Dan Weisburd put together an issue of the Journal of CAMI about suicide in 1999 and asked me to contribute an article. I hesitated. Even though we'd had no suicides at the Village, suicide is a truly terrifying topic. Whether we have a mental illness, are a family member or staff, suicide stirs up primal feelings in us. It is simply shocking. My first reaction, like most people was to want to avoid suicide entirely.

In some ways, our reactions to suicide are a magnification of our reactions to mental illness overall. We find it both unintelligible and unacceptable. "My friend would never do that." We have a desperate need to attain some sense of control over it so it won't be so frightening. So we distance it from the person, sure it's the mental illness and not really them that's suicidal. "Are you sure it was suicide? He seemed so normal yesterday." We lock people up until they "come to their senses" and disavow it. Then we can all feel better again. The terror has almost passed. "Don't you ever do that to me again."

How could I write an article without being dismissed as naive where the underlying point is that if we stop being terrified of suicide, if we can view it as part of life instead of in a forbidden class of its own, it seems to dissolve away? But, how could I not write an article that holds out the possibility of literally saving lives?

Challenging the Suicide Status Quo

(1999)

The Village Integrated Service Agency in Long Beach, where I work, has been able to develop a number of innovative approaches working with people with serious mental illnesses and become a widely studied model program as a result. We have not yet publicized our innovations in suicide assessment and interventions. At this point, after eight years, I feel secure enough in our understanding and of our results to go out onto this emotionally charged limb. Before I came to the Village, one person I knew in my practice killed themselves intentionally each year, and I began to accept that as part of my job. By contrast, thus far at the Village, no one has intentionally killed themselves. While a statistician might not find that significant, it has made a difference to me.

When I was in medical school at Washington University in St. Louis, I learned about a groundbreaking study they had done there. They separated out people who had suicidal behaviors from those who actually killed themselves and found the two groups to be very different. Although they didn't know any of the subjects clinically, they did a detailed "objective" investigation. They found that the dead subjects tended to be older, male, have either major depression, substance abuse, or a chronic painful incurable physical illness. They'd talked about suicide, had past attempts, made plans and tended to use violent methods. These findings and others like them are familiar to all of us, because they've formed the basis of our suicide risk assessments ever since. They also represent a firm embracing of a medical, scientific model of understanding suicide, supplanting the previous psychodynamic models. Perhaps its time for them to be replaced by a psychosocial rehabilitation-recovery model.

It seems to me that the single most important risk factor for suicide is not having an ongoing relationship with some mental health worker. Despite their devaluation by the medical model, relationships are crucially important. For example, in a recent investigation of people who had killed themselves after discharge from a public psychiatric hospital in Los Angeles, the most striking finding to me was that they couldn't gather any information on these people because no one had responsibility for their ongoing treatment. They'd all "fallen between the cracks." This parallels my own experience, where all the people who killed themselves had been "lost to follow-up" in some way. It may well be that we have had no suicides at the Village primarily because we maintain ongoing contact with people.

The variables identified by the standard suicide assessments (except depression and substance abuse) aren't really directly treatable. As a result, the standard intervention for people assessed to be a high risk is to hospitalize them as a preventative. We keep them, involuntarily if necessary, usually for 72 hours, or until they change their mind and don't want to kill themselves any longer. This intervention is very expensive and of unclear effectiveness, but it does protect people temporarily and the assessor almost completely.

A psychosocial assessment focuses instead on quality of life, empowerment, relationship, and recovery issues. Factors like hopelessness, feeling trapped without choices, facing loss or risk of loss, alienation, emotional or physical pain, lack of resources, powerlessness, giving up, and betrayal seem to me to potentially correlate with suicidality. Unfortunately, these "subjective" factors are very difficult to objectify and quantify, so that a researcher who doesn't know someone will have difficulty testing and proving my hypothesis. Fortunately, these factors are relatively easy to assess by someone who has an ongoing relationship with the person. Even more fortunately, they are almost all directly treatable. Our intervention for people assessed to be at high risk is to help them change their lives and their relationships to actually reduce their risk.

As an example, a forty-year-old man who had schizophrenia and chronic physical problems who avoided all risks and confrontations was living with his younger, adventuresome sister. She had been planning for them to move to a town that "sounded good" in Arizona. Although he was frightened by this idea, he remained very passive until all the arrangements had been made. At that point he came to me saying he was suicidal and needed to be in a hospital. After a long discussion of his fears and issues, I said I'd agree to a two-day hospitalization if he'd agree to a meeting with me and his sister to work things out. He thought about it and said perhaps he didn't need the hospitalization if we could have the family meeting now. I drove with him to his house that same afternoon, met with them for two hours and discussed the issues involved. Afterwards, he was no longer suicidal and they moved successfully to Arizona the next month. The standard system can't "afford" psychiatrists making two hour home visits, but paradoxically it can "afford" hospitalizations.

Probably most importantly, every member of the Village has at least one and usually several staff they can talk to who know them. We contact them in the community if they don't come in to see us. I'm convinced that doing this proactive, assertive outreach is our single most important psychosocial suicide prevention intervention. As another example, before I came to the Village I knew a 45 year old woman with manic-depression who lived alone in an apartment and was extremely anxious and isolated. I saw

her for medication visits about once a month. She was "inappropriate for psychotherapy" and was one of many "meds only" patients in our clinic. I didn't know it, but her landlord gave her a notice raising her rent $50 which she couldn't afford. She thought she'd be homeless again and couldn't bear that thought. She became depressed and even more withdrawn and missed her next medication appointment. I was called two months later when she was found dead in her apartment from a Lithium overdose. This would be very unlikely to happen at the Village because we would've reached out to her and intervened much earlier. True suicide prevention is actually done months before the person becomes suicidal, not when interventions are normally done after the person is desperate and suicidal.

Seventy-two hours in a hospital without follow-up costs about $1,500-$2,000 in the Los Angeles area. A non-professional caseworker with a caseload of about fifteen people for one year costs about $1,500-$2,000 per person. What I would like to see most is a controlled study comparing these two interventions for suicide prevention. The Village, has, in essence, conducted a one-sided uncontrolled study of this. Every member gets a personal service coordinator that follows them closely, weekly at least, using a "high risk-high support" approach that promotes learning from mistakes and growing from successes. Members are supported as they deal with negative "natural consequences", so they don't give up. Almost no one gets seventy-two hours in a hospital for suicidality. Our success seems promising enough for a controlled study of acute hospital-based suicide prevention vs. prolonged community base suicide prevention to be undertaken.

If we can establish a standard of care for the medical-legal community that seventy-two hour hospitalization is not the universally indicated intervention for even serious suicidality, we can begin to develop more alternatives without fear of liability suits. I meet a variety of mental health professionals who with disturbing regularity say openly that they want to hospitalize someone, not because they think it would be helpful, but because they want to protect their own licenses and make sure they don't end up in court. I've never met anyone afraid of being sued for not doing a home visit, not assisting someone with emergency food, or money management, not helping someone get to a substance abuse recovery program, not helping someone find an apartment, a job, or friends, not being accessible to talk in a crisis evenings or weekends, etc., etc., etc. In all likelihood those are the effective suicide prevention interventions that should be our standard of care instead of hospitalization.

Before managed care administrators everywhere leap up to use my arguments for denying more hospitalizations, I need to clarify my position. I am not urging not hospitalizing people in a system without alternatives. That would be a return to abandonment. And at least according to the recent NAMI survey of managed mental health care, none of the managed mental health programs have intensive community based alternatives in place at present. I am urging systematically replacing hospitalization interventions as a suicide intervention with intensive community based interventions. At the Village, we have done this and our results have been excellent. Doing so in a way that does not abandon people, or lose them to follow up, is probably less costly over the long run as well. Managed care administration should leap up and stand behind clinicians while they take the risks necessary for growth and recovery with the people they work with. First, give them the resources they need to truly support people in the community. Then hospitalizations can be reduced safely and effectively.

I would like to turn now to the people who don't actually kill themselves. I think these people can be divided into two groups: one group who feels overwhelming feelings of some kind that make them feel like they'd rather die than go on like this, and another group who use suicide in order to attract attention, communicate to someone else, or get some other needs met.

People who have overwhelming feelings will often feel a strong if temporary sense of relief when they are hospitalized. The pressures are often removed. They are taken care of by others. This relief is strongly reinforcing and can set up a behavioral pattern of dealing with overwhelming feelings with hospitalization. This often competes with the more difficult process of emotional growth or life changes (like leaving a battering husband or stopping drug abuse) that are actually needed to achieve long term recovery. Thus, hospitalizations are actually harmful over the long term. Two examples: A twenty-five year old woman with severe substance abuse, auditory hallucinations and AIDS was living in a board and care, buying drugs from the owners, neglecting both psychiatric and medical care, and being hospitalized almost monthly feeling overwhelmed by suicidal feelings. After she transferred to the Village, I refused to hospitalize her even after a dramatic scene at the hospital where she was banging her head on the walls and threatening to cut her neck with glass in the parking lot. (Yes, this approach requires a certain fortitude on the psychiatrist's part). Since I stood up to her she has not sought hospitalization. She has moved to stable housing, reduced her drug abuse and followed up with medical and psychiatric care. She has weekly battles with the team over almost everything, but she is growing. A twenty-eight year old man with manic depression, substance abuse and a personality disorder had been hospitalized so many times for suicidality he had been given shock therapy, a conservatorship and was going to long term locked placement until he transferred to the Village. We lived with him through several lost apartments, a beating, a suicide attempt, jumping out of a car and abusing several girlfriends, but never hospitalized him. He has gradually become proud of his increasing maturity and has maintained an apartment for six months. He no longer goes to his mentally ill mother for help. He takes medication regularly, has decreased his substance abuse, is off conservatorship, has tried working and treats his girlfriends better. He is planning to go back to school.

These are very difficult emotional processes for members, family and the staff to go through. Often staff or family wants to hospitalize these people to get themselves emotional relief (that can become a reinforced pattern too). It is necessary for the team to work both together and consecutively to maintain the intense emotional relationships needed over the long term without hospitalization. The road to a successful community life does not go through the hospital, it goes through hard work in the community.

I believe our emotional reactions determine our suicide interventions far more than clinical, pragmatic considerations. If we meet someone who is so miserable that he would rather die than face their problems, we cannot accept that and, as best we can, we force him not to kill himself. If we meet someone who is so miserable that he would rather use drugs until he dies rather than face his problems, we say we won't do anything until he wants help. I've seen ambulances leave someone in an apartment dangerously toxic on heroin who died several hours later. I've never seen an ambulance leave someone in an apartment who says he's suicidal, even when I've asked them to. In reality, the person turning to

drugs is much more likely to die than the person turning to suicide. Our emotional reactions are very different, so our interventions are very different. Both sets of people actually need similar, emotionally intensive, community-based interventions to face their lives and go on successfully.

When I was a resident, I spent four months on the consultation and liaison service at Los Angeles County – USC Medical Center, a huge hospital. I had the job of going around the medical hospital assessing the people who had suicidal behavior the night before. Many of these people were in the group of those trying to communicate something to someone else. And most of the time it worked – boyfriends came back, parents let them come back home for another chance, crashed cars were forgiven, abortion plans were changed, etc. If we are working with these people regularly, helping them identify their needs, problems, and desires, and helping them identify how to communicate them and get them met, we can usually come up with some better method of communication than suicide threats or attempts. Usually people are not really so powerless that suicide is the only way they can be heard. We help them find and use whatever power is available to them.

With some regularity people use suicide to communicate with the mental health system to get what they want. The mental health system is usually set up such that food, housing, daily psychiatrist visits, medication, placement assistance, safety from drug dealers, TV, laundry, medication, medical care, friends and cigarettes are regularly available to everyone in the hospital and very rarely available outside of the hospital. The system offers an all-or-nothing package for the most part. People rapidly learn that if they want any of those things they must say they're suicidal and go into a hospital. Clearly how much we hospitalize people for being suicidal affects how many people express suicidality to us. For example, recently our local veteran's hospital had a cluster of deaths by suicide that was heavily publicized. They began admitting all suicidal people to avoid liability. As the word got out, the number of people presenting to their emergency room saying they were suicidal went up dramatically. The Veteran's Administration even had to start contracting with private hospitals for extra beds. At the Village we break this pattern by "unpackaging" our services. We offer a lot of things in the community and rarely offer hospitalization. A conversation about wanting food or money or housing, etc. at the Village will be about those things. It will not turn into an artificial conversation about suicide, because bringing up suicide isn't an effective negotiating tool with us.

One of our members is a forty-five year old man with diabetes, manic depressive disorder and a million demands. He drives us crazy trying to get us to do things for him or to get us to give him things every day. After several years of constant rejections by me he at least stopped demanding hospitalizations (allegedly because he was suicidal but actually for a wide variety of needs including food, a better TV, someone to wait on him, etc.) A while ago he signed up for an HMO and found out he could get them to hospitalize him by threatening suicide. Soon he was doing so several times a week and even actually overdosed on insulin to make his point. He even got them to send "smoking" taxi cabs to take him to the hospital. Within a couple of months they became overwhelmed and he was actually endangering himself with the insulin, when he hadn't previously. They began to consider conservatorship and locked placement. After a number of calls from me, I convinced them to stop admitting him to the hospital, no

matter what, and all the suicidal behaviors stopped. Of course, he's still driving us crazy with his usual demands.

Another member is a forty-year-old man with schizophrenia who has been institutionalized most of his life. He has literally hundreds of scars up and down both arms from cutting himself. Within weeks of becoming a member and moving from the state hospital to a board and care, he got into an argument with the board and care staff over cigarettes and money and cut himself. He then stood there calmly waiting to be hospitalized and the board and care staff assisted by packing his things. When I appeared on a home visit, I dressed his superficial cuts and said I wasn't going to hospitalize him. I asked him what he planned to do next and offered him a blanket in case he ended up homeless. With our assistance, he instead negotiated with another board and care to take him in and negotiated a new cigarette and money schedule. He hasn't cut himself since, but we do see him several times a week negotiating the amazing variety of problems he has.

One of the virtues of our method is that we don't need to carefully assess people to divide them into "potentially lethal," "miserable' and "manipulating" as the standard system requires. All three groups get similar interventions – intensive community based problem solving and support by people who have relationships with the member. Our outcome to date is no suicides, rare suicidal behavior and rare use of suicidal threats to get other needs met. Our outcome, however, is not an elimination of suicidal feelings. This is only rarely a realistic goal and is usually achieved by helping people find a reason to live.

One fifty year old woman who used to spend hours on our emergency beeper talking about suicide, recently said, "I can't kill myself. I'm too busy with my life. I have an apartment. I'm going to school. I have a part time job. I go out with my friends. I'm too busy living to be suicidal." Ultimately, I believe life affirmation is the strongest anti-suicide force. A psychosocial rehabilitation recovery approach like ours is more life affirming than a medical, disease-based approach.

I would like to close with a thought about suicide prevention contracts. It is a common practice among mental health professionals to agree not to hospitalize someone who is suicidal if the person "contracts" with them not to hurt themselves until they see them again. The effectiveness of this technique is usually attributed to the power of the person's "promise" not to hurt themselves. I think its effectiveness may be more due to the power of our "promise" to actually see them again. To a lonely, desperate person in a fragmented system, that commitment of ongoing contact and caring may well be a valuable thing. Maybe more valuable than we realize.

Lest I was feeling too smug, the Village had its first suicide shortly after this article was published. I won't share the story with you out of respect for the member and his family, but I will share the reaction of the consultant we brought in after the death to give us advice. In general, he praised our work, but the comment that stuck in my mind was his parting remark. He said that he didn't understand why we kept reaching out to that man, when he clearly was doing so badly and had given us an easy out by asking to disenroll from our program. Any place else, he said, would've happily discharged him and protected themselves from liability. He shook his head in disbelief.

There's something terribly wrong in this world when abandoning suicidal people is the smart thing to do.

A lot of us went to his funeral and shared our tears with his family and friends. They were grateful.

I'm disappointed that this article, despite its confrontative tone and its controversial content, has never attracted any attention. I still believe in its person centered, relationship based approach. Over the years, the Village has continued to have strikingly low numbers of suicides and suicidal behaviors, despite working with extremely high risk people. Meanwhile, the system has continued to spend lots of money on 72 hour hospitalizations for suicidality without really connecting with anyone and the incidence of suicide has continued to rise. Recovery may be the breakthrough we really need. It's too bad suicide is so hard to talk about.