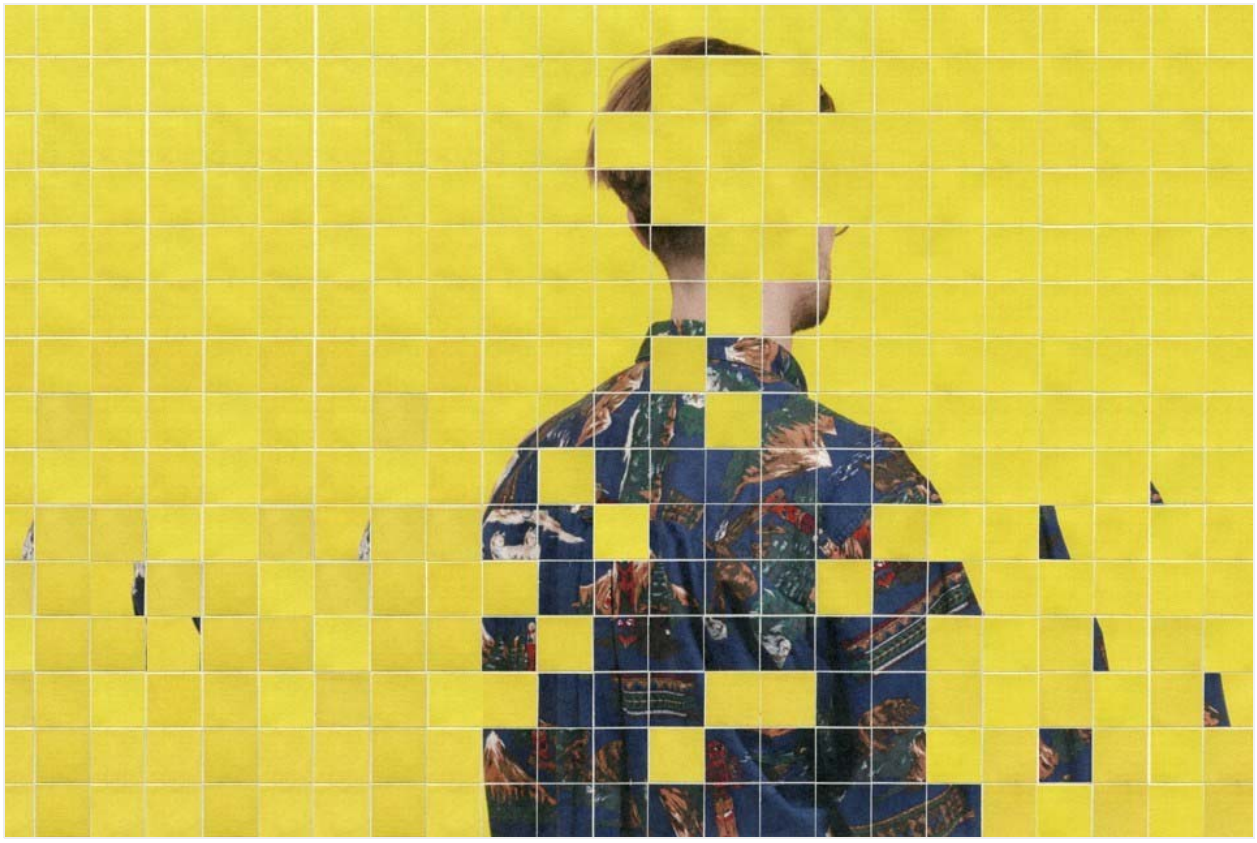
The Atlantic

A World Without Suicide

A growing number of mental-health experts are taking a proactive approach to suicide prevention—and they have a bold goal.



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SIMON USBORNE | AUG 1, 2017 | HEALTH

Steve Mallen thinks the signs first started to show when his son stopped playing the piano. Edward, then 18, was a gifted musician and had long since passed his Grade 8 exams, a series of advanced piano tests. Playing had been a passion for most of his life. But as adulthood beckoned, the boy had never been busier. He had won a place to study geography at the University of Cambridge and was

reviewing hard for his final exams. At his school, Edward was head boy and popular among pupils and teachers. His younger brother and sister idolized him.

"We didn't attach any particular significance to it," says Mallen of what he saw as merely a musical pause. "I think we just thought, 'Well, the poor lad's been at the piano for years and years. He's so busy … ' But these are the small things—the ripples in the fabric of normal life—that you don't necessarily notice but which, as I know now, can be very significant."

Three months after Edward stopped playing, and just two weeks after he handed in an English essay his teacher would later describe as among the best he had read, police knocked at the door of the family home in Meldreth, a village 10 miles south of Cambridge. Steve Mallen was at home, alone. "You become painfully aware that something appalling has happened," he recalls. "You go through the description, they offer commiserations and a booklet, and then they leave. And that's it. Suddenly you are staring into the most appalling abyss you can ever imagine."

The next time Mallen heard his son play the piano, the music filled Holy Trinity Parish Church, a mile from the station where Edward caught the train to school every morning, and where he died by suicide on February 9, 2015. Steve says 500 people came to the funeral. Friends had organized a sound system to play a performance of Edward's filmed on a mobile phone. "My son played the music at his own funeral," Mallen says as he remembers that day over a mug of tea in a café in central London. "You couldn't dream this stuff."

I first talk to Mallen, who is 52, in November 2016, 21 months to the day since Edward's death. His hair is white; his blazer, navy. He wears a white shirt and a remembrance poppy. He talks in perfect paragraphs with a default setting of

businesslike, but it is clear that the abyss still falls away before him. He says it always will. But life has also become a mission, and in the two years since his son's death by suicide, Mallen, a commercial property consultant, has become a tireless campaigner, a convener of minds. He has earned the prime minister's ear and given evidence to health select committees. The study at his home is filled with files and research papers.

"As a father, I had one thing to do and I failed," he says, his voice faltering for the first time. "My son was dying in front of me and I couldn't see it, despite my education, despite my devotion as a father … So you see this is coming from an incredible sense of guilt. I suppose what I'm trying to do is save my boy in retrospect. I stood next to his coffin in the church. It was packed with people—a shattered community—and I made him a public promise. I said that I would investigate what had happened to him and that I would seek reform for him, and on behalf of his generation.

"Quite simply, I'm just a guy honoring a promise to his son. And that's probably the most powerful motivation that you could imagine, because I'm not about to let him down twice."

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Edward's suicide was one of 6,188 recorded in the U.K. in 2015, an average of almost 17 a day, or two every three hours. In the U.K., suicide is the leading cause of death among women under 35 and men under 50. The World Health Organization estimates that 788,000 people died by suicide globally in 2015. Somewhere in the world, someone takes their life every 40 seconds. And despite advances in science and a growing political and popular focus on mental health, recorded suicides in the U.K. have declined only slightly over the past few decades, from 14.7 per 100,000 people 36 years ago to 10.9 in 2015.

A simple belief drives Mallen: that Edward should still be alive, that his death was preventable—at several stages during the rapid onset of his depression. Moreover, Mallen and a growing number of mental health experts believe that

this applies to all deaths by suicide. They argue that with a well-funded, better-coordinated strategy that would reform attitudes and approaches in almost every function of society—from schools and hospitals to police stations and the family home—it might be possible to prevent every suicide, or at least to aspire to.

"Even if you believe we are never going to eradicate suicide, we must strive toward that."

They call it Zero Suicide, a bold ambition and slogan that emerged from a Detroit hospital more than a decade ago, and which is now being incorporated into several National Health Service trusts. Since our first meeting, Mallen has himself embraced the idea, and in May of this year held talks with Mersey Care, one of the specialist mental health trusts already applying a zero strategy. His plans are at an early stage, but he is setting out to create a Zero Suicide foundation. He wants it to identify good practices across the 55 mental health trusts in England and create a new strategy to be applied everywhere.

The zero approach is a proactive strategy that aims to identify and care for all those who may be at risk of suicide, rather than reacting once patients have reached crisis point. It emphasizes strong leadership, improved training, better patient screening and the use of the latest data and research to make changes without fear or delay. It is a joined-up strategy that challenges old ideas about the "inevitability" of suicide, stigma, and the idea that if a reduction target is achieved, the deaths on the way to it are somehow acceptable. "Even if you believe we are never going to eradicate suicide, we must strive toward that," Mallen says. "If zero isn't the right target, then what is?"

Zero Suicide is not radical, incorporating as it does several existing prevention

strategies. But that it should be seen as new and daringly ambitious reveals much about how slowly attitudes have changed. In *The Uses of Literacy: Aspects of Working-Class Life* (1957), a semiautobiographical examination of the cultural upheavals of the 1950s, Richard Hoggart recalled his upbringing in Leeds. "Every so often one heard that so-and-so had 'done 'erself in,' or 'done away with 'imself,' or 'put 'er 'ead in the gas-oven,'" he wrote. "It did not happen monthly or even every season, and not all attempts succeeded; but it happened sufficiently often to be part of the pattern of life." He wondered how "suicide could be accepted—pitifully but with little suggestion of blame—as part of the order of existence."

Hoggart was writing about working-class communities in the north of England, but this sense of expectation and inevitability defined broad societal attitudes to suicide as well. It was also a crime. In 1956, 613 people in England and Wales were prosecuted for attempting to "commit" suicide, 33 of whom were imprisoned. The law only changed in 1961, but the stigma endured; mental health experts and the U.K. helpline Samaritans advise against the use of the term "commit" in relation to suicide, preferring "to die by suicide," but the word still regularly appears in newspaper headlines. The same voices have strongly opposed the view that suicide is "part of the pattern of life," ultimately giving rise to the idea that its eradication—or at least a drastic reduction—might be possible.

* * *

Traditionally, suicide has been viewed as a deliberate action, a conscious choice. As a result, mental-health systems have tended to regard at-risk patients in one of two ways. "There were the individuals who are at risk but can't really be stopped," says David Covington, a Zero Suicide pioneer based in Phoenix, Arizona. "They're 'intent on it' is the phrase you hear. 'You can't stop someone who's fully intent on killing themselves.' So there is this strange logic that individuals who die couldn't be stopped because they weren't going to seek care and tell us what was going on. And those who do talk to us were seen as somehow manipulative because of their ambivalence. You heard the word 'gesturing.' So

we have this whole language that seemed to minimize the risk."

Covington is president and CEO of RI International, a mental-health group based in Phoenix that has more than 50 crisis centers and other programs across the United States, as well as a number in Auckland, New Zealand. A prominent and energetic speaker, he is also president-elect of the board of directors of the American Association of Suicidology, a charitable organization based in Washington, D.C., and leads an international Zero Suicide initiative. When he started in mental health more than 20 years ago, he was dismayed by the gaps in training and thinking he found in the system. Breakthroughs have come only recently, long enough for Covington to have observed and promoted a shift away from a fatalism—and a stigma—that was preventing any progress in reducing death from suicide while we eradicated diseases and tackled other threats, such as road accidents and smoking.

Covington credits a book and a bridge with accelerating that change. In *Why People Die by Suicide* (2005), Thomas Joiner, a professor of psychology at Florida State University, drew on the testimony of survivors, stacks of research and the loss of his own father to upend minds. He recognized the myriad pressures on a suicidal mind—substance abuse, genetic predisposition to mental illness, poverty—but identified three factors present in all of those most at risk: a genuine belief, however irrational, that they have become a burden to those around them; a sense of isolation; and the ability, which goes against our hard-wired instincts of self-preservation, to hurt oneself (this combines access to a means of suicide with what Joiner describes as a "learned fearlessness"; Covington calls it an "acquired capability"). "[The book] gave an architecture to what was going on that we had not seen before," Covington says. "It was like a crack through the entire field."

The steel net ... is designed not to

catch people, but to deter them from jumping.

Then came the bridge—or *The Bridge*, the 2006 documentary about suicides at the Golden Gate Bridge. A swirl of outrage greeted its release, although anger was generally directed at the filmmaker rather than the toll of death and bereavement at the San Francisco landmark. Its maker Eric Steel also faced accusations of ghoulishness; *The Bridge* features footage of people falling to their deaths and subsequent interviews with their families. "This could be the most morally loathsome film ever made," film critic Andrew Pulver wrote in *The Guardian*. Yet Steel intended to shock, and to expose an attitude to suicide on the bridge that exemplified society's. "It hit the public psyche, it challenged core myths in a way that was extremely powerful," Covington says.

In the 1970s, local newspapers launched countdowns to the 500th death on the bridge since its completion in 1937 (deaths have occurred on average once every two to three weeks). In 1995, a radio DJ promised a case of Snapple to the 1,000th victim's family. Only when police intervened did official counting cease, at 997.

For decades the bridge's directors have resisted calls, on financial and aesthetic grounds, for a safety barrier between the pedestrian walkway—which has a low railing—and the water 75 meters below. In 1953, one bridge supervisor argued that it was better that jumpers die there than on a pavement below a tall building. But in 1978, Richard Seiden, then a professor emeritus at the University of California, Berkeley's School of Public Health, found 515 people who had been stopped from jumping from the Golden Gate Bridge between 1937 and 1971. Ninety-four percent were living or had died of natural causes.

The study, which Covington says was "ignored for 25 years," suggested what several others have shown: Simply by removing access to danger, and an easy

outlet for "learned fearlessness," simple interventions can dramatically reduce suicide rates. On a bridge that could not be constantly patrolled, it also intensified calls for a safety net. Later, in 2008, the bridge's board of directors voted in favor of one. Construction began only in May of this year. The steel net, to be placed six meters below the walkway, is due to be completed in 2021. It is designed not to catch people, but to deter them from jumping.

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Edward Mallen's own Golden Gate Bridge was the train station he used every day to get to school. His father Steve will never know what went through his mind that day, but those who survive attempts to take their own life—and go on to talk about it—are being embraced in the fight for further understanding. As of 2005, a year before Steel's documentary came out, only 26 people had lived after hitting the water below the Golden Gate Bridge at 75 mph. Those whose injuries —broken bones, punctured organs—do not kill them on impact typically then drown in pain. Recovered bodies have shown the effects of shark and crab bites.

Kevin Hines was 19 and suffering from severe bipolar disorder when he caught a bus, alone, toward the bridge in September 2000. His family knew that he had been mentally ill, and he was receiving treatment, but the voices in the young

man's head, which often came with hallucinations, willed him to take his life. They told him that he was nothing but a burden to everyone around him, and that if he revealed to anyone the extent of his suffering he would be locked up. "When you self-loathe long enough, and believe the voices, you lose all hope and suicide becomes an option," Kevin says by phone from his home in Atlanta. "What people in that position can't recognize is that the voice is nothing but a liar—a false reality created by your brain's misaligning chemistry … they believe the people around them don't have the ability to empathize."

Kevin was neglected by his birth parents, who had drug and mental health problems. As a newborn, before he was placed into foster care, they left him alone on the concrete floor of a motel in San Francisco and fed him Coke and stolen, sour milk. A landmark 1998 study published in the *American Journal of Preventive Medicine*, and cited in a report published in March by the Samaritans, showed that people with exposure to four or more "adverse childhood experiences" (known as ACEs, which include physical abuse, violence against the mother, exposure to substance abuse, or the imprisonment of a parent) were 12 times more likely to have made a suicide attempt in their lifetimes.

Kevin's devoted adoptive parents were aware something was wrong, and helped him get treatment, but Kevin kept everyone in the dark. He told doctors he was following a plan he had not read and that he was taking his medication, which he only took sporadically, often while drinking until he blacked out. "I was a wrestling state champion, a football player, by all accounts doing great on the outside." By the night before his bus ride, Kevin had suffered days of decline. "That's when the bridge was the spot I decided on," he recalls.

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Kevin rejects the notion that anyone "chooses" to take their own life. "It's not a choice when a voice in your head, a third party to your own conscience, is literally screaming in your head, 'You must die, jump now.'" He also challenges the idea

that suicide is a selfish act, because to a person in extremis, compelled to believe they are a burden, living can feel like the selfish act. Yet he also remembers feeling how little it would have taken to deter him that morning in 2000. "I had made a pact with myself, and many survivors report this, that if anyone said to me that day, 'Are you OK?' or 'Is something wrong?' or 'Can I help you?'—I narrowed it down to those three phrases—I would tell them everything and beg for help." As he sat on the bus, where he remembers crying, yelling aloud at the voices to stop, nobody said anything. "It still baffles me that human beings can't see someone like that, wailing in pain, and say something kind—anything," he says.

"It was instant regret the moment my hand left the rail."

As Kevin walked along the bridge and leaned over the rail, he thought help might have arrived when a woman approached him. "But she pulled out a digital camera and asked me to take her picture. She had a German accent. I figured the sun was in her eyes, maybe she didn't see the tears. So I take this woman's picture five times, hand her the camera, she thanks me and walks away. At that moment I said, 'Absolutely nobody cares. Nobody.' The voice said, 'Jump now,' so I did."

It takes just under five seconds for a person to fall from the Golden Gate Bridge into the water below. "It was instant regret the moment my hand left the rail," Kevin recalls. "But it was too late." He opened his eyes deep underwater, his spine broken. "All I wanted to do was survive. I remember thinking, before I broke the surface, I can't die here. If I do, nobody will know I didn't want to die, that I'd made a mistake." Kevin struggled to stay afloat while the coastguard came to his aid. He spent weeks recovering in a psychiatric ward and says it took years to be honest with himself about his mental health. He still works hard to

stay stable, and has become a powerful voice in suicide prevention, as a researcher, writer and speaker. "Of the 25 or 26 people who have survived jumping from the Golden Gate Bridge and are still alive, 19 have said they felt instant regret the second their hand left the rail," he says. "The act of suicide is separate from the thought of suicide."

Removing the means of suicide has become a growing part of modern prevention strategies, whether or not they come with a "zero" tag. In the early 2000s, the U.K. Department of Health asked the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, based at the University of Manchester, to recommend a way to reduce suicides in mental health wards. "From our data, we said remove the ligature points that make it possible for people to hang themselves," recalls Louis Appleby, a professor of psychiatry and the director of the inquiry. He also leads the National Suicide Prevention Strategy for England.

By 2002, wards were required to remove non-collapsible curtain rails in bathrooms and around beds. A later study by Appleby's team, published in 2012, showed that inpatient suicide cases by hanging on the ward in England and Wales fell from 57 in 1999 to 15 in 2007. "There was also a broader effect, because mental health wards seem to have got safer more generally as the issue of safety became more prominent," Appleby says. Outside hospitals, measures that have reduced suicide by specific methods, whether or not that was the intention, have included legislation to reduce the size of paracetamol packages (intended) and the conversion of coal-gas ovens to natural gas in the 1950s (unintended).

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Edward Mallen and Kevin Hines had some things in common; they were young men suffering from severe mental illness. But while Kevin identifies his traumatic first months as a cause, Edward had no adverse childhood experiences. His father is not aware of a history of depression in his family, but can only surmise that genetic flaws created the fatal cocktail of chemicals that compelled him to

end his life. Research in this field is evolving. Last year, scientists at Massachusetts General Hospital identified 17 genetic variations that appeared to increase the risk of depression, in an analysis of DNA data from more than 300,000 people, published in *Nature Genetics*. "There are vulnerability factors we all have and part of them are genetically influenced," says Rory O'Connor, a professor of psychology at the University of Glasgow, where he leads the Suicidal Behavior Research Laboratory.

More significantly, Kevin and Edward both attempted suicide while seeking treatment for mental illness. According to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, just over a quarter of suicide victims have had contact with mental health services in the preceding 12 months. Soon after the piano playing stopped, it became clear Edward was not well. Mallen remembers his son withdrawing. He became pale and looked unwell. He told his mother, Suzanne, that he was down, but never revealed to his parents he felt suicidal. Two weeks before his death, Edward saw his family's general practitioner, who immediately referred him to an NHS crisis intervention team, recommending he be assessed within 24 hours. But when a triage mental health nurse with limited experience spoke to Edward, he downgraded the risk and recommended a five-day wait. Moreover, while Edward had turned 18 less than two months before his death, he had given permission for his parents to be told about his suicidal thoughts. They never were.

"The real concern here is that this was not an isolated incident."

After an inquest in June last year, Cambridgeshire and Peterborough NHS Foundation Trust said in a statement that "while there are elements in what occurred that may well not have been foreseeable there were also things the Trust

could have done better. The Trust has held an internal inquiry and also commissioned an independent report and it is implementing [their] recommendations."

Mallen describes in an email his son's case as "a haphazard fiasco of confused process, unclear responsibilities and tortuous post-tragedy contention which greatly deepened a family's distress," adding: "The real concern here is that this was not an isolated incident."

The Zero Suicide approach started as an attempt to reduce deaths in mental health systems. At a meeting in 2001 at the Henry Ford Health System, which manages hospitals, clinics and emergency rooms across Detroit, Ed Coffey, then the CEO of its Behavioral Health Services, remembers discussing *Crossing the Quality Chasm*, a report published that year by the Institute of Medicine (now the National Academy of Medicine) that called for sweeping healthcare reforms. The report had triggered a debate about the idea of "perfect care," and Coffey wondered what that might mean for mental health. "I remember a nurse raising her hand and saying, 'Well, perhaps if we were providing perfect depression care, none of our patients would commit suicide,'" Coffey has said. (Coffey, who is now president and CEO of the Menninger Clinic, a psychiatric hospital in Houston, Texas, did not respond to requests for interview.)

Coffey took that as a challenge and set about reforming the Henry Ford Health System's own approach with a new, Zero Suicide goal in mind. The initiative involved improvements in access to care and restrictions in access to the means of suicide. Any patient with a mental illness was treated as a suicide risk and asked two questions at every visit: "How often have you felt down in the past two weeks?" and "How often have you felt little pleasure in doing things?" High scores triggered new questions about sleep deprivation, appetite loss and thoughts about self-harm. Screenings would create personal care and safety plans and involve a patient's family. Every death would be studied as a "learning opportunity."

What caught global attention were the results that the Henry Ford system reported. In 1999, its annual suicide rate for mental health patients stood at 110 per 100,000. In the following 11 years, there were 160 suicides, but the average rate fell to 36 per 100,000. And in 2009, for the first time, there were zero suicides among patients. The stats were startling. But the strategy also faced criticism, partly in the way staff felt it made medical professionals hostages to fortune, with many already operating in a culture of blame. Louis Appleby also points out a lack of hard evidence to back up the strategy. But he does believe in its power to raise the profile of suicide prevention and compel mental health authorities to consider their own practices. At Magellan Health Services in Arizona, where Covington was an early adopter of Zero Suicide before moving to RI International, the network has reported a 50 percent fall in the suicide rate in the past 10 years. "We had an enormous pushback in our community and healthcare providers to get started," he admits. "But as soon as the resistance gave way, 'zero' goes into the brain … Once that seed plants, people get really excited."

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In 2013, Ed Coffey visited Mersey Care—which employs more than 5,000 people and serves more than 10 million across North West England—to talk about suicide prevention. In 2015, the trust, which sees more than 40,000 patients a year, became the first in the U.K. to adopt a Zero Suicide policy, which it ratified last year, committing to eliminating suicide from within its care by 2020. In a nondescript office at the trust's headquarters at a business park in east Liverpool, I meet Jane Boland, a health administrator and Mersey Care's suicide prevention clinical lead. When she started as a mental health clinician 18 years ago, she says suicide training did not exist. "We weren't taught how to speak to someone who is suicidal," she recalls. "It was talked about as an occupational hazard, an inevitability." As part of Mersey Care's new policy, Boland is responsible for delivering training to all the trust's staff, from senior clinicians to receptionists and cleaners. "And these 5,000 people don't exist in isolation," she

says. “They’re out in the city, on trains, noticing when people aren’t feeling great.”

The training begins with an online course designed to help staff look out for signs of distress. It also challenges the inevitability and selfishness myths around suicide. Boland gives talks too, and invites people who have been affected by suicide to share their experiences. She has even persuaded her own husband to talk about the death by suicide of his sister when he was 16 and she was 21. “He’d talked to me about it, but I hadn’t realized I was one of about four people he’d ever told,” Boland says. “Now he tells hundreds of people that there’s not a day goes by that he doesn’t think about this sister, and you can hear a pin drop.”

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Mersey Care's plan also includes easier access to crisis care, better safety plans for each patient and swifter investigations after deaths or suicide attempts, with a focus on learning rather than blame. Joe Rafferty, the trust's chief executive, told

me in May this year that it is too soon for the policy to have shown an effect on its suicide rates, which are 5.5 per 100,000 patient contacts (Rafferty says this equates to a death per fortnight on average, and places Mersey Care in the lowest 20 percent of mental health trusts).

"But the big win has been around culture and attitude," he says. "Even two years ago I'd talk to senior colleagues about suicide and the conversation would finish with, 'Don't worry, we're in the lowest quintile' or 'We benchmark very favorably' … The biggest change has been moving to an absolute view that the benchmark should be zero."

Rafferty sees the Zero Suicide foundation he has discussed with Steve Mallen as a way to spread this thinking to other trusts, and to any organization that might be willing to change. Mersey Care is already trying to reach some of the 70 percent of suicide victims who do not have contact with mental health services in the year before they die. Boland works with local authorities and has delivered suicide training to Job Center staff in Liverpool. The trust is in talks about delivering training to taxi drivers and barbers.

Versions of a Zero Suicide strategy have also been adopted by NHS clinical networks covering large areas of the southwest and the east of England. The spread of the approach coincides with belated political focus on suicide. In January 2015, Nick Clegg, then the deputy prime minister, launched a new mental health initiative and called on the NHS to adopt a Zero Suicide campaign. Earlier this year, the health select committee welcomed the Zero Suicide pilots, but noted that the strategy had not been more widely adopted, while outcomes were still to be evaluated. The most recent Conservative manifesto made no mention of suicide, but reaffirmed government commitment to improving mental health care. The current government target, set by the independent Mental Health Taskforce, is a modest reduction of 10 percent by 2020. Meanwhile, mental health advocates are pushing hard for better funding for mental health research, which remains a fraction of that devoted to physical health conditions such as cancer.

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As a businessman, Steve Mallen finds it hard to understand why, if not the moral case for suicide prevention alone, the economic case has not brought about more rapid change.

"We're losing so many people who would have gone on to contribute to society," Mallen says. He wants a new focus on earlier intervention, in schools and homes and general practitioners' offices, to identify problems before they lead to crisis, and improvements in mental health literacy. "Edward existed in a family, in a friendship group, at a sixth-form college and nobody picked up what was happening to him," he says. "Yet in retrospect when I think back, the signs were there."

Edward's death devastated his family. "He was empathetic, sharing, nurturing," Mallen says, preferring not to name his other two children, who are themselves now approaching adulthood. "We never had a lot of squabbling. He also kept me and Suzanne in check. He was wise beyond his years. Losing any member of a family is difficult, but it's like the heart has been ripped out of the middle of ours and that has made it practically impossible."

Mallen, in common with the mental health experts I speak to, does not believe total eradication is possible. Suicide will always be more complicated than polio. But no one doubts that huge reductions can—and must—be made, and there is a growing body of evidence to show how. If there is one thing he could change first, it would be continuing shifts in attitudes.

"Why didn't my son ask for help?" he says as he heads to the station for the train home to Cambridge. "If my son had been taught about mental health in the same way he was taught about diet, citizenship, physical health, he would have understood that it's okay to feel shit. But despite his brilliance, he didn't have the education to help him come forward. At the start of that eight-week period when he stopped playing the piano, he would have said, 'Dad, I think I might need some help.' And we'd have got him help."

This post appears courtesy of Wellcome *and* Mosaic Science.

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