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Suicide Prevention by Long Term Contact

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Introduction

This is an interim report of a project to devise and carry out a suicide prevention program that is (a) effective, (b) applicable to a large population and (c) requires minimal input of personnel, space and funds. An earlier preliminary report (3) details the ratianale and hypotheses being tested, which may be summarized as follows:

Suicidal impulses generally reflect intense feelings of both isolation and hopelessness. Efforts to modify such feelings are handicapped if the person's need for independence, or other source of ambivalence, is so great that he cannot accept assistance from other persons. This is seen especially in highly conscientious individuals with uncompromising standards of performance. If such a person is obliged to obtain help due to special circumstances, such as an incapacitating depression or an incomplete suicide attempt, he tends to avoid long-term plans and to discontinue therapy as soon as he can. This kind of person is of special concern to a suicide prevention program because he usually does not make his problems known before attempting suicide, and resists those procedures calculated to reduce the risk of his suicide when that risk is recognized by others.

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To find a means of alleviating the feelings of isolation and the sense of hopelessness that are conducive to suicide, an investigation was devised based on three hypotheses:

1) A suicidal person's feelings of isolation will be reduced if he experiences regular and long term contact with another person who is openly concerned about the former's well-being.
2) 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 a sincere expression of unconditional concern.
3) Such a program of contact will exert a suicide prevention influence on those high risk persons who decline to enter an established health care system.

Method

Persons admitted to a psychiatric inpatient unit because of a depressive or suicidal state (ideas, threats or attempt) are recognized as an exceptionally high risk population for suicide. From nine in-patient services in San Francisco over a five year period (1968-1973) 2,661 persons from this population have been identified, interviewed at length, and subsequently divided into two primary groups, "treatment" and "no treatment" subjects. "Treatment" subjects are those who continue their treatment program for one month or longer after discharge from the hospital. "No treatment" subjects are those who either decline therapy or drop out of a treatment program within a month. These categories are an arbitrary means of identifying persons who tend to accept help when they need it, in contrast to those who resist assistance even under severe stress.

"Treatment" subjects are assumed to be receiving the benefit of those social and professional resources our society has to offer, though in practice we realize these are variable. No further effort is made to contact these patients after their treatment status is determined thirty days after discharge.

"No treatment" subjects are divided randomly into two subgroups, "contact" and "no contact". No further inquiry is directed toward the "no contact" subgroup.

Persons in the "contact" group receive a regular communication from the research staff member who interviewed them when they were in the hospital. This is in the form of a telephone call or, most often, a short letter. The message is simply an expression of concern that the person's life situation is reasonably satisfactory, and inviting a response if the person wishes to send one. An effort is made to personalize these notes in order to avoid a "form letter" impression. They are always individually typed. An example of a contact letter would be:

Dear _____,

It has been sometime 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,

Such a note is not calculated to have a significant effect by itself. It is the cumulative effect of repeated expressions of this kind for several months or years that we postulate as having potential psychological force.

The schedule for these contacts is monthly for four months, then bimonthly for eight months, and finally trimonthly for four years--a total of five years and twenty-four contacts. This represents an effort to foster a feeling of relatedness and to reduce feelings of isolation and hopelessness in those persons who decline formal therapy.

Our hypothesis, that such contact will exert a suicide prevention influence, will be supported to the extent that the rate of suicide in the "contact" group is lower than that in the "no contact" group which serves as a control. Data regarding mortality are obtained from the California State Department of Health, coroners' records, death certificates, clinical sources and information from family members and others. This report reflects our findings after five years of study and a mean followup of 2.5 years.

Results

The neat categories described above were not strictly adhered to by our subjects, many of whom were very mobile, necessitating the addition of the following subject groups:

Pending- information regarding treatment status one month after discharge not yet obtained; inquiry procedure still in progress.

Undetermined- information regarding treatment status one month after discharge not available after at least three inquiries and checking collateral sources; letters not returned by the Postal Service.

Declined contact- Subject requested no further contact.

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

Suicide before discharge from inpatient unit.

Suicide less than 30 days after discharge- This circumstance precluded evaluation of the influence of contact by the project design.

Non-suicidal Death

The distribution of suicidal deaths in each category of subjects is indicated in Table 1. Included for comparison are the figures reported two years ago when the total sample was 1,802 and the mean followup was 1.5 years.

TABLE 1

Distribution of Subjects by Category and Known Mortality: 1.5 Years (N=1,802) and 2.5 Years (N=2,667)Mean Followup

Category of Subject	Number in Category		Number of Suicides		Percent Suicide		Suicide Rate *	
	1.5 Yr	2.5 Yr	1.5 Yr	2.5 Yr	1.5 Yr	2.5 Yr	1.5 Yr	2.5 Yr
Treatment	968	1,526	25	63	2.6%	4.1%	1,730	1,650
No Treatment: Contact	195	245	3	7	1.5%	2.9%	1,030	1.140
No Contact	.267	397	4	15	1.5%	3.9%	1,000	1,510
Pending, more than 30 days after discharge	228	160	2	5	0.9%	3.1%	580	1,250
Undetermined	---	80	--	2	---	2.5%	-----	1,000
Declined contact	---	8	--	0	---	0%	-----	0
Lost	114	198	0	4	0%	2.0%	0	800
Suicide before discharge	6	6	6	6	---	---	-----	-----
Suicide less than 30 days after discharge	10	13	10	13	---	---	-----	-----
Non-suicidal death	14	34	--	--	---	---	-----	-----
TOTAL	1,802	2,667	50	115	2.8%	4.3%	1,850	1,720

*Suicides per 100,000/year

Discussion

Our main concern is the difference in outcome between the "contact" and "no contact" subgroups, as this is the only point at which we can go beyond description or comparison and draw inferences based on a control population. A primary element is the time required to generate in the contact subject what Frank calls a sense of "connectedness to others", (1) and Kaiser characterizes as "a delusion of fusion". (2) This is the element postulated as exerting a stabilizing, suicide prevention influence. Since many uncontrollable variables which we cannot monitor will also effect the subjects, the larger the sample and the longer the duration of contact the more likely are these unpredictable influences to effect our "contact" and "no contact" subgroups equally, and render the contact procedure the only clear difference between them.

The sample size of the "contact" and "no contact" subgroups is influenced not only by the self-selection process (refusing treatment beyond one month), but also by the extreme mobility of many of our subjects. The size of the "contact" subgroup is diminished and some degree of randomization is lost when we lose track of a "contact" subject, as it is necessary to put that subject into the "lost" category. This does not apply to "no contact" subjects, and largely accounts for the difference in size of the two subgroups even though theoretically (by random distribution) they would be about the same size. A subject's option to refuse continued contact also contributes to diminished size and randomization of the contact group.

We postulated a five year period of contact, as outlined above, to demonstrate the influence of this procedure. When we reported our preliminary findings two years ago, with a mean followup of 1.5 years, essentially no difference was seen between the suicide rate of the "contact" and "no contact" subjects (3), and the question was raised whether the duration of contact was too short

for such a demonstration.

Table 1 indicates that our present data, reflecting a 2.5 year mean followup, shows a difference between these groups in the predicted direction, with suicides of the "contact" subjects comprising 2.9% of the sample (rate: 1140) and suicides of the "no contact" subjects comprising 3.9% of the sample (rate: 1510). This difference is not statistically significant, and its clinical significance is yet to be determined. The rates of suicide must continue to diverge for any confidence in this observation to be warranted.

Even if the data continue to support our hypothesis, the reasons for the reduced suicide in the contact group will deserve further attention. Contact subjects or their families have frequently indicated to us that some renewed assistance was needed, that the person was unable to request it of a clinical facility, and that if the members of our investigative staff who had been sending letters to them were to arrange for assistance they would accept such arrangements. In this way a number of persons have been readmitted to a clinical program who might otherwise have remained in progressively worsening circumstances. Maintaining a channel for treatment resistant persons to return to professional sources of aid may be the most important function of whatever feeling of relatedness is generated by our long term contacts.

Another issue which demands attention is the frequency (5%) with which our subjects have suicided during the first thirty days after discharge. For these persons, of course, any program of long term contact is pointless. There is clearly a need for an intensive thirty to sixty day post discharge program to bridge the person's transition back into the life situation we wish to stabilize. Our program addresses the intermediate and longer term

high risk population, but is not geared to the short term risk.

Examining these short term suicides more closely, we find that the "treatment" subjects are the most vulnerable group in our sample. Our assumption that what therapeutic resources are available are being provided to these subjects is not very reassuring. To what extent this group represents an irreducible minimum for suicide, or whether current organization of health resources is faulty, are the object of a separate analysis focusing exclusively on the "treatment" group.

A highly subjective source of data regarding the effects of long-term contact comes from the responses of our subjects to our invitation to correspond with us if they wish. About one fourth of the contact subjects send us information about their situation, frequently commenting on how gratifying it is to hear from us repeatedly, as they were sure no one really cared about them. This response often follows an initial period of distrust, or assumption that the letter is just a routine procedure. We can assume that many neutral or negative responses remain unwritten, although an occasional request to discontinue contact has been received, entered in Table 1 as "refused contact".

The importance of taking the initiative and persisting without putting any demands on the contact subject, in order to communicate the sincerity of one's concern, is of primary theoretical importance, especially with persons prone to depression. A concrete example of this was manifested in a male subject who did not respond to the first three contact letters but replied to the fourth with a very polite note, saying, "I'm doing quite well---thank you for your interest". There was no reply to our fifth letter. He moved rather frequently, and our sixth letter was returned several times, but finally reached him one year after his discharge. He replied, "You are the most persistent son of a bitch I have ever encountered, so you must really be sincere in your interest in me," going on to

a lengthy discussion of some important issues in his life.

Conclusions

For the present we have encouraging, though not convincing, evidence that identification of a high risk population for suicide, and implementation of a program of contact calculated to reduce that risk, can serve to provide a suicide prevention influence that is demonstrable and measurable. The procedures do not require a large investment of personnel, space, equipment or funds. The techniques involved address intermediate and long term suicide potential in persons characteristically resistant to continuing therapeutic efforts. Benefit is provided both psychologically and in practical ways, especially with facilitation of procedures required to obtain clinical resources during recurrent crises. The latter may be a crucial function of the contact procedure, especially in this type of high risk group which characteristically declines to enter an established health care system.

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