

the Magnet and the Veil

By William M. Glenn

The soaring Bloor Street Viaduct, arching 500 metres across the Don Valley in the heart of downtown Toronto, can be an oddly romantic place. Beneath the pavement, the valley falls surprisingly away below the bridge to a dizzying depth of just under 40 metres. On a bright May morning, a spring breeze blows up from Lake Ontario a few kilometres to the south. On its wide open sidewalks, pedestrians alternatively edge closer to the rushing traffic or the stone balustrade, depending on their particular tolerance for heights. Far below, among the trees that line its banks, the waters of the Don River swirl beneath the centre span. To the east, six lanes of expressway are, as usual, clogged bumper-to-bumper with rush hour traffic.

But the Bloor Viaduct is not just another engineering marvel. Since 1919, it has been one of North America's strongest suicide magnets, second only to San Francisco's Golden Gate Bridge in attracting the desperate, the hopeless and the mentally ill. Over the years at least 400 lost souls have perched along its parapet, oblivious to the city pulsing with life all around them, and made this scrap of valley gouged through the urban landscape their last stop on earth.

In recent years, the rate has been picking up, with one person jumping to his or her death from the viaduct, on average, every 22 days.

Al Birney knows about loss. In his soft Gaelic lilt, he talks about a day back in 1997 when the son of a good friend jumped from the Bloor Viaduct. As chairman of the "Bridge Committee" of the Schizophrenia Society of Ontario (SSO), Al Birney spent the next six years, along with his friend Michael McCamus, rallying local politicians, police, emergency response personnel, mental health advocates and concerned residents to the cause of building a suicide barrier. "Since we started this thing, 80 more people died jumping off that same bridge," says Al Birney.

Somewhat surprisingly, opposition to building a barrier

on the viaduct was widespread. Some city councilors insisted it would cost too much. The preservationists worried that a barrier would mar a historically important structure and an architectural gem. The Toronto Transit Commission said that a fence would hamper maintenance on the subway line that runs beneath the roadway. Some locals complained it would ruin the view.

But there was one argument that came up over and over and over again. "Just about everybody said the project didn't make sense," Al Birney sighs. "They told us that if we put up a barrier on the viaduct, people would simply go commit suicide someplace else."

It's a pretty logical argument. But there's nothing logical about suicide.

When one looks at national averages, suicide by jumping — either from a height or in front of a train — is a relatively rare occurrence compared to the much more common hangings, drug overdoses and deaths by gunshot that populate the coroners' reports. Typically, only three to five percent of suicides choose the violent (but extremely effective) death by jumping. However, the rate can increase to as much as 30% in an urban area, such as downtown New York, which boasts a number of towering apartment blocks and other precipices of opportunity. And certain sites — the Eiffel Tower, the Empire State Building, the Golden Gate Bridge, Niagara Falls and Toronto's own Bloor Street Viaduct, to name the top five — have each acquired an international reputation or iconic status as the perfect place to end it all.

The attraction is three-fold. First, most suicide magnets are readily accessible. Situated in the middle of a city, they can usually be reached by walking, biking or taking a subway or a cab right to the edge of oblivion.

Second, they have a notoriety or public reputation that this is the place where people go to kill themselves. The psychiatrists call it suggestibility. The tour bus drivers rhapsodize about past suicides, the media breathlessly

report on the latest cases and the barflies lay bets on the next one. There's even a pool on the Internet where you can guess the age, sex and date of the next fatality.

And third, each location supports or encourages a romanticized view of death. The views from the Sydney Harbour Bridge or the Sunshine Skyway across the mouth of Tampa Bay or England's Beachy Head — all on the list of established suicide magnets — are breathtaking. Even the Bloor Viaduct offers an enticing glimpse of nature in the midst of the city. A jumper might easily imagine stepping off into a finer, happier world. A short plunge into the water and then nothing. No pain, no doubt, no despair.

The Bloor Viaduct has all three features of suicide magnet, says Michael McCamus, spokesperson for the SSO's Bridge Committee. And its popularity has increased in recent years. One woman wheeled her wheel chair across the city to get to the viaduct. Another carried a stool to climb over the railing. It's not uncommon for out-of-town suicides to drive over several other suitably high and equally convenient bridges to get to the one with the beautiful view, the one all the other jumpers use.

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When it comes to death by jumping, not just any bridge will do. The San Francisco-Oakland Bay Bridge was built at about the same time as its more famous cousin, the Golden Gate Bridge, which is less than 10 kilometres to the west. It's just as high and just as lethal, but five times as many people have jumped off the Golden Gate. It's the thing to do. "It's considered kind of tacky to jump off the Oakland Bay Bridge," Michael McCamus explains. For one thing, you can only get to it by car. For another, all the famous, well publicized suicides use the Golden Gate. The Oakland Bridge simply doesn't have the same mystique.

So who jumps off bridges? Who is attracted to the suicide magnets? In study after study, a consistent profile of the suicidal jumpers emerges. They are predominately young, in their early to mid-30s. They are usually male, by as much as a six-to-one ratio. And many of them are psychiatric patients suffering from depression or some form of psychotic illness, often schizophrenia. (It should be noted that these are North American statistics; the ratio of, say, male to female jumpers may change in other countries; in Switzerland, jumpers tend more often than not to be women.)

An analysis of the 54 people who committed suicide by jumping from the Jacques Cartier Bridge in Montreal between 1988 and 1993 is typical. The age of the victims ranged from 13 to 68, with most clustered around the median age of 30 years. Men outnumbered women by 46 to 8 (or 5.7:1). Forty-four of the suicides had experienced recent personal problems. Thirty-six suffered from a diagnosed mental illness (depression, psychosis or a bipolar disorder). Half of them had told friends, family or mental health workers about their intention to commit suicide. One-quarter had

specifically mentioned the Jacques Cartier Bridge.

The Centre for Research and Intervention on Suicide and Euthanasia in Montreal has also studied the epidemiology of suicide. In 10 years, from 1986 to 1996, there were 129 suicides in the Montreal subway system, the Métro. Over the same period there were 323 suicide attempts, or 2.6 attempts for every successful suicide, and another 362 "prevention interventions" in which the subway authorities intercepted an individual they believed exhibited suicidal intentions before any attempt occurred. Of the 129 suicides, the researchers were able to determine that 105 — more than 80% — had histories of mental illness: 50% suffered from depression, 25.5% from schizophrenia, 16.5% from some non-specific psychosis, 5% from manic-depression (as it was called) and 3% from alcoholism. In three-quarters of the 105 cases, the individual was either living in a treatment facility or had been prescribed psychotropic medications shortly before the date of the suicide.

At least 100 of the jumpers in the Montreal study had also experienced an "adverse life event" — ranging from the breakup of a love affair to the death of a child or other relative, to problems at work or home — sometime in the two weeks immediately preceding their suicides. Most killed themselves in the Métro station closest to their homes. Only 27 left notes.

"There is so much despair in the mental health field," says Al Birney, "and so little is being done about it." There are more than 200,000 people with schizophrenia in Canada. "At some point in their lives, 46% will attempt suicide," he says, "and 12% will succeed."

Research shows that jumpers tend to act impulsively. "Schizophrenics don't say 'Next Tuesday, I'm going to commit suicide'," says Wendy Douglas, head of communications for the Schizophrenia Society of Ontario. Suicide is typically an impulsive and emotional reaction. "If the bridge has a safety barrier they probably won't travel across the city to find another bridge. They don't have a Plan B," she says.

A Texas study of 153 nearly lethal suicide cases showed that about one-quarter were impulsive attempts; that meant the subject had spent less than five minutes between making a decision to commit suicide and the actual attempt. Astonishingly, seven of the subjects said they had spent "less than one second" deliberating whether to kill themselves. They just went ahead and tried to do it. Most had not considered another form of suicide; if this didn't work, there wasn't a fall-back position. Again men were twice as likely to act impulsively, and they tended to be violent men who were quick to fight. Indeed, a serious altercation in the preceding hours may have sparked their suicidal urges. Drugs or alcohol didn't seem to play a major role.

Similar studies by other researchers found the number of impulsive suicides to range as high as 40% to 50% of the

total. "Suicide is often a spontaneous decision," says Al Birney. "If there's a fence, they may decide to live. The mentally ill don't reason the same way as the rest of us do. If something puts them off, even for a few moments, it may put them off the idea of suicide forever."

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Will a person denied the opportunity to commit suicide in one place inexorably try to end his or her life someplace else? Twenty years ago, Dr. Richard Seiden, a former professor of suicidology with the University of California at Berkeley, attempted to answer this difficult question by tracking the fate of those people who had tried to jump from the Golden Gate Bridge, but had been pulled back from the brink in time. Those who actually step off into space almost always die; the 250-foot plunge into the cold, choppy waters of San Francisco Strait is fatal more than 99% of the time.

From the day the bridge opened on May 18, 1937, through April 1, 1978, there were a total of 625 suicide deaths officially recorded and at least another 200 cases in which the bodies were never recovered. (Today, the official tally sits at about 1,200, with the actual number of suicides thought to be over 2,000. The thick fog, dangerous ocean-bound currents and swirling tides of the strait make body recovery difficult.) Over the same 41-year period, 515 persons had been restrained from jumping by police, bridge workers or bystanders; some were committed to hospital for observation, but the majority were seen by emergency room physicians, who officially pronounced that they had, indeed, attempted suicide and then sent them home, usually in the company of friends or family.

Dr. Seiden collected all the available data on these individuals from the hospital records and conducted a search of the death certificates held by the State of California Office of Vital Statistics (which, through a reciprocal agreement with other jurisdictions, could also track many of the potential suicides who may have died out-of-state). Of the survivors, Dr. Seiden discovered that 32 had died violently — representing about half of the total fatalities in the group — some from alcohol abuse, some from drug overdose, some in suspicious single-car accidents. About one-third of these violent deaths occurred within six months of the original suicide attempt, within the clinically determined high risk period for suicides. But 451 of the 515 were still alive, some of them many years after their first and often only attempt at suicide. Only five to seven percent had eventually managed to kill themselves.

"When a person is unable to kill himself in a particular way, it may be enough to tip the vital balance from death to life in a situation already characterized by strong ambivalence," Dr. Seiden writes. "The findings confirm... that suicidal behaviour is crisis-oriented and acute in nature. Accordingly, the justification for prevention and intervention, such as building a suicide prevention barrier,

is warranted and the prognosis for suicide attempters is, on balance, relatively hopeful."

Barriers buy time. If a screen or a net can make suicide more difficult, the self-destructive impulse has time to subside. Rather than seeking another, more accessible place to kill themselves, prospective suicides could, instead, decide to call a crisis counselor, seek treatment or get back on their medication.

If the suicidal urge on the bridge is frustrated, they will probably not go down into the subway and jump in front of the next train.

One of the most interesting findings of suicide research is the concept of "means restriction". Experience has shown that closing off access to one popular form of suicide does not seem to drive people to other forms of self destruction, but rather results in a drop in the overall suicide rate. The most celebrated example occurred in the early 1960s, when England switched from coke gas (which contained a high percentage of carbon monoxide) to the less lethal natural gas for fueling kitchen ovens across the country. No longer could despondent householders turn on the gas, stick their heads in the oven and quickly expire. Overnight, the number of suicides dropped by about one-third — not surprisingly, the same percentage that had opted for gas in the past — and those numbers stayed down for at least 15 years.

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A handful of Golden Gate jumpers have survived the terrible fall to provide us with a little more insight into their near-death experiences. Dr. David Rosen, professor of psychiatry at Texas A&M University, interviewed six of them and published the results in the *Western Journal of Medicine*. All said they had been attracted by the notoriety of the bridge and the beauty of the location. The Golden Gate Bridge was

the only place they had considered committing suicide, the only site they had planned for their deaths. And virtually every survivor said that the moment they stepped off into space, they had second thoughts. They wished they hadn't taken the plunge. They wanted to live.

However, those who support the erection of suicide barriers aren't concerned about just the jumpers. A suicide can have a devastating effect on the police, firefighters and emergency crews that respond to an incident, as well as any bystanders who witness it. There's a large high school, Rosedale Heights Secondary School, immediately adjacent to the western end of the Bloor Viaduct. Over the years, more than a few students have seen somebody jump from the bridge and many have seen the ambulances and police crews hoisting bodies up out of the valley below. "Witnessing a suicide, particularly during the impressionable teenage years, dramatically increases your own risk later in life," says Michael McCamus. "It appears to break the taboo. Witnesses are much more likely to commit suicide than [the average member of] the general public."

Controlling *the Copycats*

The first sections of the Vienna subway opened in 1978. It took a while for the first jumpers to make an appearance — a single one in 1980, a second in 1982. But by 1984, the numbers were starting to creep up, and the local press began paying attention. Each new suicide was described in ever more lurid detail by the newspapers and was almost always followed by a cluster of up to five copycat attempts, most of them successful. It appeared that the new subway had become an accepted place to kill oneself.

In 1987, there were 11 suicides and another 11 attempts. That was also

the year that the Austrian Association for Suicide Prevention drafted its media guidelines for the responsible reporting of suicides. The guidelines were based on the assumption that media reporting could trigger further suicides, especially if the reporting included specific details on the method used, was featured prominently in the paper, employed a dramatic headline and included photographs of the victim. By the following year, the press had stopped all reporting of subway suicides.

The number of subway jumpers dropped by three-quarters and that

new low rate has remained relatively stable in subsequent years. Last year, international guidelines "Reporting on Suicide: Recommendations for the Media" were published by a coalition of U.S. public health groups, in collaboration with the World Health Organization, the National Swedish Centre for Suicide Research and the New Zealand Youth Suicide Prevention Strategy. Rather than ban all suicide reporting, the document provides guidance on positive angles to pursue, information about mental illness, and cautions about reporting that could encourage imitative suicides.

Toronto police were also concerned about suicides landing on or among the cars and trucks on the busy expressway that shares the valley floor with the muddy Don River. In 2002, one jumper actually landed on the hood of a passing car — and lived.

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It's true that many of the suicide barriers that have been installed on bridges, towers and lookouts around the world are damned ugly. Unfortunately, very little innovative or creative design work has been done in the area of suicide prevention. "Most barriers are very badly designed and very badly conceived," says Dereck Revington, a professor of architecture at the University of Waterloo. "They consist of little more than chain-link fencing that arches over the pedestrian walkway." His company, Dereck Revington Studio in Toronto, won the international competition held by the city back in 1998 to design a suicide barrier for the Bloor Viaduct. "First and foremost, my design was intended to deter suicide," he says, "but I also tried to create a new civic promenade."

The viaduct, more properly called the Prince Edward Viaduct, was championed by one of the great civic visionaries in Toronto history, R.C. Harris, in the early years of the 20th Century.

Dereck Revington says that the top of the viaduct — which carries traffic, both vehicular and pedestrian, a half kilometre across the Don Valley — was a very flat, menacing expanse. "It's one of the greatest bridges in Canada," he says. The suicide barrier, which was to be completed in April of 2003, "enhances the structure and fulfills the promise of the bridge."

"It was conceived as a musical instrument," Dereck Revington explains. The suicide barrier consists of an outer veil of 10,000 post-tensioned, stainless steel rods — each just eight millimetres in diameter — that are spaced 12 cen-

timetres apart and tightly strung like the strings of a harp, from bank to bank. The veil is supported by a series of great bow-string masts that are aligned with the crescent-shaped arches of the original viaduct. A second, inner veil of irregularly spaced rods is anchored to the new hardwood railing.

The overall effect is a light and shimmering enclosure — Dereck Revington likes to call it a "luminous veil" — that counterpoints the dance of light over the surface of Lake Ontario to the south and the dark valley floor 40 metres below. "The design allowed us to create a very effective barrier, while preserving the view," he says.

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There had been considerable debate over the cost of the barrier project and, more precisely, over who will pay it. An offer by a local company to underwrite a significant share of the cost of the project in return for the right to place illuminated signs in the previously pristine Don Valley further complicated matters. The stigma of suicide combined with the stigma of electronic billboards delayed the project for close to two years, says Michael McCamus; in that time, another 30 people jumped and died. Eventually, in the spring of 2001, city council put up the whole \$5.6 million needed (although it is still soliciting offers from sign companies that might want to make a deal) and construction of the barrier began. The final rod was welded into place in March of 2003.

Today, the luminous veil crowns the Bloor Viaduct in a shimmering halo. Michael McCamus calls the barrier functional but beautiful in its own right. "Already, it's one of the signature pieces of architecture in Toronto," he says. "I wouldn't be surprised to see the veil featured on postcards and T-shirts and baseball caps one day."

And Al Birney is pleased. "The families of mentally ill people used to have nightmares about the Bloor Street Viaduct.

Now they can sleep easier," says Al Birney, who shared the 2002 Toronto Volunteers of the Year Award with Michael McCamus for the campaign to make the bridge suicide-proof. "We couldn't cover everything, not subway jumpers and drug overdoses and hoses attached to tail pipes, but at least we got the barrier up on that bridge." **MD**

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The Top 10 ways to detoxify a Suicide Magnet

- 1 • Install physical barriers. Whether it be a higher railing, mesh screen or safety net, a well designed physical barrier can deter all but the most determined suicides. And once the impulse is thwarted, the individual may never try again.
- 2 • Restrict or control access. Bridges with pedestrian access are favoured by suicides. However, some will drive a car or take a cab to a favoured suicide magnet that bars pedestrian traffic. A barrier must be high enough that an individual can't easily climb over it from the hood of his or her car.
- 3 • Install and label crisis phones. Help lines, when installed on suicide magnets, have proven successful in preventing some suicides. However, a caller must be quickly patched through to a trained counselor at a suicide prevention centre.
- 4 • Train employees to watch for warning signs. A lone tourist who seems preoccupied, who won't meet

- your gaze, who isn't carrying a camera or a backpack, might be a potential suicide. Local psychiatric hospitals can instruct bridge staff about potential danger signs.
- 5 • Implement regular patrols. Bicycle or motorized patrols can both dissuade potential jumpers and respond to emergency situations quickly. This should be a permanent position at long bridges, skyways and other suicide magnets.
- 6 • Install video surveillance cameras. Cameras monitored by security staff who understand the warning signs of potential suicides can help direct trained interveners to trouble spots as incidents develop. The placement of cameras at high risk locations might also deter potential jumpers.
- 7 • Improve emergency response times. By improving response times, the low survival rates for jumpers can be significantly improved. Emergency crews should be trained to deal with the specific

- kinds of extreme trauma seen in survivors.
- 8 • Improve water rescue capabilities. A number of suicides who survive the fall drown before they can be rescued. Drowning is the primary or contributing cause of death in 16% of suicides from California's Golden Gate Bridge.
- 9 • Minimize publicity or reporting of previous suicides. Suicides tend to occur in copycat clusters. To reduce the incidence of imitators, media have to be circumspect in the way they report suicides. A broad coalition of mental health and suicide prevention groups has prepared guidelines for the responsible reporting of such incidents.
- 10 • Listen for the warning signs. Before they make their attempt, many suicides confide their intentions to friends, relatives or hospital workers. In many cases they name the particular suicide magnet they intend to visit.