The suicidal act generally does not occur suddenly without warning beforehand; actually, the suicidal person has given many clues, warnings, and indications of his intentions. Alertness and sensitization to these clues will help prevent suicidal behavior.

The Suicide Prevention Center*

The number of active suicide prevention agencies in the United States might be counted on the fingers of two hands, and within many communities the number of facilities available for ongoing suicide prevention activities is nil. The basic question in any community is whether or not there are adequate facilities for dealing with the important, other than purely medical aspects of individual suicide attempts. It was in an effort to give at least a partial positive answer to this question in one specific metropolitan area that the Suicide Prevention Center (hereinafter referred to as the SPC) was initiated. The need for community organizations established specifically to explore new avenues leading to more effective suicide prevention programs would seem to be evident. In 1958, under the purview of a five-year U.S. Public Health Service project grant (administered through the University of Southern California), the SPC was established in the Los Angeles community. The purposes of this chapter are to indicate the goals of the SPC and how it attempts to achieve these aims and to describe SPC operations and functions.

Considering the magnitude and seriousness of suicide as a public health problem, it is remarkable how little organized work has been done to further the basic understanding and prevention of suicide. The primary aims of the SPC have to do, of course, with both long-range and immediate prevention of suicide. The three main goals of the SPC are as follows: (A) The primary goal of SPC activities is to save lives. The selection, diagnostic, referral, and therapeutic activities of the SPC are conducted with this goal in mind. We shall refer to this activity as the clinical aspect of the SPC. (B) Another aspect of SPC activities is to establish the SPC as one of the public health agencies in the Los Angeles area. These activities focus on the integration and liaison of the SPC with such other agencies in the community as the city health department, the county health department, the police

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department, the Welfare Planning Council, and the coroner’s office. We shall refer to these activities as the community aspect of the SPC. (C) A concomitant SPC goal is to utilize its psychiatric, psychological, and social work data, obtained from a variety of suicidal types, to test various hypotheses concerning suicidal phenomena. We shall refer to these activities as the research aspect of the SPC.

The remainder of this chapter will describe in detail each of the three major functions indicated above: to save lives, to integrate with other agencies within the community, and to obtain important, systematically organized data that can be employed in research designs.

Clinical Aspect

Obviously, suicide prevention efforts must be directed toward living persons before they kill themselves. The question arises whether or not there is, usually, a preliminary prodromal phase during which the suicide victim reveals his self-destructive intention. On the basis of recent studies by Robins et al. [6], Dorpat et al. [1, 2], Stengel and Cook [8], Jensen and Petty [4], and the SPC [5, 7], it is possible to conclude that the great majority of suicides do display a recognizable presuicidal phase. The concept is proposed that there exists in the community, at any given period, a population of persons who can be designated as potentially suicidal or presuicidal because they have threatened verbally to commit suicide, or have made recent suicide attempts, or have shown certain specific behavior changes (e.g., the depressive syndrome or sudden increase in barbiturate and alcohol intake) that are prodromal for suicide. Cases for direct antisuicide efforts would come from this group of presuicidal persons on the presumption that it would include within it, as a smaller subgroup, a good proportion of those who will actually commit suicide.

Relatively little is now known about the total number, range, and characteristics of the population of presuicidal persons. At what rate do individuals leave this population and new persons enter? What happens eventually to most presuicidal persons? Do presuicidal persons tend to repeat suicidal behavior from time to time over the years? Do they usually seek help from physicians? What proportion see psychiatrists? If suicide attempts and suicide threats were made reportable conditions, some major gaps in our knowledge could be filled, but, unfortunately, according to Los Angeles city and county public health authorities, it is impossible at this time to make these conditions reportable. Meaningful statistics on self-destructiveness can be derived from hospital records only with maximal research effort, for there is no code number in the standard nomenclature of medical diseases for suicide, suicide attempts, or suicide threats. Relatively few hospitals use a special code number for suicide or suicide attempts, whereas others do not designate suicidal behavior in any way on the charts but code only the nature of the injury.

At present, at least three methods are being employed by the SPC to obtain needed data on presuicidal persons. These are (A) surveying the physicians in the community, using questionnaire and interview techniques; (B) abstracting large numbers of charts from emergency hospitals, general hospitals, and psychiatric hospitals; and (C) accumulating detailed case materials at the SPC. In addition, information about persons who have committed suicide has been collected through interviews with surviving relatives, friends, physicians, and other informants. Eventually, it should be possible to compare data from