Responses

Intervention is a challenging process. The best approach is to ask directly and caringly:

"Are you thinking about ending your life?" OR "Are things so bad for you right now that you think suicide is the only answer?"

The person will have found someone who cares and is willing to talk about this subject. The person is often relieved and able to begin an exploration of alternatives and to engage in some emotional release. Assess the lethality of the proposed method of suicide. What are the person's exact intentions? What mitigating circumstances might be present? Who and what can the person call upon for support? Lethality can range from a well thought out action involving a very lethal method (e.g. hanging, shooting, poisoning, jumping) to an action with a very low level of lethality. The more specific the plan and lethal the method, the higher the risk. The person will often express significant ambivalence about dying. Listen in a non-judgemental way. Encourage the person to express their feelings openly. Mitigating circumstances can negatively or positively affect the suicide process.

Negative factors include: intoxication, alcoholism, disorientation, misperceptions of reality, confusion, high levels of stress, disorganization, and hopelessness.

Positive factors include: a support network, good physical health, clear reason(s) to live, and no previous suicide attempts.

Determine if the person has the method IMMEDIATELY AVAILABLE. If so, they should be asked for the pills, gun, knife, etc. and these should be removed for safekeeping.

MOST IMPORTANTLY, remember that the direct, caring question should be a neutral one like, "Are you thinking of ending your life?" Questions like, "You're NOT thinking of committing suicide are you?" indicate that the answer you want to hear is "No, I'm not." Your goal is to open up communication, not shut it down.

More points to remember:

Never promise total confidentiality. A clear or apparent threat means you will need to seek assistance for the person.

Be willing to discuss the suicidal thoughts and feelings to determine the immediacy of the danger, to identify the best referral source and to provide the person with an outlet for their thoughts and emotions.

Indicate your genuine concern - both verbally and non-verbally.

Arrange a safety contract. Ask the person to promise to stay in contact until you have established an appropriate referral. If the risk seems imminent, do not leave the person alone. Rather, escort them to a safe place like the Centre for Student Development and Counselling, the Medical Centre, or, if after hours, to the emergency room of your local hospital.

Refer the person to an appropriate service for assistance. Be willing to accompany the person to the initial contact session.

Contact:

Security
ext. 5040

Centre for Student Development and Counselling
ext. 5195

Medical Centre
ext. 5070

Emergency/ Ambulance services
911

Gerstein Centre Crisis Line
416-929-5200

Peer Helpline Good2Talk
866-925-5454

St. Michael's Hospital Psychiatric Emergency Services
416-808-2222
(non-emergencies)

Distress Centres of Toronto
416-408-4357

Lesbian, Gay, Bi, Trans Youth Line
416-962-9688

Children's Aid Society of Toronto
416-924-4646

Toronto Metropolitan University

Centre for Student Development & Counselling

Suicidal Students

Risks, Realities, Responses

www.torontomu.ca/student-wellbeing/counselling

Prepared by the Centre for Student Development and Counselling, Student Wellbeing

Risks

70-75% of individuals who attempt or die by suicide give some indication of their impending actions.

Two particularly STRONG INDICATORS of potential suicide are a feeling of hopelessness and a belief that things are out of control.

Some other indicators:

- A prior attempt.
- Direct or indirect suicidal threats.
- A specific plan.
- Chronic illness, fatigue.
- Severe depression.
- Feeling isolated.
- Family or relationship difficulties.
- Inconsolable grief.
- Financial stress.
- Alcoholism, chronic use of other drugs.
- Family history of suicide.
- Sudden change in behaviour such as over-elation, sudden calm, ignoring schoolwork, giving away valued personal possessions, or poor impulse control.

Realities

Suicide is a highly personalized and individualized response to a perceived set of life stresses and situations. Although statistics and demographics can give us information about how likely a person is to attempt suicide, this kind of information is no substitute for an honest conversation with the person in question. You need to ask yourself, "Is this person considering suicide and what can I do to help them stay alive?"

An encounter with a suicidal person is always a deeply emotional experience. There is a fear of not knowing what to do or doing the wrong thing. However, the basic empathic, "I care about you," indicates that hope and help are available - two key ingredients in the intervention process. Misinformation and the fear of making the situation worse often prevent individuals from becoming involved.

There are many myths about suicide.
What are the myths and what are the facts?

Myth: Asking "Are you thinking about attempting suicide?" will lead the person to a suicide attempt.

Fact: Asking a direct, caring question will often minimize the anxiety and act as a deterrent to suicidal behaviour.

Myth: People who talk about suicide rarely attempt or complete suicide.

Fact: Approximately 70-75% of those who attempt or complete suicide give some verbal or non-verbal clue about their intentions.

Myth: The suicidal person wants to die.

Fact: Suicidal persons often reveal considerable ambivalence about living vs. dying and frequently reach out for help before and after a suicide attempt.

Myth: All suicidal persons are depressed.

Fact: Depression is often associated with suicidal feelings but not all persons who attempt or complete suicide are depressed. A number of other emotional factors may be involved.

Myth: Suicidal persons are mentally ill.

Fact: Many persons who have attempted or completed suicide would not have been diagnosed as mentally ill.

Myth: Once a person has attempted suicide, they will always be suicidal.

Fact: After a suicide attempt, a person may be able to manage their life and engage in no further suicidal action.

Myth: Suicide is more common in lower socio-economic groups.

Fact: Suicide crosses all socio-economic group boundaries.

Myth: Suicidal persons rarely seek medical help.

Fact: Studies of persons who have completed suicide indicate that 50% had sought medical help within six months prior to their action.

Myth: Suicide happens without warning.

Fact: Persons who have attempted or died by suicide usually give some indication of their intended behaviour.

Myth: Self-harm (e.g. cutting) is in the same class of behaviour as suicide and attempted suicide.

Fact: Self-harm is usually a behaviour with its own characteristics, not a failed suicide.

Myth: Motives or causes of suicide can be readily established.

Fact: Since suicide is usually a lengthy and complex pattern of behaviour, precise motives are difficult to ascertain.

Myth: Only a professional can prevent suicide.

Fact: Lay persons and support centres have always played an important role in suicide prevention.