Ongoing contact for 2 years after discharge was associated with greater survival in patients at risk of post crisis suicide


QUESTION: In patients at risk of suicide who refuse follow up treatment, is ongoing contact after discharge from a psychiatric inpatient facility more effective than no contact for preventing post crisis suicide?

Design
Randomised [allocation not concealed*†; unblinded*], controlled trial with 15 years of follow up.

Setting
San Francisco, California, USA.

Patients
843 patients (mean age 34 y, 56% women) who had been admitted because of a depressive or suicidal state, and had declined or discontinued treatment in < 30 days after discharge. [100% of patients completed the study]†.

Intervention
389 were allocated to a schedule of regular communications (contact group) and 454 patients were allocated to the no contact group. Patients in the contact group received a short letter from the research staff expressing concern regarding how the patient was getting along, and inviting a response if the patient wished to send one. The schedule for these contacts was monthly for 4 months, then every 2 months for 8 months, and finally every 3 months for 4 years; the total number of contacts was 24 in 5 years.

Main outcome measures
Survival time from date of discharge to suicide (if it occurred) and incidence of suicide.

Main results
At 2 years, patients in the contact group had a higher survival rate than patients in the no contact group (p=0.043). At ≥5 years, survival rates did not differ between the groups. The groups did not differ for incidence of suicide (table 1).

Conclusions
In patients at risk of post crisis suicide who refuse follow up treatment, ongoing contact for 2 years after discharge from a psychiatric inpatient facility was associated with a higher suicide free survival rate than no contact. This association diminished after 5 years.

Ongoing contact vs no contact for prevention of suicide after discharge from a psychiatric inpatient facility

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Contact</th>
<th>No contact</th>
<th>RRR (95% CI)</th>
<th>NNT (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of suicide at 2 years</td>
<td>1.8%</td>
<td>3.5%</td>
<td>49% (-19 to 78)</td>
<td>Not significant</td>
</tr>
<tr>
<td>Incidence of suicide at 5 years</td>
<td>3.9%</td>
<td>4.6%</td>
<td>17% (-58 to 56)</td>
<td>Not significant</td>
</tr>
</tbody>
</table>

*See glossary.
†Information provided by author.
‡Abbreviations defined in glossary; RRR, NNT, and CI calculated from data in article.

COMMENTARY

This randomised controlled trial by Motto and Bostrom of a 5 year regular letter contact intervention compared with no contact in patients who initially refused ongoing care after hospital discharge is an important demonstration of an effective post crisis suicide prevention strategy. Motto and Bostrom’s study targeted a high risk group of patients. Patients admitted because of depression or a suicidal state are known to be at increased risk of suicide during the months after discharge. A recent review of intervention trials for individuals at risk of suicide because of previous suicidal behaviour concluded that very few significant results have been found because of the methodological difficulties involved in studying these patients.1 Firstly, there is a low incidence of outcomes resulting from suicide or suicidal behaviour, even in samples at risk and no established surrogate outcomes exist. As a result, sizeable collaborative trials are needed to assemble samples large enough to show a significant difference between the intervention and control groups. Secondly, these patients are typically difficult to engage and it is often perceived that no help for them exists. Therefore, the demonstration, as in this study, that a relatively simple method of maintaining “connectedness” with these patients was effective deserves our attention. Further study is warranted to replicate these findings, to determine whether extending the programme would lead to further prevention of suicide, to do a cost effectiveness study, and to clarify whether the “connectedness” is the active therapeutic ingredient in the intervention.

In the meantime, clinicians must recognise that patients recently discharged from hospital are at increased risk of suicide. Extra effort is required to ensure that appropriate discharge plans are in place, to ensure that patients connect with their aftercare providers, and to carefully assess patients who represent to hospital shortly after discharge.

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