Stepping Back from the Brink

An argument in favor of involuntary commitment, which could serve as an effective barrier to suicide.

By Nicole Li and Jonathon Wilson

Perhaps, at some time in our lives, we all get to *that point*—when despair at the tide of grief or loss or trauma brings one to consider suicide. *Perhaps*. Such rawness is difficult to capture on questionnaires and may remain unspoken even between best friends and spouses. The stigma of suicide—that it evinces weakness of character, cowardice, selfishness—make it an unlikely topic of frank, personal conversation. Whether or not each of us at some point in our lives contemplate the ultimate exit may be beyond determination. This article explores how individuals who reach that point may be dissuaded from taking their own lives.

Suicide is one of the leading causes of death in Washington, claiming over 1,000 lives every year, with thousands more hospitalized for attempts. Hotlines and crisis centers exist, but these are resources that one must seek out and ask for help. For someone in despair, and for those dealing with a friend or family member who displays suicidal tendencies, these resources may seem remote. What other approaches can our society take to curb suicide?

Involuntary commitment may be an effective preventive measure to suicide, because it can remove the immediacy of the moment when someone gets to *that point*.

Rate and Causes of Suicide in King County

In 2012, 269 suicide deaths occurred in King County. Of these, the vast majority were committed using firearms and suffocation—methods that are extremely lethal. However, the overall number of suicide *attempts* in King County is more than three times higher: 988. The vast majority of attempts are through poisoning methods such as overdosing on pills.

This data indicates some kind of disconnect between attempts and lethality. Why do people who want to die tend to grab a bottle of pills and not a gun? The answer may lie in the individual's access to these different methods. Most suicide attempts are impulsive actions committed in "moments of panic or despair,"[2] according to Professor David Hemenway, director of the Harvard School of Public Health.

If impulsiveness is behind the majority of attempts, then access to a particular method dictates the one that is used. A despairing individual acting on impulse is likely to reach for what is near at hand and what is easy to obtain: For many, it is easier to walk to the medicine cabinet than it is to find a gun or craft a noose. If ease of access dictates suicide methods—or even prompts attempts—then we would expect a decrease in attempts as barriers to access to different methods are implemented.

Barriers to Suicide

One of the most recognizable kinds of suicide barrier is fencing on bridges to prevent people from jumping. Other barriers may not be as obvious. For example, one effective barrier to suicide was accidentally discovered in the 1960s, when the United Kingdom switched its domestic gas production system from using coal to using natural gas.

In 1900s England, a common method of suicide was carbon monoxide poisoning via gas inhalation. It was a common suicide option in the kitchen and was employed by poet Sylvia Plath, who famously took her own life in 1963. However, the UK nationalized its gas industry in 1948, and in 1950, gas production began shifting from relying on coal to using natural gas. The result was a drop in carbon monoxide (CO) content in the gas supply from

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King County Suicide Statistics—2012[1]

Type	Attempted (Including Successful)	Successful Suicides	Success Rate	Percent of Total Successful	Suicides per 100,000
Firearms	122	118	96.7%	43.9%	6.0
Poisoning	703	62	8.8%	23.0%	3.2
Suffocation	52	48	92.3%	17.8%	2.5
Cut/Pierce	111	8	7.2%	3.0%	0.4
Total	**988**	**239**			**12.1**

1. Washington State Department of Health
2. Kiewra K, Guns and suicide: A fatal link. Spring 2008. Retrieved from Harvard School of Public Health: *www.hsph.harvard.edu/news/magazine/guns-and-suicide/*

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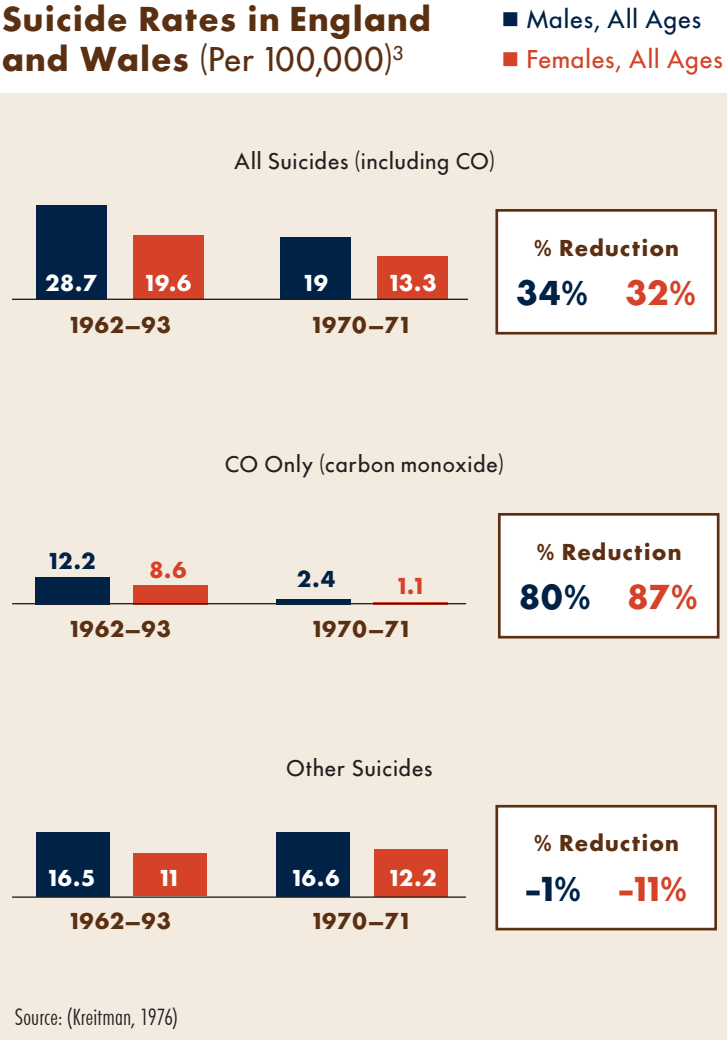
10–20 percent to only about 1 percent. This had a dramatic effect on suicide via CO poisoning, with CO suicides for males dropping 80 percent from 1962 to 1971, and female CO suicides dropping 87 percent during that period.

Suicide Rates in England and Wales (Per 100,000)[3]



Source: (Kreitman, 1976)

However, as the rate of CO suicides fell drastically, the rate of suicide by other means rose only mildly. This suggests that some individuals who might otherwise have committed suicide via CO poisoning were not dissuaded, and found alternative methods. If we assume that all of the increase in other methods of suicides was a result of decreased access to a means of CO poisoning, we can calculate the number of individuals "saved" from suicide.

Psychiatric researcher Norman Kreitman, the director of the Medical Research Council Unit for Epidemiological Studies in Psychiatry, made a direct link between the decline in CO content for domestic gas and the reduction in suicide via this method. "The fall in suicides due to this agent [CO] while those from other causes have followed quite a different trend, lead to the conclusion that there is a direct causal relationship between the two phenomena," he asserted.[4]

While it was assumed that an increase in other suicide methods was driven by the decrease in CO suicides, it is important to note that 99 percent of men and 84 percent of women who constituted the reduction (saved rate) in CO suicides did not go on to commit suicide at all between 1962 and 1971. This is in line with work done by Hemenway, which concludes, "most [suicide] attempters act on impulse, in moments of panic or despair. Once the acute feelings ease, 90 percent do not go on to die by suicide."[5] This conclusion supports the effectiveness of physical barriers to access as a means of suicide prevention.

Despite the UK coal-gas data, decades later the belief persists that simple, practical barriers to suicide are ineffective. "They'll just go somewhere else," is a frequent response to proposals to erect higher railings on bridges to deter jumpers. Studies do not support that assertion.

Prior to the installation of barriers on the Ellington Bridge in Washington D.C., an average of four people died by jumping from that bridge each year. In the *five* years following erection of barriers, only one suicide occurred from the Ellington Bridge, and the number of suicides from the nearby Taft Bridge, which had no barriers, did not change.[6]

While barriers existed on the Grafton Bridge in Auckland, New Zealand, three suicides occurred over four years, from 1992 to 1995. When the barriers were removed, 15 suicides occurred over seven years, from 1996 to 2002, constituting a 185 percent increase in the number of suicides per year; after which the barriers were reinstalled.[7] At Clifton Bridge in Bristol, England, 41 suicides occurred between 1994 and 1998; when a partial barrier was erected, suicides were reduced by over half. From 1998 to 2003, 20 suicides occurred, with no significant increase in suicides at nearby bridges.[8] Despite all of this data, there are still no barriers on perhaps the most famous "suicide bridge"—the Golden Gate Bridge in San Francisco.

Shortcomings of Physical Barriers

While the coal-gas and bridge studies provide striking examples of how restriction of physical access can reduce the number of suicides committed, they are limited examples. Gas was a state-controlled industry, with the only access to it being through a state utility. Likewise, installing higher bridge railings is within the power of the

3. Kreitman N, "The Coal Gas Story: United Kingdom Suicide Rates, 1960-71." *British Journal of Preventative and Social Medicine,* 1976; Vol. 3, No. 2:86-93.
4. "The Coal Gas Story: United Kingdom Suicide Rates, 1960-71."
5. *Guns and suicide: A fatal link.*
6. O'Carroll PW, Silverman MM, Berman. AL (ed), "Community Suicide Prevention: The Effectiveness of Bridge Barriers." *Suicide Life-Threat Behav,* 1994; 24:89-99.
7. Beautrais 2001.
8. Bennewith 2007.

Individuals "Saved" from Suicide from 1962 to 1971 (Per 100,000)

	CO Only Reduction	Other Suicide Increase	Individuals "Saved"	Save Rate
Males	**9.8**	**0.1**	**9.7**	**99%**
Females	**7.5**	**1.2**	**6.3**	**84%**

Source: (Kreitman, 1976)

state. Would similar state-imposed restrictions work for the most prevalent method in King County, overdosing on pills? The answer to that question, unfortunately, is no. For many medications, there is no way to reduce their lethality without reducing their effectiveness.

A study performed by Simon, et al., on impulsive suicide attempts—which Hemenway notes constitutes the majority of attempts—found that most attempters have underlying mental health issues. Simon's study revealed that 85 percent of people who attempt suicide are clinically depressed, and that 66 percent report feelings of hopelessness. It should be noted that these represent survivors, and the sample should be generalized to the overall population of attempters.

Of these survivors, only 33 percent reported having previously seen someone for emotional issues, and only 28 percent of them discussed their suicide attempt within the 30 days leading up to it. This reveals a shocking disparity: 85 percent of attempters are depressed, and yet only one-third had seen mental health professionals.[9] This means that two-thirds of people who attempt suicide do not receive needed mental health care.

Involuntary commitment as a potentially helpful option

Another barrier to serious harm to self or others may be placing individuals in a safe place where they have no access to any means of suicide. Involuntary commitment gets people into the health care system and is an avenue to potentially save lives. While involuntary commitment has a storied reputation, it can be a viable option for getting potentially suicidal individuals the help they need. Applying Simon's findings that 85 percent of those who attempt suicide are depressed to statistics in King County in 2012, it would follow that there were 840 individuals with depression who attempted suicide. Of these 840, only 280 would have seen a mental health provider about their depression. This leaves potentially 560 people in King County who did not receive the help that might have averted a suicide attempt.

King County outlines four specific instances in which a person may be committed against his or her will:

1. If he or she has threatened to harm himself or herself or others; or
2. If he or she has substantially damaged someone else's property; or
3. If he or she is in danger as a result of not caring for basic needs such as eating, sleeping, clothing and shelter due to a mental disorder; or
4. If they display severe deterioration in functioning ability and are not receiving essential care (King County Crisis and Commitment Services, 2009).

These rules are intended to protect an individual's liberty. Witnesses to these behaviors will be called upon to provide a written statement of facts, thereby agreeing to testify at a commitment hearing. If, upon receipt of the initial statement and initial review by the designated mental health professional, it is deemed that the person is in immediate danger, he or she may be detained and placed in a 72-hour detention.

This immediate detention period may interrupt an impulsive suicide attempt and allow the person to work through feelings of panic and despair. It may also, however, increase the person's feeling of powerlessness and cause him or her to feel shame and embarrassment. Involuntary commitment must therefore be considered carefully.

To initiate an involuntary commitment for someone who is believed to be suicidal, the first step is to contact the Crisis Clinic (206-461-3222). After review by a crisis counselor, if the situation requires immediate attention, the case will be referred to King County Crisis and Commitment Services. The individual will be further evaluated by a county-designated mental health professional (DMHP) who will discuss voluntary treatment options. Should these voluntary options be refused, and the individual in question has displayed one of the four behaviors listed above as justification for involuntary

9. Simon TR, Swann AC, Powell KE, Potter LB, Kresnow MJ, O'Carroll PW, "Characteristics of Impulsive Suicide Attempts and Attempters." *Suicide & Life Threatening Behavior,* 2001: Vol. 32, No. 1:49-59.

commitment, then the DMHP will arrange for the written statement to be taken and for detention to be arranged if the professional believes that an emergency exists.

If an emergency does not exist—meaning the threat is not deemed to be imminent—then court proceedings will be started, and it will be up to a judge to determine if the individual should be committed. While this latter option would not be interrupting an imminent suicide attempt, it does provide an opportunity to get individuals into the mental health care system, where treatment for underlying issues may occur.

Limitations to Involuntary Commitment

While involuntary commitment provides a means to interrupt a potential suicide attempt, it has limitations. First, as a result of the County's attempts to protect personal liberties the potential suicide attempter must have explicitly expressed a desire to harm themselves. As shown in the research performed by Simon, et al. this represents only 28 percent of attempters.[10] Second, it is not a rapid process and involves multiple levels of review by county personnel before a commitment can be made. Additionally, as involuntary commitment detains people against their will at the express request of another civilian, albeit after review by mental health professionals, there is the potential for abuse.

Recommendation

Involuntary commitment may be a good option for getting someone who is potentially suicidal, and has mental health issues, the help they need. However, as it requires a clear communication of a threat of personal harm, which represents a minority of suicide attempters, and is relatively slow, its applicability as a method for interrupting an impulsive suicide is limited.

A more rapid, short-term response is necessary. A 24-hour commitment may well be sufficient to interrupt an immediate suicide threat and save a large number of lives. Additionally, a shorter commitment time infringes somewhat less on individual liberty. As a result, a more rapid response would be feasible. The Community and Crisis Services, which can be reached through the Crisis Clinic, should be staffed with a small, around-the-clock, interdiction team that has the authority to intervene in a potential suicide situation. Additionally, provided that the situation warranted it, they should have the power to involuntarily commit the person to a mental health care facility for a 24-hour period for a psychiatric evaluation to determine whether the individual needs ongoing mental health treatment.

While this is a strong stance to take, it would provide the county with the ability to immediately intervene in a suicide attempt and to perform a 24-hour commitment. Given that most suicides are impulsive acts driven by momentary emotions, this could potentially save lives. Ultimately, however, it will be up to the legislature, and the voters of Washington to determine if this is an appropriate approach. ■

Summary Findings

- Roughly 1,000 people attempt suicide in King County every year; approximately 27 percent succeed.
- Physical barriers to suicide can be remarkably effective, as demonstrated in the coal-gas and various bridge examples.
- While physical access to pills and poisoning agents—the most common method of suicide attempt in King County—cannot be restricted, 85 percent of suicide attempters are depressed and only 1 in 3 have previously received mental health care.
- Involuntary commitment represents an avenue to get these individuals into the health care system, where they might obtain the mental health care they need.
- Most suicide attempts are acts of impulse, and approximately 90 percent of individuals deterred do not go on to commit suicide; the 72-hour minimum period of involuntary commitment, and the 24-hour proposed period, provide a way to interrupt a potential suicide attempt and to save lives.

Note: This article does not constitute a legal opinion nor is it a substitute for legal advice. Legal inquiries about topics covered in this article should be directed to your attorney.

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10. "Characteristics of Impulsive Suicide Attempts and Attempters."