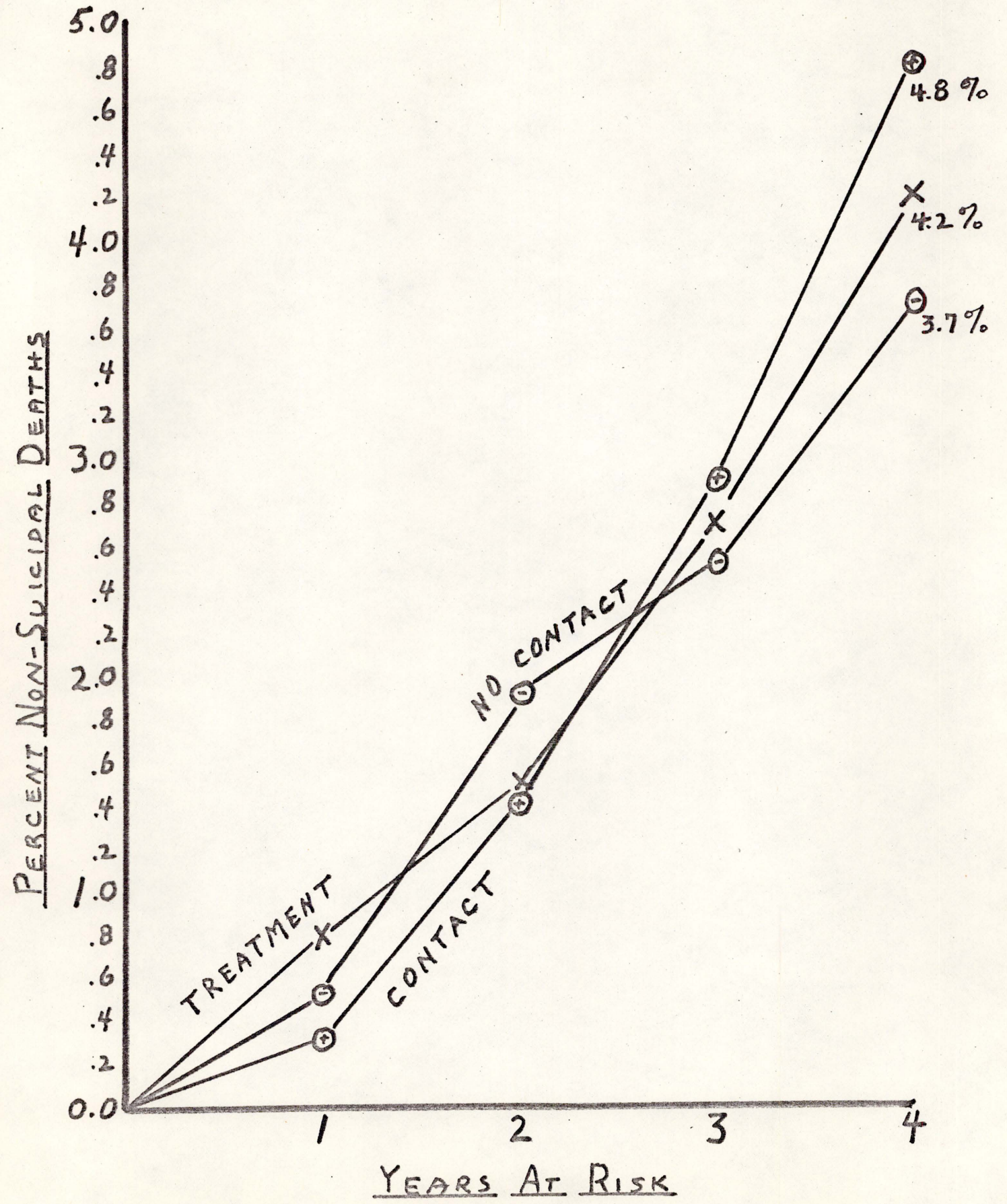
CATEGORY	N	PERCENT
TREATMENT	1,933	64.4%
CONTACT	401	13.4
NO CONTACT	452	15.1
SUICIDE BEFORE STATUS DETERMINED	25	0.8
NON-SUICIDAL DEATH BEFORE STATUS DETERMINED	6	0.2
LOST	132	4.4
STATUS UNDETERMINED	57	1.9
TOTAL	3,006	

TABLE 2

DISTRIBUTION OF CONTACT SUBJECTS

SUBGROUP	N	%	MEAN TIME AT RISK	DEATH NON-SUIC	DEATH SUICIDE
COMPLETED CONTACT	34	8.5%	78 MONTHS	-0-	-0-
PARTIAL CONTACT: ACTIVE	194	48.3	38 "	7	11
PARTIAL CONTACT: LOST	162	40.3	55 "	5	1
REFUSED CONTACT	11	2.7	53 "	1	-0-
TOTAL	401			13	12

AS OF 4/1/75


PERCENT NON-SUICIDAL DEATHS: CATEGORY BY YEARS AT RISK
PERCENT NON-SUICIDAL DEATHS
5.0
.8
.6
.4
.2
4.0
.8
.6
.4
.2
3.0
.8
.6
.4
.2
2.0
.8
.6
.4
.2
1.0
.8
.6
.4
.2
0.0
1
2
3
4
YEARS AT RISK
4.8 %
4.2 %
3.7 %
NO CONTACT
TREATMENT
CONTACT

Percent Suicide: Category By Years At Risk