

**Systematic telephone contacting of patients leaving the Emergency Department
after a suicide attempt: does it affect the one-year outcome ?
SYSCALL, a randomized controlled study.**

Guillaume VAIVA ^{1,2}, François DUCROCQ ¹, Philippe MEYER ³, Daniel MATHIEU ¹,
Alain PHILIPPE ², Christian LIBERSA ¹, Michel GOUEMAND ¹.

- (1) *University Hospital of Lille, School of Medicine, France*
(2) *Institut National de la Santé Et de la Recherche Médicale (INSERM U513), School of Medicine, Créteil, France*
(3) *General Hospital of Valenciennes, France*

Address of the main author: Docteur Guillaume VAIVA

Clinique Michel Fontan - CHRU de Lille

6 rue du Professeur Laguesse

59037 LILLE cedex, France

Tel : (033) 3 20 44 63 83 Fax : (033) 3 20 44 63 96

Email : gvaiva@chru-lille.fr

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ABSTRACT.

Objectives. To determine the effects of a telephone contact and/or telephone intervention (one month or three months post-attempt) for patients after deliberate self poisoning compared with usual treatment. To compare the impact of the active intervention and usual treatment on suicide attempt repetition and health care contacts.

Design. Randomised multicenter controlled trial.

Participants. 605 adults who had deliberately poisoned themselves, presented to the emergency department of 13 general hospitals and discharged without hospitalisation.

Setting. Community based study.

Intervention. The principle of telephone recontact was to go back over the management recommended during the Emergency stay: either the treatment plan was shown to be satisfactory, or difficult to follow and an attempt was made to make it work or to make a new treatment plan, or the patient was seen as being in danger of attempting suicide again. Control patients received “treatment as usual,” which in most cases consisted of referral back to their general practitioner.

Outcome measures. Subsequent attempts at self harm and deaths by suicide at 13 months follow-up. Secondary outcome measures included types and number of health care contacts.

Results. Looking at all the randomized patients (intention-to-treat basis), we did not find any statistically significant differences between the 3 groups ($p = 0.25$): first-month recontacting ($N = 147$, proportion adverse outcome 23,1 % ν 29,8% in control group ($N = 312$), difference in proportion 6,7%, 95% confidence interval -1.8 to 15.2), third-month recontacting ($N = 146$, proportion adverse outcome 24,7 % ν 29,8% in control group, difference in proportion 5,2%, 95% confidence interval -3.5 to 13.8), comparison between first-month and third-month intervention (proportion adverse outcome 23,1 % ν 24,7%, difference in proportion 1,5%, 95% confidence interval -11.3 to 8.2). Participants in fact recontacted for the one month telephone intervention were less likely to report re-attempt to harm themselves at follow up (proportion re-attempters 12,1 % ν 22,1% in control group, $p = 0.03$, difference in proportion 10%, 95% confidence interval 0.02 to 0.18), but not those recontacted for the three month

telephone intervention no (proportion re-attempters 16.8% v 22,1% in control group, $p = 0.27$, difference in proportion 5.3%, 95% confidence interval -0.04 to 0.14).

Conclusion. Telephone contact one month post-attempt may be a valuable strategy after people have deliberately tried to poison themselves.

INTRODUCTION

Subjects who have attempted suicide are at high risk of committing suicide (12–30%) or completing suicide (1–3.3%), during the first year following the attempt¹⁻⁸. The majority of patients who leave the Emergency department directly, are considered as having the lowest short-term psychopathological risk and/or are those who are best looked after by their family. However, when they are referred to the community services, it is not checked if the treatment plan recommended in the Emergency department is carried out.

Many patients repeat suicide attempts or commit suicide, even if they are being treated^{9 10}. A review of the controlled studies of treatment strategies, found very few methods which have significantly reduced the repetition of suicidal behaviour^{11 12}. Evans¹³ reported a non-significant lower rate of repeated self-harm in the experimental group, for those individuals who had deliberately harmed themselves for the first time, and who were offered easy access to a trained psychiatrist, who encouraged them to seek help in the case of any future difficulties. Cedereke¹⁴ reported the results of a controlled study assessing the usefulness of two telephone calls, 4 and 8 months after the suicide attempt (N=107), in addition to the usual treatment, compared to a control group (N=109). No significant difference was found between the two groups for the number of further suicide attempts at 1 year. He concluded that this method was nevertheless useful, since it offered a healthcare contact to the patients, who were not followed up by the psychiatric services before their index suicide attempt.

A strategy of systematically recontacting patients, could assure that the solutions offered at the time of the suicide attempt in the Emergency department are suitable, and could recheck their suitability at a later date. The aim of our study was to evaluate if systematic recontacting by telephone, including an attempt to enhance compliance with the treatment plan and brief crisis intervention if needed, had an impact on the number of further suicide attempts at 1 year.

MATERIAL AND METHODS.

Patients.

SYSCALL was a multicentre study, performed in 13 of the 16 most important Emergency centres in the North of France (population of 4.5 million). The study was approved by the Ethical Committee of the University Hospital Centre of Lille (decision n° CCPPRB 98/33).

Inclusion criteria. The patients were men or women aged between 18 and 65 years old, who had survived a suicide attempt by overdose of medication, had been examined by a psychiatrist who had allowed them to be discharged from the Emergency department, who lived in the region and could read and write French, who could give the name of their general practitioner, who could be contacted by telephone and who had given their written consent for being recontacted.

Exclusion criteria. The patients who were excluded were those hospitalized after their stay in the Emergency department, those suffering from addiction to illegal drugs, and homeless people.

Design of the study.

We designed 2 groups for a telephone intervention (figure 1): 1) patients recontacted at the end of the first month after the suicide attempt, 2) patients recontacted at the end of the third month. We compared each of the telephone intervention groups with a control group, who were not recontacted during the 12 months following the suicide attempt. We compared the 2 intervention groups with the control group, with a randomisation into 3 groups in the ratios 1:1:2.

Inclusion. The patients were selected in the Emergency department. The consent form for participation in the study was sent to the patient's general practitioner.

Randomization. After the patients gave their signed consent, they were allocated to a group in each centre, according to the number in a opaque sealed envelope, opened by the investigator. The allocation sequence was provided by a statistician, who did not take part in the assessment of the patients at any point of the study, and was based on a computer-generated list of pseudo-random numbers to assign the

patients either to "systematic telephone contacting" or to "usual treatment", in blocks of 8 participants (2:2:4 per block). We used two strata for the randomization process: one for the patients who had attempted suicide less than 4 times in the previous 3 years, and the other group for those who had attempted suicide more than 4 times in the previous 3 years. For each stratum, the patients were assigned by random allocation, for recontacting at the end of the first month, or at the end of the third month. No change was possible after allocation, this being verified by the randomization staff. The allocation number list was stored in tamper-proof envelopes in a locked cabinet, accessible only to authorized persons.

Sample size.

The successful study by Linehan et al., using dialectic cognitive therapy, whose outcome was a change in the form of suicidal behaviour, needed a population of 44 subjects to produce significant differences (Linehan 1991). More recently, Guthrie et al., using a similar method to ours, reached statistical significance with 95 subjects (Guthrie 2001). In comparison with these studies, ours was less specific from a psychotherapeutic point of view, but our telephone interventions took place over a shorter period, at more specific times, so we estimated that we would require a population that was four times larger (N=400), in order to reach statistical significance. We also estimated that we would not be able to recontact 30% of the patients by telephone, and that 25% of them would be lost to follow up, therefore we decided to include 600 individuals in our study.

Baseline assessments.

The baseline assessment included: 1) general information required for recontacting and follow up; 2) information about the stay in the Emergency department; 3) information about the suicidal crisis, screening for mental disorders with the "Minimal International Neuropsychiatric Interview for DSM-IV" (MINI), SCL-90, and Beck's hopelessness scale¹⁵⁻¹⁷.

Intervention at 1 or 3 months.

The telephone calls were made by a psychiatrist with at least 5 years' experience in managing suicidal crises. None of the psychiatrists making the telephone calls had met the patients in the Emergency departments. If 3 attempts at telephoning on 3 different days and at 2 different times (midday or evening) were unsuccessful, recontacting was abandoned.

The principle of recontacting was to go back over the management recommended in the Emergency department: either the treatment plan was shown to be satisfactory, or difficult to follow, and an attempt was made to make it work, or to make a new treatment plan, or the patient was seen as being in danger of attempting suicide again, and so an appointment for a consultation was quickly organised in the Emergency department, in which he had originally been treated. The psychotherapeutic approach used was psychological support, mainly based on empathy, reassurance, explanation and suggestion. The experimental intervention therefore included a specific effort to enhance compliance and to provide brief crisis intervention where needed.

A letter was systematically sent to the patient's general practitioner, informing him of the telephone call, and giving him a summary of the interview and of its conclusions. If the patient could not be contacted, a letter was also sent to inform the general practitioner.

Outcome data assessments.

The assessment was made by telephone, by a specially-trained research psychologist, who was blind to the initial group randomization.

The patient himself informed us of any further suicide attempts, but the episodes were only recorded if they met a standardized definition⁷. All the data were validated by regular visits throughout the study period, by a Clinical Research Assistant, to check through all of the suicide attempt files in each of the 13 Emergency departments and on any deaths or further suicide attempts. This allowed 30% of the repeat suicide attempts to be identified.

The assessment included information about the use of health services on the basis of a well-established method for recording data on health economics¹⁸.

For the patients who could not be contacted for the final assessment, the following procedure was used: 1) telephone contacting by the general practitioners; 2) checking the attendance files and the medical records of the Emergency departments concerned; 3) a letter sent to the Registrar General's office at the Town Hall, to check if the patient had died¹⁰.

Data analysis.

Statistical analysis was performed using the SAS software for PC (SAS Institute), V 8.2.

Firstly, the groups were compared on an intention-to-treat basis. The patients were included in the groups, into which they had been allocated by randomization, regardless of whether their assigned follow up had taken place (successful telephone recontacting and/or the 12-month follow up assessment). Using this approach, all of the patients were included. Further suicide attempts, deaths by suicide and the patients “lost to follow up”, were all considered as adverse outcomes.

Secondly, we analysed the data of the patients successfully contacted at 1 month and 3 months, to assess the effect of telephone contacting on further suicide attempts. We compared the normally distributed variables using the t-test. The qualitative data were compared between the groups using the Khi-2 test or Fisher's exact test.

RESULTS.

Sample. Each centre recruited patients over a 6 month period. Participation in the study was proposed to 842 subjects (patients were not selected during the night or at the weekend), and 605 patients were included (figure 1). There was no difference in the mean age of the patients included in the study, from those refusing to participate. The sex ratio of the patients included was 3 males/7 females, compared with 4 males/6 females in the patients not included ($p = 0.0001$, $\text{Khi}2 = 47$ df 1).

Attrition. In the two "recontacting" groups, 204 (70%) of the 293 patients to be contacted by telephone were in fact contacted (figure 1). 89 of them could not be contacted after 3 attempts. Those who could not be contacted had the following characteristics: there were fewer depressed patients according to MINI (35% vs 48%; $p= 0.05$, $\text{Khi}^2 3.8$; $\text{df}1$), and fewer with a somatization disorder on SCL-90R (12,5% vs 24,4%; $p= 0.03$, $\text{Khi}^2 4.8$; $\text{df}1$). No difference was found for age, sex, socio-demographic factors and number of previous suicide attempts, or the severity of psychopathological disorders on SCL-90R.

At the end of the 13-month follow up period, we tried to assess all the patients who were included at the start of the trial, regardless of whether their assigned telephone intervention had taken place. 57 of them were lost to follow up (9.2%). Follow up to assess mortality was 100% (6 deaths, of which 3 by suicide and another by probable suicide). The patients lost to follow up were: more often men (38% versus 27%; $p= 0.07$), had arrived at the Emergency department alone (59% versus 42%; $p= 0.01$), were more often drunk (53% versus 40%; $p= 0.05$), and fewer had Social Phobia on MINI (2% versus 13%; $p= 0.02$).

The randomized groups were no different for their socio-demographic characteristics, psychopathological assessments (MINI), previous suicide attempts or their ongoing treatment in the Emergency departments (Table I).

Impact of telephone recontacting.

Looking at all the randomized patients (intention-to-treat basis), we did not find any statistically significant differences between the 3 groups ($p = 0.25$, Table II): first-month recontacting ($N= 147$, one death (cancer), proportion adverse outcome 23,1 % v 29,8% in control group ($N= 312$), difference in proportion 6,7%, 95% confidence interval -1.8 to 15.2); third-month recontacting ($N= 146$, one death from suicide, proportion adverse outcome 24,7 % v 29,8% in control group, difference in proportion 5,2%, 95% confidence interval -3.5 to 13.8); comparison between first-month and third-month

intervention (proportion adverse outcome 23,1 % v 24,7%, difference in proportion 1,5%, 95% confidence interval -11.3 to 8.2).

The mortality rate was too low to attempt any statistical analysis. There were 6 deaths, 3 of which were by suicide and one possible suicide (road traffic accident). There were 2 deaths amongst the recontacted patients (one was a possible suicide and the other one from cancer), 2 in the control group (2 by suicide), and 2 deaths in the patients lost to follow up (one by suicide and one from an ischaemic vascular attack).

For the patients who were in fact recontacted, 107 telephone interviews were performed at 1 month. Compared with the controls, the number of further suicide attempters after 1 month was significantly lower (12.1% (13 re-attempters) vs 22.1% (62 in the controls); $\chi^2 = 4.7$, $df=1$, $p=0.03$, difference in proportion 10%, 95% confidence interval 0.02 to 0.18). This difference in suicide re-attempters was seen over the first 6 months. There were no deaths from suicide in the group of patients who were in fact recontacted.

For those who were recontacted at 3 months, compared with the controls, the number of further suicide attempters was not significantly lower (16.8% (16 re-attempters) vs 22.1% (62 in controls); $p=0.27$, difference in proportion 5.3%, 95% confidence interval -0.04 to 0.14). 11% (N=10) had committed suicide again after 3 months (against 15% in the control group; $p=0.7$).

Attendance to treatment.

The patients from the two "telephone recontacting" groups had talked about their attempted suicide with their general practitioner more often than the controls (Table III).

Out of the 107 recontacts at 1 month, 72 were ordinary calls (5 to 10 minutes), 22 were true telephone crisis intervention (15 to 45 minutes) and 13 gave the chance to detect patients with a high suicide risk. Out of the 72 patients who seemed to be all right at the time of recontacting, 7 made a further suicide attempt during the following year. Out of the 22 patients who benefited from telephone crisis intervention, 5 attempted suicide again in the following months. 13 patients were sent to the

Emergency department, all of them being seen within 3 days at the latest. 10 of them were considered by the psychiatrist as being in danger and 8 of them were hospitalized. Only one of these 13 patients reattempted suicide, 6 months later.

DISCUSSION.

The percentage of further suicide attempters in the group with treatment as usual is similar to the data in the literature (between 12% and 30%)^{3 12 19}.

Our results may show the usefulness of systematic recontacting of suicide attempters at the end of the first month following treatment in the Emergency department. We feel that most further suicide attempts that were "avoided" by systematic recontacting, were detected during the telephone intervention and efficiently referred to and managed by the respective departments.

Van der Sande²⁰ noted that, whichever type of follow up was used, 8 of the 10 studies he mentioned were negative for mortality and morbidity at 1 year, although 2 studies showed a temporary tendency to reducing further suicide attempts^{21 22}. More recently, Guthrie showed the efficacy of a series of psychoanalytically-inspired consultations at the patient's home, during the first month after a suicide attempt¹¹. His study looked at patients who were not hospitalized after their suicide attempt, in a very similar population to ours. In fact, even though the reduction in the number of further suicide attempts seems to be greater in Guthrie's study, it was easier and much cheaper to set up telephone recontacting than in our study.

Methodological considerations.

In this study, we made no attempt to control for the non-specific effects of psychotherapy, since it was a pragmatic study. Our aim was to compare a specific intervention with a treatment as usual in France for patients who harm themselves.

Three-quarters of the eligible patients agreed to participate. Our recruitment rate was much higher than in previous studies, this showing that the patients were more open to telephone recontacting than to an appointment in the psychiatric clinic ¹¹.

Limits and perspectives.

Out of the further suicide attempts, 48 occurred before the end of the first month, and so before the first theoretical recontacting period. The first perspective would be to test earlier recontacting, between the 15th and 21st day, to see if a larger number of new suicide attempts could be avoided.

The second limit of our method was the number of patients for whom recontacting was programmed, but who could not be reached at the time of the telephone intervention. We believe this to be the main reason for the negative result of the intention-to-treat analysis. In our study, the decision to abandon recontacting was based on a strict criterion: after 3 unsuccessful attempts to telephone. When the final assessment was made, we did not retain this criterion stipulating a maximum number of calls, and so we were able to include the maximum number of patients possible. As a result, we recommend that the number of telephone calls for recontacting should not be limited, to reduce the number of patients who can not be reached.

CONCLUSION.

For patients who commit suicide and who are left to go home directly from the Emergency department, the management plan recommended leaves a large part of the responsibility on social support and on community services.

In this population, telephone contact one month post-attempt, in addition to the usual treatment, may be a valuable strategy after people have deliberately tried to poison themselves. Our hypothesis is that by detecting the high-risk situations during systematic telephone calls, by referring them to treatment centres and by organizing treatment, this should contribute to reducing the number of new suicide attempts.

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Table I. Characteristics of the different groups at the start of the trial.

	Treatment as usual	1st month recontacting	3rd month recontacting
	<i>N=312</i>	<i>N=147</i>	<i>N=146</i>
Age (years)	35 (sd11)	38 (sd12)	35 (sd11)
Gender	Females = 71% Males = 29%	Females = 78% Males = 22%	Females = 72% Males = 28%
Married	51%	54%	45%
Employment	63%	61%	63%
Duration (hours) of emergency stay	18 (sd8)	20 (sd10)	18 (sd8)
Significant others during emergency stay	56%	56%	60%
Psychiatric consultation counselled	80%	83%	72%
Psychiatric treatment programmed	21%	24%	23%
Time (days) to programmed consultation	12 (sd14)	8 (sd7)	14 (sd30)
Repeated Suicide Attempt more than 4 in the last 3 years	9,3%	9,3%	9,4%
Number of medications used for Suicide Attempt	1,7 (sd1)	1,8 (sd1)	1,8 (sd1)
Alcohol with overdose	45%	32%	36%
Communication of suicidal ideation	30%	36%	29%
Evidence of planning	22%	19%	10%
Wanted to die	2%	2%	2%
Suicide note	7%	8%	11%
Bad observance to treatment	25%	26%	18%
Automedication	28%	33%	25%
Family history of mental disorders	27%	30%	33%
Painful physical disease	11%	11%	7%
Chronic physical disease	13%	19%	11%
Social and affective isolation	33%	38%	33%
Painfull life-event in the past 6 months	47%	57%	45%
SCL-90R Total score	110 (sd63)	115 (sd62)	124 (sd74)
Hopelessness Beck Total Score	8,3 (sd5)	8,3 (sd4)	9,2 (sd5)

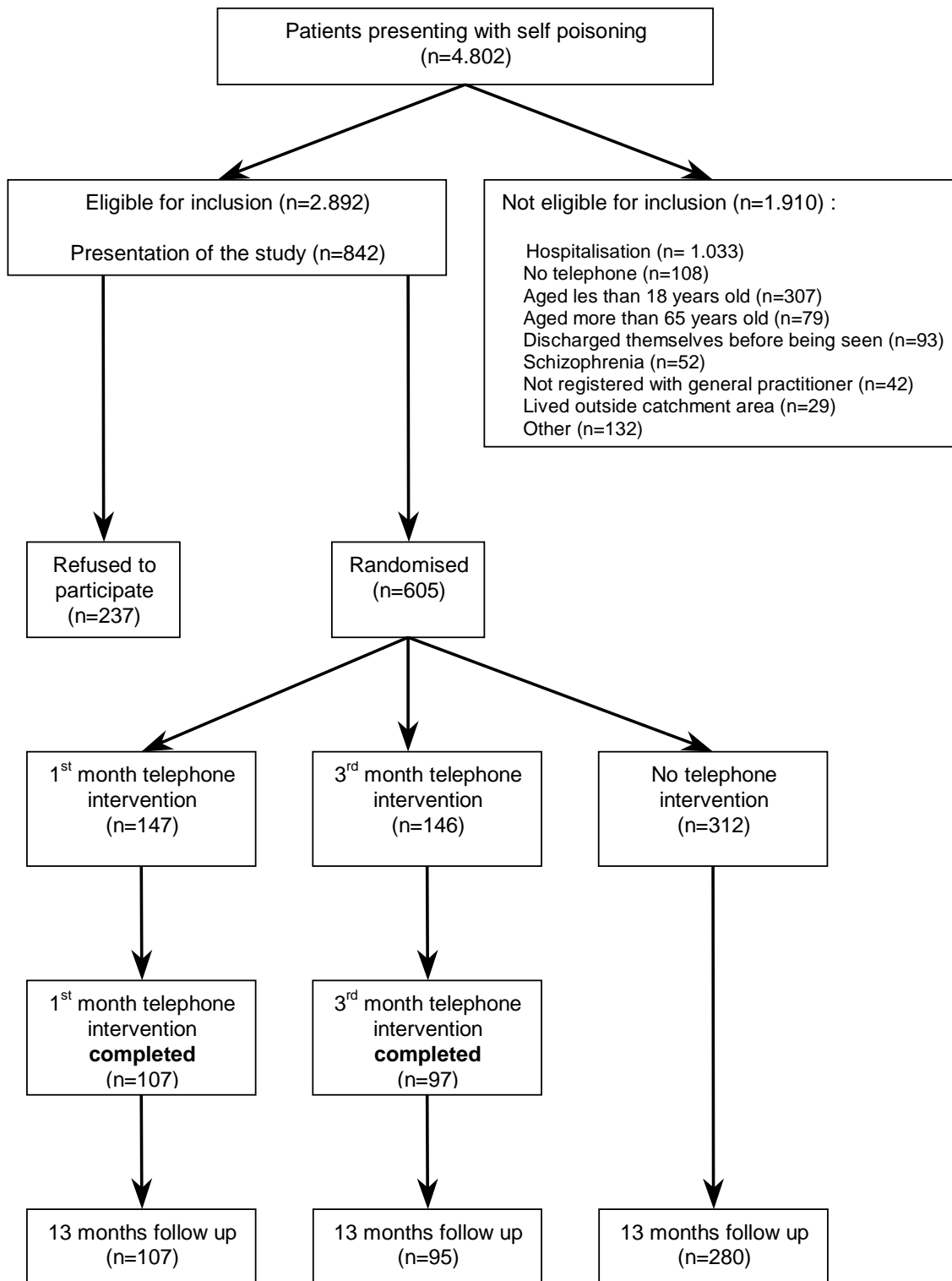
Table II. Results of the Intent-To-Treat analysis.

	Treatment as usual		1st month recontacting total population			3rd month recontacting total population			
	<i>N=312</i>	%	<i>N=147</i>	%		<i>N=146</i>	%		
Total re-attempters	59	18,9%	24	16,3%	<i>dif 2,6</i> <i>CI -4.8 to 10</i>	20	13,7%	<i>dif 5,2</i> <i>CI -1.9 to 1.3</i>	<i>p = 0.37</i> <i>Khi 1.97</i>
Total deaths by suicide	2	-	0	-		1	-		
Lost at follow up	32	10,3%	10	6,8%	<i>dif 3,5</i> <i>CI -1.8 to 8.7</i>	15	10,3%	<i>dif 0</i> <i>CI -6 to 6</i>	<i>p = 0.46</i> <i>Khi 1.56</i>
Total adverse outcomes	93	29,8%	34	23,1%	<i>dif 6,7</i> <i>CI -1.8 to 15.2</i>	36	24,7%	<i>dif 5,2</i> <i>CI -3.5 to 13.8</i>	<i>p = 0.25</i> <i>Khi 2.77</i>

Table III. Consummation of Health Cares during the 13 months follow-up (Number of patients) for patients in fact recontacted at 1 month and 3 months, and controls.

	Treatment as usual		1 st month recontacting completed			3 rd month recontacting completed		
	<i>N=280</i>	%	<i>N=107</i>	%	<i>Comparison with controls</i>	<i>N=95</i>	%	<i>Comparison with controls</i>
Talking about Suicide with General Practitioner	204	73 %	82	87 %	<i>p=.004 (df1) Khi2= 8,5</i>	72	88 %	<i>p=.004 (df1) Khi2= 8,2</i>
Psychotropic medications	115	41 %	43	46 %	<i>p=.38</i>	30	36 %	<i>p=.36</i>
Psychotherapy	104	37 %	42	45 %	<i>p=.18</i>	31	38 %	<i>p=.96</i>
Types of psychotropic medications	Anxiolytics Antidepressant	16 % 19 %	Anxiolytics Antidepressant	15 % 26 %	<i>p=.33</i>	Anxiolytics Antidepressant	15 % 20 %	<i>p=.69</i>
Psychiatric hospitalisation	62	22 %	21	22 %	<i>p=.99</i>	21	24 %	<i>p=.77</i>
Number of hospitalisations	0.39 (sd1)		0.30 (sd0.6)		<i>p=.41</i>	0.29 (sd0.7)		<i>p=.42</i>
Duration of hospitalisations (days)	24 (sd32)		21 (sd13) CI -17.8 to 12		<i>p=.79</i>	27 (sd19) CI -18 to 22.5		<i>p=.82</i>

Figure 1. Progress of participants through trial.



**Systematic telephone contacting of patients leaving the Emergency Department
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What is already known on this topic.

- Deliberate self poisoning is one of the commonest reasons for admission to hospital in Europe and up to 15% of patients who poison themselves eventually kill themselves.
- There are very few intervention of proved efficacy for these patients.
- These interventions have an expensive cost and concern just a part of suicide attempters.

What this study adds.

- Compared with usual treatment and 3 months telephone recontacting, telephone contact one month post-attempt, in addition to the usual treatment, may be a valuable strategy to reduce suicide attempt repetition.
- This strategy is proposed by the Emergency Department Team.
- The strategy would concern a very large panel of suicide attempters.

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The study needed important involvement of Contributorships, in the Emergency Departments :
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