# Suicide in the Montreal Subway System: Characteristics of the Victims, Antecedents, and Implications for Prevention

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***Objective:*** *To understand the characteristics of persons who commit suicide in the Montreal subway system (the Montreal Metro), their personal and psychiatric histories, and the nature of the event in order to develop better prevention strategies.*

***Method:*** *Systematic analysis of coroner's office investigations of the 129 suicides in the Montreal Metro from 1986 to 1996.*

***Results:*** *Of the 129 people who committed suicide, 81% had expressed a prior suicidal intention, 66% had previously attempted suicide, and 9% had attempted suicide in the metro. One hundred and five of the victims had serious mental health problems, most frequently depression; 73% had had inpatient psychiatric treatment, and at the time of death, 27% resided in a mental health treatment institution. Recent adverse life events included failed relationships, work problems, and family difficulties.*

***Conclusions:*** *Suicide victims intentionally go to the metro to kill themselves, often tell others beforehand, and are generally in treatment for serious psychiatric problems. Possible prevention strategies include modification of the environment and procedures in the metro, changing public conceptions of metro suicides, and modifying practice in psychiatric facilities.*

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***Key Words:*** *suicide, metro, subway, train, injury prevention, prevention*

Almost all underground public transportation systems report numerous suicide attempts and completions. The only subway systems where suicides do not occur physically limit passengers from access to the trains and tracks with a system of doors that open only when the train has stopped. For example, in Singapore, a door system was installed to improve the air conditioning and resulted in a total elimination of suicides. This article presents the results of a study of the coroner's office investigations of all the suicidal deaths (129 cases) in the Montreal subway system (the Metro) from March 1986 to the beginning of 1996.

The operation of subways varies greatly. For example, the Boston subway is an old system where trains enter stations relatively slowly. When Guggenheim and Weisman studied Boston subway deaths from 1966 to 1972, they reported that only 32% of suicide attempters actually died (1). However, in the London underground between 1981 and 1986, 43% of attempters died (2). This compares with a 48% death rate in the Toronto subway from 1954 to 1980 (3) and a 42% death rate in Hong Kong (4). O'Donnell and Farmer compared suicide data on 23 different systems throughout the world and found that the percentage of attempters who died varied from 20% to 80% (5). Their review indicated that invariably there are more male victims than females, most are younger than 41 years of age (except in Tokyo, where suicides are most frequent in those aged 51–60 years), and most deaths occur between 10:00 AM and 4:00 PM.

Besides physically limiting access to tracks and trains with barriers, several methods have been used to help reduce subway suicides (6,7). In London, "suicide pits" (areas with suspended rails; the train can pass over a person who has fallen) have been installed in many stations to reduce the risk of injury from being hit by a train (6). O'Donnell and Farmer found that fewer persons who attempted suicide died in stations with suicide pits (45% compared with 66%) (8). In

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Nuremberg, when a passenger steps over a line on the platform, a guard viewing this on the video surveillance system tells the person over a loudspeaker to step back.

Subway suicides constitute a complex phenomenon which is affected by many factors. It appears that publicizing subway suicides is related to increased suicides by this means. The number of suicide deaths in the metro system in Vienna from 1984 to the beginning of 1987 increased dramatically as local newspapers competed to print detailed descriptions whenever subway suicides occurred. Subway suicides in Vienna diminished drastically after the Austrian Suicide Prevention Association and the Vienna Suicide Prevention Center convinced the newspapers to stop publicizing subway suicides (9). There was a 75% decrease in the number of suicides, and this decrease was maintained for 5 years.

Several investigators have found a high incidence of diagnosed mental illness in individuals who kill themselves in public transportation systems: Lindekilde and Wang found a high incidence of mental illness in a Danish sample of railway suicides (10). In Boston, Guggenheim and Weisman found that more than one-half of those who attempted and completed suicide had received psychiatric hospital treatment prior to the attempt (1). Cocks found that 58% of attempters in London from 1981 to 1986 had received inpatient psychiatric treatment and 13% were psychiatric inpatients at the time of the incident (2). Symonds, in a study of railway (not underground) fatalities in England and Wales, found that suicide deaths were not related to volume of traffic on the lines, residence of the victim in either a rail-dense area or an area with a high suicide rate, or the proximity of a psychiatric hospital (7). However, all but 10 of their 77 cases had some psychiatric diagnosis established retrospectively, with the most common diagnosis (34 of 77) being depression (affective disorder). Twelve of the 77 were inpatients at the time of their suicide, and 61% had definite evidence of previous psychiatric contact. Farmer, O'Donnell, and Tranah reported that there is an "unusual" clustering of suicides at some stations that are adjacent to psychiatric units (11).

O'Donnell, Arthur, and Farmer, in a 10-year follow-up study of 94 persons who attempted suicide by jumping in front of London underground trains, found that "despite the apparent seriousness of the method" only 7 of the 94 (7.4%) actually died from a subsequent suicide attempt (by any method), a rate not higher than in previous studies of attempted suicides by other methods (12). This is consistent with research in suicidology suggesting that those who are unsuccessful in completing a suicide by a chosen means do not often kill themselves by another means after their initial failed attempt (13). Therefore, prevention of subway suicides may diminish overall suicide rates and not just incite suicidal persons to use other methods.

## Methods

We studied all reports from the Quebec Chief Coroner's office on deaths in the Montreal Metro from March 1986, when records were centralized to the Provincial Coroner's office, until 1996. We included all deaths through the end of 1995, and since 5 suicide death reports for 1996 had reached the central office at the time of our study, we included those reports. Two research assistants and the principal investigator transcribed information from the coroner's records.

## Results

During this period, there were 151 deaths in the Montreal Metro, which the coroner's office identified as 120 suicides, 17 accidents, 5 homicides, and 9 "undetermined" deaths. In 9 of the 26 cases where the death was "undetermined" or an "accident," our investigation led us to believe that these were suicides that had been misclassified. In these cases, there were clear indications of a history of suicidal ideation, suicide threats, and a history of mental illness; further, descriptions of the event indicated that the incident involved voluntary actions. We included these 9 cases in our investigation and thus studied a total of 129 suicides.

From March 1986 to the end of 1995, there were 323 suicide attempts recorded by the surveillance department of the Montreal transportation authority. Thus there were approximately 2.6 attempts for each completed suicide; 28% of Montreal Metro suicide attempts are fatal. Besides the 323 suicide attempts, the transportation authority recorded 362 "preventive interventions," in which persons they judged to be suicidal were intercepted before a suicide attempt occurred.

### *Characteristics of the Event*

Figure 1 shows the number of completed suicides per year in the Montreal Metro. Apart from the peak in 1995, there appears to be no consistent pattern. It is important to note that the years 1986 and 1996 are incomplete and may not be used for comparison. Analyses of number of completed suicides by month of the year shows no consistent pattern. The largest number of deaths occur in January and February, and October has the fewest completed suicides. Two-thirds (66%) of suicides occurred between 9:00 AM and 4:00 PM (Figure 2). Only 10% of suicides took place between 8:00 PM and closing at 2:00 AM. There were no suicides between 6:00 AM, when the Metro opens, and 7:00 AM.

In 75% of the cases, the death took place in the metro station, although not necessarily immediately. In the other 25%, the death occurred later in hospital, sometimes after many weeks or months of medical treatment. Guggenheim and Weisman (1), in their Boston study of attempters, concluded that individuals who had chosen this method often believed that this was a certain means of dying immediately and with little

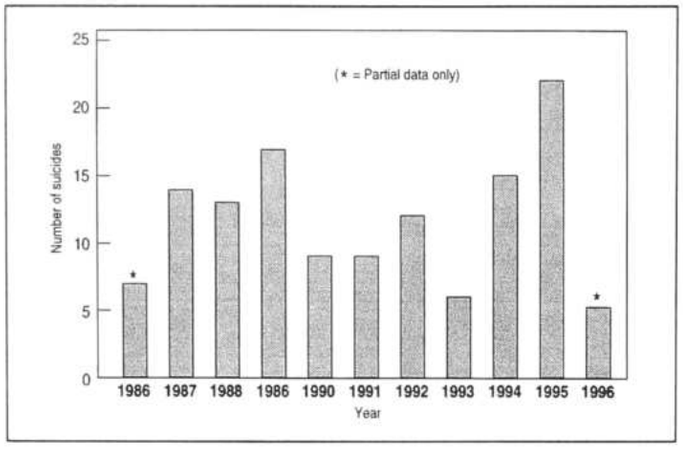


**Figure 1.** Suicides in the Montreal Metro by year

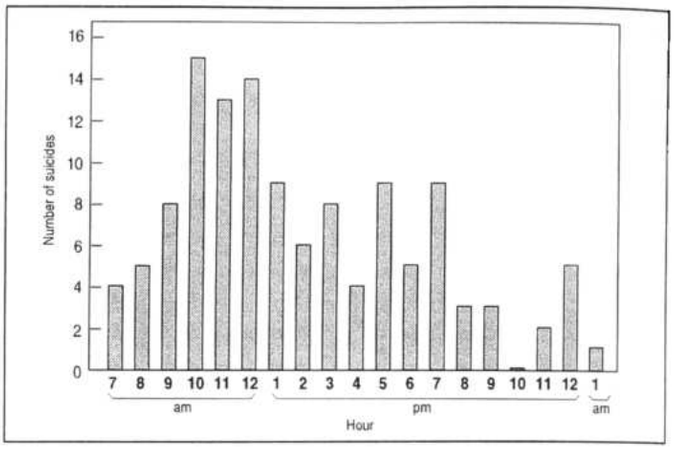


**Figure 2.** Suicides in the Montreal Metro by time of day

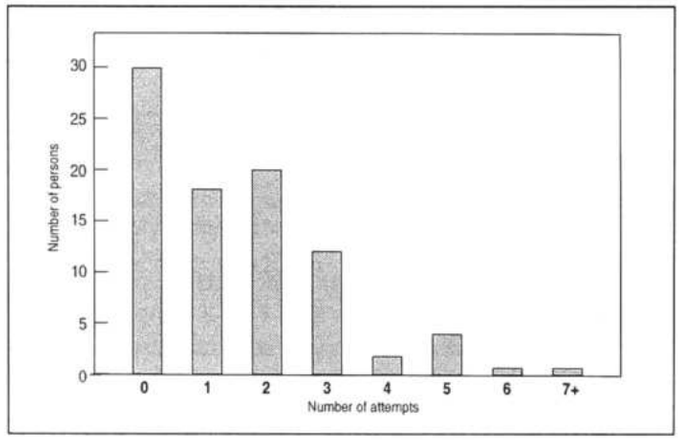


**Figure 3.** Previous suicide attempts by suicide victims in the Montreal Metro

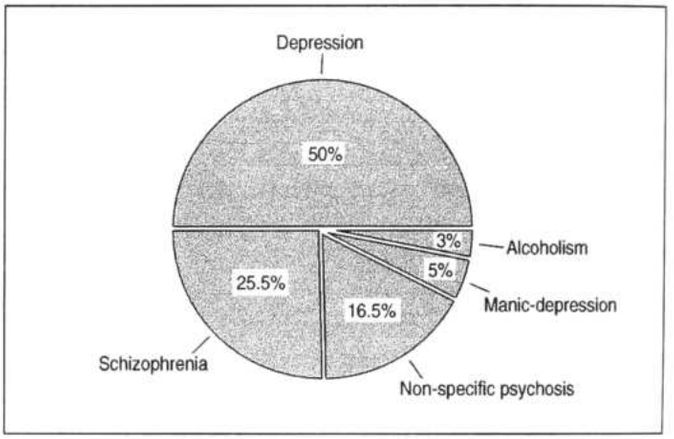


**Figure 4.** Primary mental health diagnosis of suicide victims in the Montreal Metro

suffering, although only 27% died immediately; most deaths occurred later in a hospital, usually after prolonged suffering.

In Montreal, there appears to be no consistent pattern of preference for any particular metro station for completing suicide, although reliable analysis of frequency differences by station is impossible because of the low number of suicides compared with the number of stations (65). However, we analyzed whether or not the suicide occurred in the metro station nearest the residence of the person. Of the 127 people for whom the residence could be identified, 70% killed themselves in the station closest to their residence (for individuals who resided in an institution, the institution was considered their residence).

*Sociodemographic Characteristics of Victims*

Of the 129 suicide victims, 79 (61%) were men, and 50 (39%) were women. All age-groups were represented; the ages ranged from 15 to 79 years, with an average age of 38 years. Almost two-thirds (64%) of the suicides were by persons younger than 40 years of age.

Most were single (60%), about one-quarter (24%) were married, and the others were separated, divorced, or widowed. For most victims (112 of 129), we had information as to whether the person lived alone or with others and if the person resided in a mental health facility (usually a psychiatric unit of a hospital) at the time of the suicide. Forty-five percent lived alone, 28% lived in a family situation or with others, and 27% lived in a mental health facility at the time of their death. The circumstances concerning the suicides of individuals living in institutions varied greatly: some escaped and killed themselves within hours of leaving, others were on weekend leave or left "to go to the corner store"; in other situations, the leave status of the suicide completer is unknown.

We have information on personal income in only 48 of the 129 cases. However, 44 of the 48 individuals were receiving social assistance payments.

*Antecedent Factors as Revealed in Autopsy and Psychosocial Investigations*

In 78 of the 129 cases, detailed blood analyses were conducted to determine blood alcohol levels and the presence of

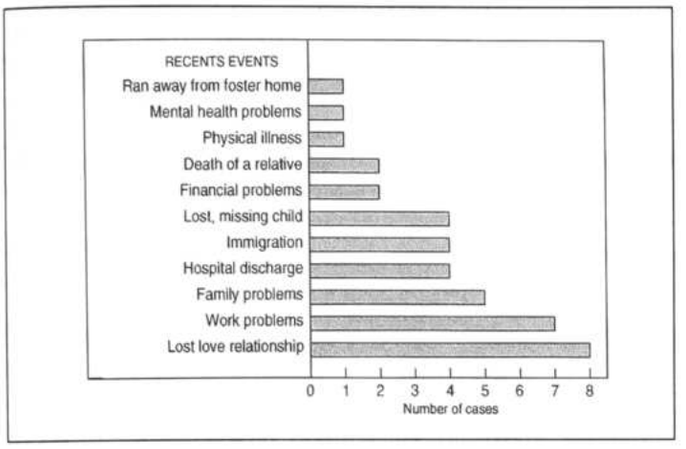


**Figure 5.** Life events that occurred within 2 weeks before the Metro suicide

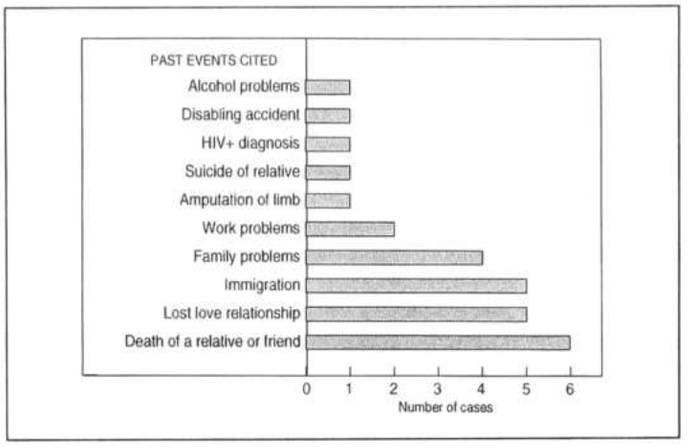


**Figure 6.** Past events cited by family as possibly linked to the suicide in the Metro

drugs. Alcohol was found in 20 cases (25%), and a drug was found in 18 cases (24%). Even though alcohol or some drug was present, the level of the substance was generally not high, and the drugs included certain medications for mental health illnesses (however, autopsy blood analyses did not include tests for all psychotropic medications). Based on these analyses we cannot conclude that problems of alcoholism or drug abuse played an important role in Metro suicides.

For 29 cases we have no information about suicidal ideation. In 100 of the 129 cases, there was an indication of whether or not the victims expressed the intention to commit suicide before killing themselves. Of these 100, 81 had previously expressed their desire or intention to kill themselves, usually on several occasions. In 19 instances, family members said that the victim had never talked about suicide. Nevertheless, in 3 of these 19 instances, although the family insisted that there was never any expression of an intention to commit suicide, a family member immediately went to the nearest metro station when the person was found to be missing, only to learn that the person had indeed committed suicide there.

We tried to determine if the suicide victims had expressed their intention to kill themselves on the day of their death and, more specifically, if they had told someone that they intended to kill themselves in the metro. These data are not systematically available, and we were able to establish suicidal ideation or lack thereof in only 50 of 129 cases. In 26 instances, the suicide victims had expressed their intention to kill themselves on that day. In 5 of these 26 instances, it was noted that these threats were not taken seriously.

We have information about previous attempts for 88 of the 129 cases. Only 30 of these 88 (34%) had not attempted suicide previously. The remainder had attempted suicide at least once (Figure 3); 18 had attempted suicide once previously, 20 had attempted twice, and 20 had attempted 3 or more times. In 6 of the 20 instances where at least 3 attempts were indicated, the coroner's report stated that there were "several" prior attempts; we interpreted this to mean 3 attempts, though it is possible that some of these individuals actually made more than 3 attempts. Among these 88 persons, 11 had previously attempted suicide in the Montreal Metro. Thus, 12.5% of persons for whom we have data on prior attempts (9% of the total sample) had previously attempted suicide in the Montreal Metro.

We have data in 122 cases indicating whether or not the individual had a history of mental illness. In 105 of these cases, a mental illness was identified; only 17 (14%) indicated no previously diagnosed mental illnesses. Most had a primary diagnosis of depression (Figure 4). The second most common diagnosis was schizophrenia, and other severe mental illnesses were classified under the rubric "nonspecified psychosis." In 13 instances a secondary diagnosis was also included. Eight of the secondary diagnoses were depression, 2 were schizophrenia, 2 were alcoholism, and 1 was paranoia. It is important to note that, because of the confidential nature of medical reports in Quebec, diagnoses were reported by family members, except in the case of individuals who resided in an institution at the time of their death (in these instances, the institution indicated the diagnosis in the dossier). Sometimes, medication the person was taking provided additional information indicating the most probable diagnosis. We changed the classification of an individual if we had strong reasons to believe that the diagnosis was different based on the type of psychotropic medications taken. For example, a victim who was taking a therapeutic dose of lithium was classified in "manic depression." Although accurate diagnosis is not possible on the basis of these data, it is evident that the vast majority had severe, chronic mental illnesses.

It is difficult to assess how many of the 105 persons with an identifiable problem were in active treatment at the time of their death. All were reported to have been in treatment at some time, and in 76 of the 105 cases (72%) the person was

either residing in a treatment facility or was reported to have been prescribed psychotropic medications around the time of suicide. Data on inpatient treatment in psychiatric units are available for 115 cases: 84 persons (73%) had inpatient psychiatric treatment at least once; 63 individuals (55%) also had some physical illness at the time of their death. However, interpretation of these data was limited by the fact that the severity of the illnesses was not indicated in most cases.

Although most had a history of psychiatric treatment, one can still ask: why did this person kill him- or herself at this time rather than another time? Suicidologists suggest that there is often an identifiable "precipitating event" occurring shortly before the suicide attempt. We identified 11 categories of recent adverse life events that were indicated in the coroners' reports as having possibly precipitated the suicide. At least 1 such event could be identified in 100 cases. The most frequent categories were the recent end of a love relationship, problems at work, and family difficulties (Figure 5). Other events included: recent discharge from a hospital, immigration to Canada, having lost a child, financial problems, death of a relative, physical illness, mental illness, and running away from a foster home. Although these events were reported to have occurred within 2 weeks before the suicide, we can only speculate about a possible causal link to the suicidal behaviour. We also identified events occurring in the year before the suicide that family members interpreted as being linked to the suicidal death (Figure 6). These 10 past events included: death of or separation from a loved one, immigration, moving to a new place, and family troubles.

Only 27 of the 129 victims left a suicide note. These notes varied greatly, ranging from a brief message indicating whom to inform about the death to long life histories and specific messages to family members, former lovers, or friends. In several instances, the coroner's office indicated that they had difficulties identifying a family member to contact after the death. In 12 suicides, the coroner's dossier indicated that the victim had not had any contact with family members for many years, and in 3 instances, no one claimed the body.

## Discussion

This study suggests that many of those who kill themselves in the Montreal Metro intentionally go there to commit suicide and frequently tell others that they are ending their lives that day. Most had previously attempted suicide; in fact at least 9% had previously attempted to kill themselves in the Montreal Metro. Victims tended to choose the metro station nearest their place of residence. Although most victims were younger than 41 years old, all age-groups are represented. However, as is generally the case elsewhere, this method is more common among men. The majority had previously been diagnosed and treated for mental health problems. In fact, most were in treatment at the time of their death. A very high number of victims (27%) resided in a psychiatric unit or institution at the time of their death.

We were usually able to identify recent adverse life events and past events that may help explain the suicide. Although many expressed their intention to kill themselves on that day, the suicide threats were not always taken seriously. Those who previously attempted suicide in the metro comprise one of the most easily identifiable groups at risk to die by suicide in a future attempt.

We conclude with some suggestions for prevention of suicides in the metro, based on these results as well as on discussions with Montreal transportation personnel and workers at the Montreal suicide prevention centre (Suicide-Action Montreal):

*1. Interventions in the metro physical environment.* Research elsewhere indicates that, if it is possible to limit access to the rails and trains until the train has safely stopped in the station, suicides in the metro may be virtually impossible. However, the cost of such an intervention in Montreal would be exorbitant. We found that 28% of attempts are fatal. Therefore, interventions to decrease the risk of death, such as reducing the speed of trains when entering the station, may be effective. Since we found that most suicides occur outside of rush hours, it may be helpful to limit access to the end of the station where the trains arrive during those periods.

*2. Increased involvement of the metro security forces in suicide prevention.* Quite frequently metro security officers are involved in stopping suicidal individuals from killing themselves. There may be ways to increase the effectiveness of security forces in prevention activities, including increased collaboration with the local suicide prevention centre and community and psychiatric services. This is particularly important in the light of our finding that 9% of those who completed suicide in the Metro had previously attempted suicide in the Metro.

*3. Publicizing the availability of help in metro stations.* This study suggests that individuals who die by suicide in metro stations go to the metro with the intent of ending their life there. At other high-risk points (for example, the bridges that lead to Cape Cod in Massachusetts), posters indicate that help is available for suicidal individuals by suicide prevention organizations and telephones are available nearby. The Montreal metro system has pay telephones installed in most stations. Perhaps increased publicity about the availability of help and the possibility of direct access to suicide hotlines from the metro telephones would have a preventive effect. Evaluations of the local suicide prevention centre indicate that, in a significant number of reported cases, the urgency of crisis situations is reduced by their interventions (14).

*4. Changing impressions of the metro as an easy place to kill oneself.* Previous studies indicate that people who attempt suicide in the metro often believe that this is a certain, instant, painless means of ending one's life. However, in this investigation we found that only 28% of the attempts result in death and in many instances death occurred in hospital after long suffering. One way to change perceptions of the metro as an "easy" place to kill oneself is through media depictions of real

and fictional suicides. A large suicidology research literature indicates that publicity involving a specific means of suicide often results in increased use of that means and an increased number of suicide deaths in general (15,16). In Montreal, Metro suicides are rarely reported in newspapers, radio, and television. This practice should be continued. However, recent films have depicted suicide attempts in the Montreal metro as resulting in an instantaneous and seemingly painless death. It may be useful to sensitize filmmakers and the media about the potential dangers of depicting stereotyped suicides in the Metro. Perhaps one could engage in publicity to communicate that a suicide attempt is not certain to result in death, and metro suicide deaths are often neither instantaneous nor painless.

*5. Increased awareness in psychiatric units.* Since suicide victims often reside in psychiatric units and the majority have some form of psychiatric follow-up, it is imperative to further investigate the potential for preventive activities on the part of mental health professionals. We need to know more about what was done and not done to prevent suicides in this group, particularly since the victims often had a history of suicide attempts and had threatened to kill themselves on the day of their death. These threats were not always taken seriously. Although it may often be difficult to predict suicidal behaviour, it may be helpful to better train mental health workers on the evaluation of suicide risk and urgency (17,18).

This investigation was limited by the fact that complete data on all variables of interest are not collected systematically by coroners. This is understandable, since the coroner's primary mandate is to determine the cause of death and there is a tendency to limit the search for "causal" factors after a diagnosis of serious mental health problems has been made. However, it would be useful to better understand why so many individuals receiving treatment for mental illnesses choose to end their lives in this violent manner, even in instances where mental health professionals were quite aware of their suicide risk.

Some mental health workers questioned in these investigations expressed the belief that when someone is "really" suicidal little can be done to stop them from killing themselves. However, research in suicidology indicates that prevention is often possible even in instances when a severely troubled individual seems to have "decided" to die by suicide (19–22). One of the greatest challenges for future research is to determine what can be done to better use our knowledge to prevent suicide, particularly among individuals suffering from mental illnesses.

### Acknowledgements

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**Clinical Implication**

- The results suggest several possible prevention strategies, including changing the physical environment of the subway system and the activities of metro personnel, modifying public impressions of the metro as an easy place to kill oneself, publicizing the availability of help in metro stations, and increasing awareness in psychiatric units.

**Limitations**

- Data available for analysis are limited by lack of complete information in coroners' investigations.
- First-hand information of victims' treatments for mental illnesses was not available.

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## Résumé

***Objectif :*** *Comprendre les caractéristiques des personnes qui se suicident dans le métro, leurs antécédents personnels et psychiatriques ainsi que la nature de l'événement afin d'élaborer de meilleures stratégies de prévention.*

***Méthode :*** *Analyse systématique des enquêtes des bureaux de coroner au sujet des 129 suicides qui sont survenus dans le métro de Montréal, de 1986 à 1996.*

***Résultats :*** *Des 129 personnes qui se sont suicidées, 81 % avaient déjà exprimé l'intention de mettre fin à leurs jours, 66 % avaient tenté de se suicider, et 9 % avaient fait une tentative de suicide dans le métro. Cent cinq des victimes avaient de graves problèmes de santé mentale et souffraient le plus souvent de dépression ; 73 % avaient été hospitalisés pour un traitement psychiatrique et, au moment de leur décès, 27 % résidaient dans un établissement de soins de santé mentale. Les événements récents vécus avant le suicide incluent la perte d'un amour, des difficultés au travail et des problèmes familiaux.*

***Conclusion :*** *Les victimes de suicide vont intentionnellement dans le métro pour mettre fin à leurs jours, informent souvent d'autres personnes de leur intention et sont généralement traitées pour des problèmes psychiatriques graves. Les stratégies de prévention possibles incluent la modification du milieu et des procédures employés dans le métro, la modification de la conception du public sur les suicides dans le métro et la modification des pratiques des établissements psychiatriques.*