Firearm Suicide Prevention Task Force

Meeting Notice

Tuesday, November 15, 2016
10am to Noon
Legislative Hall, Senate Hearing Room
411 Legislative Ave,
Dover, DE 19901

Agenda

- Review the purpose of task force and timeline and Executive Order 63
- Review of current suicide data
- Review of Washington State legislation
- Discussion of goals and proposals
- Public comment

Contact: Lauren CW Vella, 302-577-5190

Firearm Suicide Prevention Task Force 11/15/16

Agenda:

- Introductions
- Review the purpose of task force and timeline and Executive Order 63
- Review of current suicide data
- Review of Washington State legislation
- Discussion of goals and proposals
- Public comment

Proposed Meeting Schedule:

Meeting #	Date	Location	Time
Meeting 2	Wednesday, November 30	Legislative Hall	9:00am – 11:00am
Meeting 3	Friday, December 9th	Legislative Hall	10:00am – 12:00pm

Membership:

Membership	Name	Title/Organization
Chair	Lisa Goodman	Chair
Vice Chair	Rep. Valerie Longhurst	State Representative
Member	Rep. Trey Paradee	State Representative
Member	Rep. Kevin Hensley	State Representative
Member	Sen. Henry	State Senator
Member	Sen. Ernie Lopez	State Senator
Member	Byran Horsey	Member of the Public
Member	Pete Rudoff	Member of the Public
Member	Cyndi McGlaughin	Foundation for a Better Tomorrow
Member	Dr. Harvey Doppelt	Division of Prevention and Behavioral Health Services, DSCYF
Member	Sec. Rita Landgraf	Dept. of Health and Social Services
Member	Jeff Hauge	Delaware State Sportsman Association
Member	Bill Farley	Commission on Veterans
Member	Drew Aydelotte	DNREC
Member	Emily Vera	Mental Health Association
Participant	George Higgins	Delaware Coalition Against Gun Violence
Participant	Rick Armitage	NRA
Member	Firearm Dealer	Governor
Member	Firearm Dealer	Governor
Member	Representative of the Senate	Pro Tempore
Staff	Lauren Vella	Delaware House of Representatives

EXECUTIVE ORDER
NUMBER SIXTY-THREE

TO: HEADS OF ALL STATE DEPARTMENTS AND AGENCIES
RE: ESTABLISHING THE FIREARM SUICIDE PREVENTION TASK FORCE

WHEREAS, suicide takes the lives of over 42,000 people in the United States each year and is the 10th ranking cause of death in America and the 2nd ranking cause of death for young people; and

WHEREAS, the impact of suicide can have a tremendous and lasting effect on the surviving families, friends and communities; and

WHEREAS, firearms are the most common instrument of death by suicide, accounting for a 49.9% of all suicide deaths; and

WHEREAS, veteran suicide is a grave concern, with the military suicide rate double that of their civilian counterparts and accounting for 8,000 veteran deaths annually; and

WHEREAS, suicide is a preventable cause of death when the right resources and services are in place; and

WHEREAS, in March 2016, the Washington State Legislature passed legislation to raise awareness and increase suicide prevention education among firearm owners by working closely with firearms dealers and ranges;

NOW, THEREFORE, I, JACK A. MARKELL, by virtue of the authority vested in me as Governor of the State of Delaware, do hereby declare and order the following:

1. The Firearm Suicide Prevention Task Force (hereinafter, the "Task Force") is hereby established to raise public awareness and increase suicide prevention education.

2. The focus of the Task Force's study, findings, and recommendations include, but are not limited to:

a. Examining the current outreach, education and training about suicide to firearm owners.

b. Reviewing models and data from other state and local governments on effective public strategies for suicide prevention among firearm owners.

c. Developing recommendations to reduce suicides by firearms in Delaware.

d. Reviewing ways to connect mental health resources with at-risk populations.

e. Engaging firearm advocates, dealers and clubs in suicide prevention efforts.

3. The Firearm Suicide Prevention Task Force shall be composed of, at least, the following 17 members:

a. Three representatives of the House of Representatives appointed by the Speaker of the House, one of whom shall be appointed vice-chair of the Task Force by the Speaker of the House.

b. Three representatives of the Senate appointed by the President Pro Tempore, one of whom shall be appointed vice-chair of the Task Force by the President Pro Tempore.

c. Two members of the public appointed by the Governor, one of whom shall be appointed chair of the Task Force by the Governor.

d. The President of the Delaware Sportsman Association;

e. The chair of the Commission of Veterans Affairs;

f. The Secretary of the Department of Health and Social Services;

g. The Secretary of the Department of Children, Youth and Families;

h. The Secretary of the Department of Natural Resources and Environmental Control;

i. Two Delaware firearm dealers appointed by the Governor; and

j. Two representatives of suicide prevention organizations, one appointed by the Speaker of the House and one appointed by the President Pro Tempore of the Senate.

4. Additional members may be appointed by the Governor.

5. Members serving by virtue of position may appoint a designee to serve in their stead and at their pleasure. All members shall serve at the pleasure of their appointing authority.

6. The House of Representatives shall assign reasonable and necessary support staff for the Task Force.

7. The Task Force shall convene in September 2016 and shall submit a report of its findings and recommendations to the members of the Delaware General Assembly & the Delaware Suicide Prevention Coalition by January 1, 2017.

8. This Task Force shall be terminated on January 2, 2017, if not reconstituted by further Executive Order.

9. Nothing in this Order is to be construed to create a private right of action to enforce its terms.

APPROVED this 23rd day of September, 2016

_____

Governor

ATTEST:

_____

Secretary of State

The Washington Post

Opinions

My husband died by suicide. Here's what happened during my awkward call with the NRA.

By Jennifer Stuber April 8

Jennifer Stuber is an associate professor of public policy at the University of Washington, where she co-founded the organization Forefront: Innovations in Suicide Prevention.

It wasn't the hardest phone call I've ever made, but it was certainly awkward. I was cold-calling the National Rifle Association. Because the NRA is well-known for offering gun safety training, I wanted to know whether the organization had ideas on how to reduce the number of firearm suicides. Half of all suicides in the United States are by firearm, and roughly two-thirds of all firearm deaths are suicides. Given the NRA's opposition to virtually all gun regulation, I knew this was a touchy area.

A far harder call was the one I received from a Seattle police officer a few years earlier. The officer told me that my husband had ended his struggle with anxiety and depression with a single bullet. Suddenly, I was a 38-year-old widow and a single parent of two young children. I was left wondering how this had happened and whether it could have been prevented. I was deeply angry at myself, at my husband, at a treatment system that failed him and at a society that made it easy to buy a pistol. I wasn't the best person to try to start a conversation with the NRA. No wonder it took me a few years to make the call.

But I learned a couple of surprising things from that call and the many follow-up meetings with a local NRA lobbyist and the executive director of the Second Amendment Foundation.

First, they were not just willing to talk but also willing to listen. There was a simple reason for their openness: They are no more immune from the pain of suicide than anyone else. Every year in the United States, about 750,000 of us experience a sudden disruption in our lives due to the suicide of a loved one or close friend. With such high rates of suicide, nearly all of us will be touched by the suicide of someone we know at some point in our lives. Gun rights advocates are no exception.

Second, I learned why the NRA had never focused its gun safety programs on suicide prevention. Like most of our society, it had bought into the myth that if someone wants to kill him or herself, there's nothing you can do about it. But the opposite is

true: Suicide is our nation's most preventable cause of death when the right resources and services are in place.

Once we got past that misconception, the NRA and Second Amendment Foundation became active participants in a year-long conversation about reducing the number of suicides by firearm in Washington state. With the leadership of state Rep. Tina Orwall (D), we formed a working group that included gun rights advocates, public-health experts and individuals who have been affected by suicide.

One of the most effective ways to prevent suicides is to make it harder for a person considering suicide to access "lethal means." Some people have the impulse to use a firearm to end their lives. Others may choose a less violent ending, such as a drug overdose. Our working group concentrated on limiting access to both of these lethal means. We were encouraged by studies showing that even temporary impediments to obtaining lethal means may save the life of an at-risk person. In some cases, all that's needed is enough time for the most serious feelings of pain and hopelessness to subside.

Last week, I was on another call, with the office of Washington Gov. Jay Inslee (D). This time, the news was good — he would sign a new law designed to reduce the number of suicides by firearm and overdose in Washington. This law, passed March 31, is the first nationwide to bring together gun advocates and the firearm industry with suicide prevention advocates. It is supported by the NRA, the Second Amendment Foundation and many others interested in injury prevention and mental health. There was strong backing by legislators on both sides of the political aisle, including one who is an avid hunter and who shared that this law would change the way he stores firearms in his home.

The law calls for developing suicide prevention messages and training for gun dealers, shooting ranges, gun shows, pharmacies and drugstores. Participation by gun stores and ranges will be voluntary, and work will be done to create incentives for the industry to participate. The legislation also begins a new program to pair suicide prevention and gun safety education with the distribution of storage devices and medication disposal kits. It updates firearm safety pamphlets and the state's hunter safety course to incorporate suicide awareness and prevention.

Over the past decade, suicide prevention has become recognized as one of our greatest public-health challenges. The new law in Washington state is a big step forward. But this bipartisan legislation can also mark the beginning of a different way of talking about gun violence in America. For too long, we've allowed the debate over legal rights to dominate the conversation. It's time to give equal emphasis to what we have in common, including the grief we all feel over suicide.

Read more about this topic:

Chris W. Cox: Why we oppose Merrick Garland's Supreme Court nomination

Colbert I. King: I'm a gun owner. The NRA doesn't speak for me.

Delaware Suicides and Firearms 1999 to 2014
Source CDC: Fatal Injury Reports

Total Number of Suicides All Causes: 1606
% by Firearm: 45 %

	Males	Female
Death by Firearm	638	87
Percentage	88 %	12 %

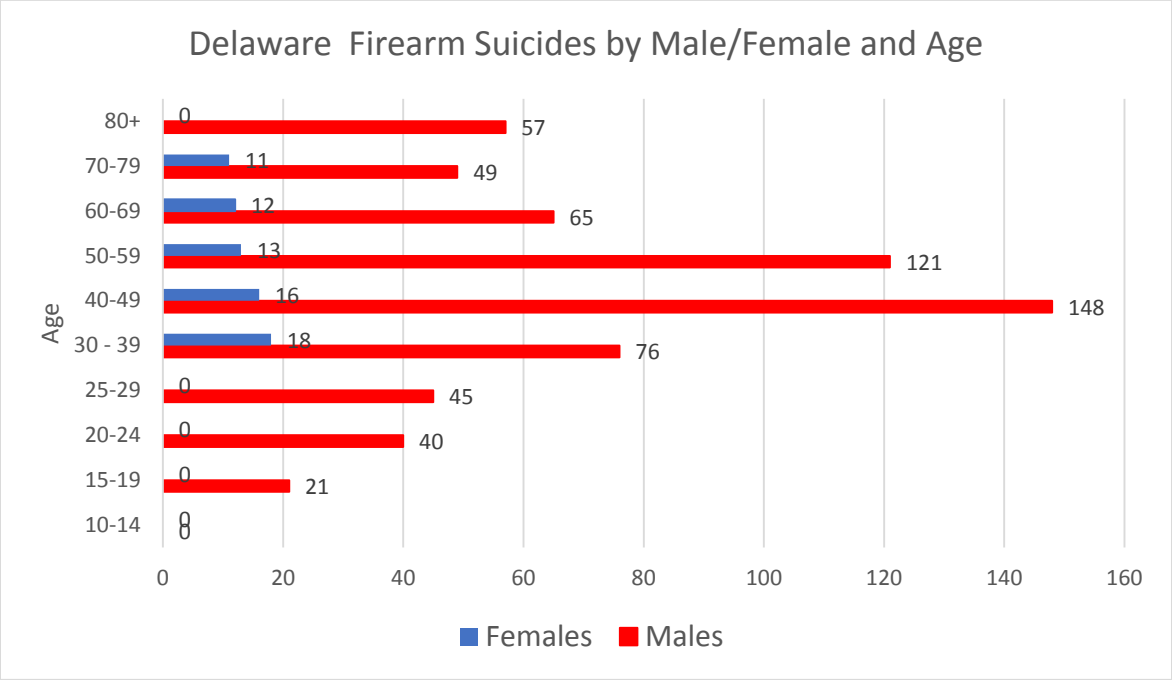
	White	Black
Death by Firearm	665	53
Percentage	92 %	8 %

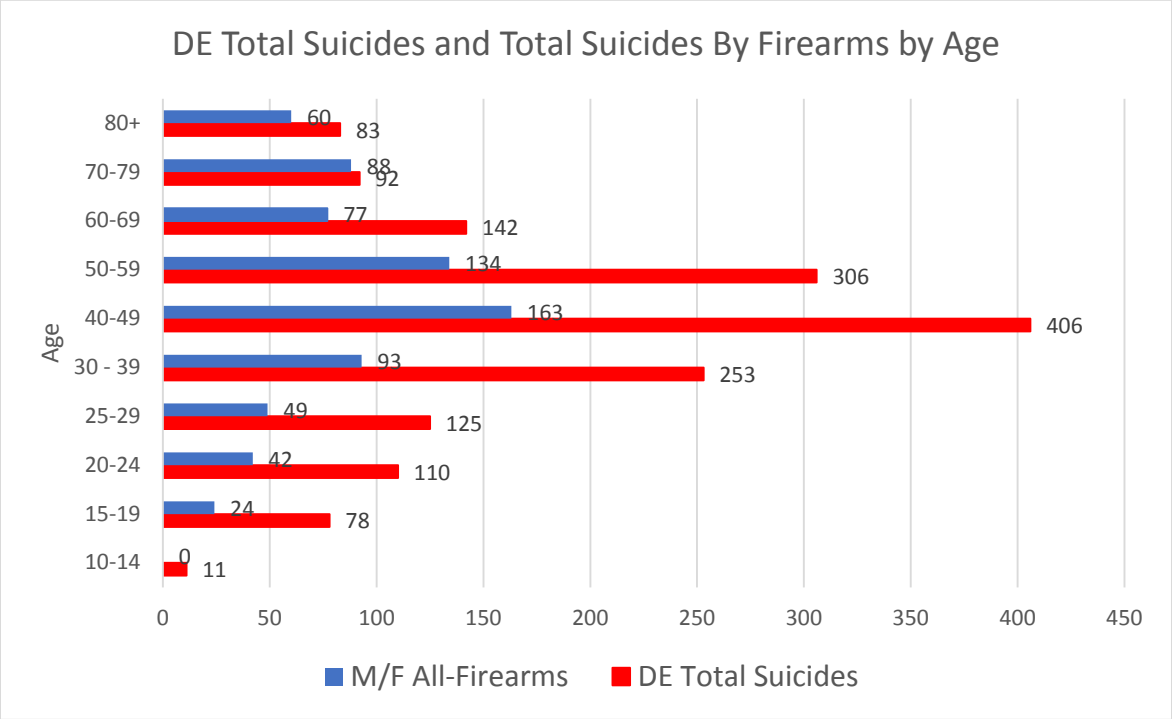
	Non-Hispanic	Hispanic
Death by Firearm	705	15
Percentage	98 %	2 %

Age Adjusted Suicide by Firearm Death Rates per 100,000
2004-2010

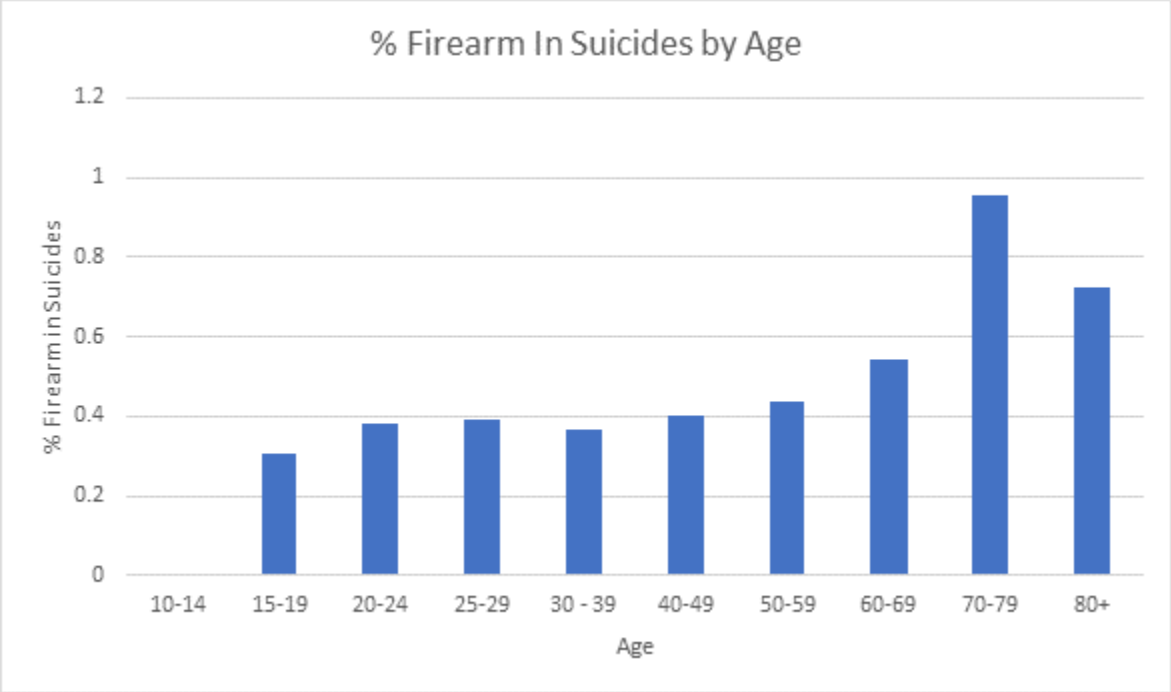
	All Races/M/F	White Males	White Females
New Castle	3.72-4.42	7.88-9.48	Small sample
Kent	4.43-6.17	9.49-13.20	Small sample
Sussex	6.18-7.22	13.21-15.32	Small Sample

Delaware Suicides and Firearms 1999 to 2014
Source CDC: Fatal Injury Reports





Delaware Suicides and Firearms 1999 to 2014
Source CDC: Fatal Injury Reports



The New York Times | http://nyti.ms/2btxwwy

N.Y. / REGION

A Suicidologist's New Challenge: The George Washington Bridge

By GABRIELLE GLASER AUG. 19, 2016

Madelyn Gould is a preternaturally sunny person. She has a broad, easy smile, a charming Brooklyn accent and an infectious laugh. When she talks about herself, she often starts with the personal: She is the mother of three sons — identical twins who are 35, and one who is 27. She is the grandmother of a 2-year-old boy, and has been married to her husband, a pediatric neurologist, for 38 years.

Tall and slender, she uses an elliptical trainer daily to keep in shape, and describes a folk-dancing class she takes every Tuesday night as the highlight of her week (aside from video chats with her grandson). She admits to having an anxious personality ("I grew up in East Flatbush!"), which she learned to tame years ago by practicing Transcendental Meditation.

Dr. Gould, a professor of epidemiology in Columbia University's psychiatry department, has a tidy office in Washington Heights that is lined with books, family photos, multicolored Post-it notes and her grandson's preschool masterpieces. The view is enviable, out across the George Washington Bridge and the shale cliffs on the far side of the Hudson River. But when Dr. Gould looks at the bridge, she sees something deeply troubling.

For the past 30 years, Dr. Gould has plumbed the depths of despair, searching for ways to prevent what has exploded into one of the most significant public health threats facing young people: suicide. She is one of the country's leading experts in its prevention and causes, and her research undergirds much of the modern thinking on

the topic, including the phenomenon of suicide contagion. She has helped to establish recommendations for reporters so that they do not glamorize suicide when covering it, and she encourages those who have survived attempts at killing themselves to discuss their recovery as a way of inspiring others who feel they have lost all hope.

She is also adamant about what she considers the most powerful deterrent of all: depriving people at particular risk of killing themselves of access to the means for doing so. She has urged the authorities to put barriers on bridges and other buildings, something that copious amounts of research show is effective. (After three suicides in the aughts at New York University's Elmer Holmes Bobst Library, Dr. Gould consulted on ways to avoid additional deaths. In 2012, the university enclosed the perimeter of the building's formerly open atrium with aluminum screens.)

The Port Authority of New York and New Jersey, which operates the George Washington Bridge, has put dozens of signs and several telephones on it to link desperate callers to trained crisis counselors, tactics that Dr. Gould's research supports. Still, a young woman leapt to her death from the bridge in June, and a month later, a passing cyclist pulled from the precipice a man who was about to jump. In the past seven years, 93 people have died at the bridge.

The authority has a plan to erect a safety barrier on the bridge, a project that will not be completed before 2024. To Dr. Gould, this is an inexcusably slow response to a well-documented public health problem. "From the perspective of saving people's lives, why not move up that time frame?" she asked.

Many who work in the grim-sounding field of suicidology — the study of what causes, and prevents, suicide — have been personally touched by suicide. But Dr. Gould fell into the field by chance in the early 1980s, after completing her dissertation about the classification of childhood psychiatric disorders, which were in their infancy. The child psychiatrist David Shaffer recruited her to Columbia to begin exploring risk factors for youth suicide.

After a spate of such suicides in Westchester County and New Jersey in the 1980s, Dr. Gould felt an added urgency to understand why suicide clusters occurred, and to learn how to prevent them. She began to use a method known as a

psychological autopsy, in which researchers comb medical records and conduct deep interviews with the friends and families of young people who had killed themselves.

By using that data, she wanted to find clues for how to prevent other suicide clusters. It was a novel idea at the time, and Dr. Gould worried that the families would reject interview requests. "We certainly didn't want to retraumatize anybody," she said. But most were willing to discuss the events that had preceded the deaths of their children: signs they had overlooked, cries for help they had dismissed.

Some clear findings emerged, and Dr. Gould, 65, has been a pioneer ever since in studying how suicide can spread. Media coverage of suicides, she said, has been definitively linked to an increase in their occurrence, especially among young people. Contagion influences at least 5 percent of suicide deaths of young people, she said.

She is particularly concerned about a nationwide rise in suicide — it increased 24 percent from 1999 to 2014, according to the federal Centers for Disease Control and Prevention, and is a leading cause of death among those under 34. "Suicide contagion is real, and the language and publicity surrounding deaths by suicide concern me immensely," Dr. Gould said during a recent interview in her office, tapping her chest with her palm for emphasis.

Much of her work involves removing the stigma surrounding suicide, and she is an outspoken advocate for directly asking young people about whether they are considering taking their lives. Schools routinely screen for eye problems and scoliosis, she said, but until recently they had balked at identifying students whose despair puts them at risk for killing themselves. When she and her colleagues were recruiting schools to participate in their research a few years ago, many refused.

"People told us, 'You can't talk about this. It will put ideas into kids' heads,'" she said. Her research has found that the opposite is true. One study of troubled youths found that those asked directly about suicidal thoughts showed less distress than those who were not asked at all. "You have to ask people, you have to be prepared for the answer," she said, "and you have to be diligent about their safety."

Dr. Gould emphasizes the need to use different terms — those in the field avoid using the word "commit" in order to make suicide sound less like a criminal act —

while avoiding descriptions of the ways people kill themselves that resemble tutorials. One study in Vienna revealed a decrease in suicides when journalists began following recommendations for more cautious coverage.

Many people, of course, now learn the sad details of suicide deaths through social media. And some, like Eric Steel, who directed the 2006 documentary "The Bridge," which examined suicides at the Golden Gate Bridge, argue that there is an obligation to keep the public informed, and to motivate the authorities to enact safety measures on landmarks known to draw the most despondent.

Mr. Steel had precisely that goal in mind when he included in his film graphic footage of people who jumped, which appalled Dr. Gould and other suicidologists. "At the time, I thought it was horrible," she said. Ultimately, the publicity generated by the documentary helped persuade officials to approve a $76 million net that, despite delays, is expected to be completed by 2020, according to news reports.

Mr. Steel maintains that stance when it comes to the George Washington Bridge, where the number of suicides in 2015 was 18, according to Neal Buccino, a Port Authority spokesman. Building the planned barrier, which will cost from $35 million to $50 million, presents complexities that Mr. Buccino said include "the challenge of designing and installing a fence that is strong enough to provide for safety, yet porous enough to prevent acting like a sail in strong winds and straining the bridge's structure."

Like Dr. Gould, Mr. Steel scoffs at such a wait.

"If a study came out that said 18 people were going to die on the bridge next year because of a mechanical issue, they'd shut it down and fix it," he said. "The solution to this issue is putting up a fence."

So far this year, eight people have leapt or fallen to their deaths, and passers-by or Port Authority workers have intervened in 40 other cases. Recently, a cyclist named Julio de Leon noticed a desperate-looking 19-year-old man on a ledge. He jumped off his bike and told the man: "Don't do it. We love you, my heart." His kind words and quick thinking brought the man to safety.

Kevin Hines, who survived a jump from the Golden Gate Bridge and appears in "The Bridge," is emphatic about the need to find ways to reach those considering suicide before they make an irrevocable decision. In the film, Mr. Hines describes the remorse he felt the moment his fingers left the guardrail, how terrified he was that his last emotion might be regret and how he begged God for help as he plunged toward San Francisco Bay. He is among a tiny fraction of people who have survived that fall — and one of the few in that group to regain full mobility.

Mr. Hines, 34, is the author of "Cracked Not Broken: Surviving and Thriving After a Suicide Attempt," and speaks around the country about suicide prevention and mental health care. (Mr. Hines has been given a diagnosis of bipolar disorder.) He has a large following online, and he frequently posts his talks and videos; he is also producing a documentary called "Suicide: The Ripple Effect," which is due out next year.

"I survived, but I hurt so many people in my life," Mr. Hines said in an interview from Atlanta, where he now lives. "Every time the phone rings, my dad wonders, 'Is Kevin alive?'"

He shattered three vertebrae and spent four and a half months in a rehabilitation unit after his jump; in the 15 years since, he has had seven stints in a psychiatric ward. His symptoms — mania, psychosis, depression — remain with him, but now he is able to manage them.

"We blame people for suicide, for mental illness, for addiction, all the time," he said. "But people die from suicide because their brains aren't working right. If you're suffering mentally, don't sit around in denial like I did for so long. Recovery happens. I'm living proof."

Mr. Hines's advocacy hit close to home early last year, when a young Brooklyn woman who was gripped by suicidal despair saw one of his videos on social media.

The woman, who asked that she be identified only by her middle initial, V, and that certain details of her life be omitted to protect her privacy as well as her family's, watched the video repeatedly — especially the scenes in which Mr. Hines describes the guilt he and his father felt when they met in the hospital after his jump.

V, a tall, athletic woman with a quick wit, is normally quiet and keeps her problems to herself. But she was so moved by Mr. Hines's powerful statements that she sent him a message, and the two began to correspond.

Knowing that I was working on this article, Mr. Hines approached V to find out if she would be willing to be interviewed. She agreed, and we met on a cold spring Saturday. Over omelets at an Upper West Side diner, she described her early life.

Her mother struggled with depression and drugs and was often suicidal. When V was 9, she came home from school one day to find her mother's arms bleeding from a suicide attempt. Because V's mother often became enraged at family members if they called for an ambulance, V cleaned the wounds with hydrogen peroxide and stitched them up herself with a needle and surgical thread from a medical kit her mother had stolen from a hospital. "It was sort of my personal project to take care of her," said V, 24, who dresses neatly in jeans and button-down shirts.

V fell into depression herself as a teenager when her family began to move frequently, forcing her to change schools as often as every six months. The only adult who ever seemed to pay attention to her was an art teacher, who told V she was talented but needed to make different friends. That helped turn V away from school and into an increasingly desperate cycle of suicidal thoughts, particularly during the gloomy winter months. She sought counseling occasionally but, fearful she would be hospitalized, never revealed the truth of her despair.

V, who has expressive hazel eyes she often hides with vintage sunglasses, dropped out of high school and worked at a series of menial jobs, always looking forward to the six months of the year when the sunlight outlasted the dark. She taught herself coping strategies: She learned to meditate by focusing on a skylight in her bedroom, and by drawing and photographing tiny squares of nature — a few inches of a tree, for example – for hours on end.

Things began to look up in 2011. She had completed her G.E.D., and enrolled that year in a City University of New York college that she prefers not to identify. She earned top grades in science, a field she had never considered. She started boxing at

a local gym, quickly gaining speed, strength, agility and confidence as she sparred with opponents in front of hundreds of onlookers.

But in 2013, she ruptured a tendon, and doctors said that even with surgery, she would not box again. She tried other types of exercise — swimming, hula-hooping — but nothing matched the rush she felt in the ring. Her mind returned to suicide as the only way to end her emotional and physical pain.

When she saw Mr. Hines's video, she watched it over and over. "I'd been thinking about doing this myself for years," V said, "and suddenly I realized, 'I don't want regret to be my last emotion. And I don't want to do that to the people I love.'" She had a longtime boyfriend she cherished, and a loyal, caring best friend with whom she had never shared her dark thoughts.

She poured herself into school and found demanding intellectual work outdoors that helped sustain her. She directed her energy into drawing and taking photographs, and finding corners of the city where nature helped to hush her sadness. Next month, she will enter her final year of college.

Epidemiologists typically work at a remove from their subjects. It's not often that they encounter the people whose lives their research has influenced. But when I mentioned Kevin Hines, whom Dr. Gould had met, her face lit up. "His story gives me goose bumps," she said, running a hand up the length of her arm.

Because V, like Dr. Gould, is a proud Brooklynite who now hopes for a career in science, I wondered what it might be like to introduce them. So on a breezy July day, we all gathered in Dr. Gould's office. She motioned to me to sit at her desk, so that she could be closer to V. For two hours, they focused on their home borough, the lives of women in science and V's hopes for her future. Dr. Gould encouraged her to get a Ph.D. They discussed their shared love of meditation, and the idea that thoughts, however scary, need not represent reality.

The talk turned to depression. V paused to consider her words. "I've learned that I can be O.K. with being miserable," she said. "I tell myself, 'All right, I'm miserable, but I'm just going to wait.'" Some of her best art, she said, came from those dark periods.

"I used to think about ending my life," she said. "But the more I learned, the more I realized that what happens in your mind at the point of death, that's your last thought."

Dr. Gould nodded, leaning closer. "I decided instead that I'd rather make more art, learn more, be a part of something," V said. "And I realized that you're in people's lives for a reason. They want you there."

"It's important to stay."

Correction: August 28, 2016

An article last Sunday about a leading suicide researcher at Columbia University misstated the timing of a project to install fences on the sidewalks of the George Washington Bridge, from which people have jumped to their deaths. The project will begin next year, not in 2020. The article also misstated the number of years since Kevin Hines left a rehabilitation unit after his jump from the Golden Gate Bridge in San Francisco. It has been 15 years, not 11.

A version of this article appears in print on August 21, 2016, on page MB1 of the New York edition with the headline: Shedding Light in Suicide's Shadows.

CERTIFICATION OF ENROLLMENT

ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2793

64th Legislature
2016 Regular Session

Passed by the House March 8, 2016
Yeas 94 Nays 2

Speaker of the House of Representatives

Passed by the Senate March 1, 2016
Yeas 47 Nays 0

President of the Senate

Approved

Governor of the State of Washington

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2793** as passed by House of Representatives and the Senate on the dates hereon set forth.

Chief Clerk

FILED

Secretary of State
State of Washington

ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2793

AS AMENDED BY THE SENATE

Passed Legislature - 2016 Regular Session

State of Washington 64th Legislature 2016 Regular Session

By House Finance (originally sponsored by Representatives Orwall, Blake, Kretz, Sullivan, Cody, Jinkins, Kagi, Goodman, Ormsby, Tharinger, Rossetti, and Reykdal)

READ FIRST TIME 02/09/16.

AN ACT Relating to providing for suicide awareness and prevention education for safer homes; amending RCW 9.41.310 and 43.70.442; adding a new section to chapter 43.70 RCW; creating new sections; providing an effective date; and providing expiration dates.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The legislature finds that: Washington's suicide rate is fourteen percent higher than the national average; on average, two young people between the ages of ten and twenty-four die by suicide each week; almost a quarter of those who die by suicide are veterans; and many of the state's rural and tribal communities have the highest suicide rates. The legislature further finds that when suicide occurs, it has devastating consequences for communities and schools, yet, according to the United States surgeon general, suicide is the nation's most preventable form of death. The legislature further finds that one of the most immediate ways to reduce the tragedy of suicide is through suicide awareness and prevention education coupled with safe storage of lethal means commonly used in suicides, such as firearms and prescription medications. The legislature further finds that encouraging firearms dealers to voluntarily participate in suicide awareness and prevention education programs and provide certain safe storage

devices at cost is an important step in creating safer homes and reducing suicide deaths in the state.

NEW SECTION. **Sec. 2.** (1)(a) Subject to the availability of amounts appropriated for this specific purpose, a safe homes task force is established to raise public awareness and increase suicide prevention education among new partners who are in key positions to help reduce suicide. The task force shall be administered and staffed by the University of Washington school of social work.

(b) The safe homes task force shall consist of the members comprised of a suicide prevention and firearms subcommittee and a suicide prevention and pharmacy subcommittee, as follows:

(i) The suicide prevention and firearms subcommittee shall consist of the following members and be cochaired by the University of Washington school of social work and a member identified in (b)(i)(A) of this subsection (1):

(A) A representative of the national rifle association and a representative of the second amendment foundation;

(B) Two representatives of suicide prevention organizations, selected by the cochairs of the subcommittee;

(C) Two representatives of the firearms industry, selected by the cochairs of the subcommittee;

(D) Two individuals who are suicide attempt survivors or who have experienced suicide loss, selected by the cochairs of the subcommittee;

(E) Two representatives of law enforcement agencies, selected by the cochairs of the subcommittee;

(F) One representative from the department of health;

(G) One representative from the department of veterans affairs, and one other individual representing veterans to be selected by the cochairs of the subcommittee; and

(H) No more than two other interested parties, selected by the cochairs of the subcommittee.

(ii) The suicide prevention and pharmacy subcommittee shall consist of the following members and be cochaired by the University of Washington school of social work and a member identified in (b)(ii)(A) of this subsection (1):

(A) Two representatives of the Washington state pharmacy association;

(B) Two representatives of retailers who operate pharmacies, selected by the cochairs of the subcommittee;

(C) One faculty member from the University of Washington school of pharmacy and one faculty member from the Washington State University school of pharmacy;

(D) One representative of the department of health;

(E) One representative of the pharmacy quality assurance commission;

(F) Two representatives of the Washington state poison control center;

(G) One representative of the department of veterans affairs, and one other individual representing veterans to be selected by the cochairs of the subcommittee; and

(H) No more than two other interested parties, selected by the cochairs of the subcommittee.

(c) The University of Washington school of social work shall convene the initial meeting of the task force.

(2) The task force shall:

(a) Develop and prepare to disseminate online trainings on suicide awareness and prevention for firearms dealers and their employees and firearm range owners and their employees;

(b) In consultation with the department of fish and wildlife, review the firearm safety pamphlet produced by the department of fish and wildlife under RCW 9.41.310 and, by January 1, 2017, recommend changes to the pamphlet to incorporate information on suicide awareness and prevention;

(c) Develop suicide awareness and prevention messages for posters and brochures that are tailored to be effective for firearms owners for distribution to firearms dealers and firearm ranges;

(d) Develop suicide awareness and prevention messages for posters and brochures for distribution to pharmacies;

(e) In consultation with the department of fish and wildlife, develop strategies for creating and disseminating suicide awareness and prevention information for hunting safety classes, including messages to parents that can be shared during online registration, in either follow up electronic mail communications, or in writing, or both;

(f) Develop suicide awareness and prevention messages for training for the schools of pharmacy and provide input on trainings being developed for community pharmacists;

(g) Provide input to the department of health on the implementation of the safe homes project established in section 3 of this act;

(h) Create a web site that will be a clearinghouse for the newly created suicide awareness and prevention materials developed by the task force; and

(i) Conduct a survey of firearms dealers and firearms ranges in the state to determine the types and amounts of incentives that would be effective in encouraging those entities to participate in the safe homes project created in section 3 of this act;

(j) Create, implement, and evaluate a suicide awareness and prevention pilot program in two counties, one rural and one urban, that have high suicide rates. The pilot program shall include:

(i) Developing and directing advocacy efforts with firearms dealers to pair suicide awareness and prevention training with distribution of safe storage devices;

(ii) Developing and directing advocacy efforts with pharmacies to pair suicide awareness and prevention training with distribution of medication disposal kits and safe storage devices;

(iii) Training health care providers on suicide awareness and prevention, paired with distribution of medication disposal kits and safe storage devices; and

(iv) Training local law enforcement officers on suicide awareness and prevention, paired with distribution of medication disposal kits and safe storage devices.

(3) The task force shall consult with the department of health to develop timelines for the completion of the necessary tasks identified in subsection (2) of this section so that the department of health is able to implement the safe homes project under section 3 of this act by January 1, 2018.

(4) Beginning December 1, 2016, the task force shall annually report to the legislature on the status of its work. The task force shall submit a final report by December 1, 2019, that includes the findings of the suicide awareness and prevention pilot program evaluation under subsection (2) of this section and recommendations on possible continuation of the program. The task force shall submit its reports in accordance with RCW 43.01.036.

(5) This section expires July 1, 2020.

NEW SECTION. **Sec. 3.** A new section is added to chapter 43.70 RCW to read as follows:

(1) Subject to the availability of amounts appropriated for this specific purpose, the department shall develop and administer a safe homes project for firearms dealers and firearms ranges to encourage voluntary participation in a program to implement suicide awareness and prevention strategies.

(2) As part of the safe homes project, the department shall certify a firearms dealer or firearms range that meets the requirements of subsection (3) of this section as a safe homes partner.

(3) The department, in consultation with the safe homes task force created in section 2 of this act, shall develop criteria for certification of a firearms dealer or firearms range as a safe homes partner that include, at a minimum, the following requirements:

(a) Posting of suicide awareness and prevention posters, developed by the safe homes task force, at the firearms dealer's or firearms range's premises;

(b) Distribution of suicide awareness and prevention brochures, developed by the safe homes task force, to firearms purchasers and customers;

(c) Completion by the firearms dealer and employees, or firearms range and employees, of an online suicide awareness and prevention training developed by the safe homes task force; and

(d) Offering safe storage devices, in the form of a lock box or life jacket, for sale at cost to firearms purchasers, or customers.

(4) The department shall:

(a) Provide technical assistance to firearms dealers and firearms ranges that want to participate in the safe homes project;

(b) Track and report status updates of the program to the legislature in accordance with RCW 43.01.036; and

(c) Conduct, or contract with local health departments to conduct, random audits of businesses who participate in the safe homes project to ensure compliance with the requirements of this section.

(5) The department shall implement the safe homes project beginning January 1, 2018.

(6) For the purposes of this section:

(a) "Firearms dealer" means a firearms dealer licensed under RCW 9.41.110; and

(b) "Firearms range" means an entity that operates an area or facility designed for the safe discharge or other use of firearms for sport, recreational, or competitive shooting or training purposes.

Sec. 4. RCW 9.41.310 and 1994 c 264 s 2 are each amended to read as follows:

(1) After a public hearing, the department of fish and wildlife shall publish a pamphlet on firearms safety and the legal limits of the use of firearms. The pamphlet shall include current information on firearms laws and regulations and state preemption of local firearms laws. By July 1, 2017, the department of fish and wildlife shall update the pamphlet to incorporate information on suicide awareness and prevention as recommended by the safe homes task force established in section 2 of this act.

(2) This pamphlet may be used in the department's hunter safety education program and shall be provided to the department of licensing for distribution to firearms dealers and persons authorized to issue concealed pistol licenses. The department of fish and wildlife shall reimburse the department of licensing for costs associated with distribution of the pamphlet.

Sec. 5. RCW 43.70.442 and 2015 c 249 s 1 are each amended to read as follows:

(1)(a) Each of the following professionals certified or licensed under Title 18 RCW shall, at least once every six years, complete training in suicide assessment, treatment, and management that is approved, in rule, by the relevant disciplining authority:

(i) An adviser or counselor certified under chapter 18.19 RCW;

(ii) A chemical dependency professional licensed under chapter 18.205 RCW;

(iii) A marriage and family therapist licensed under chapter 18.225 RCW;

(iv) A mental health counselor licensed under chapter 18.225 RCW;

(v) An occupational therapy practitioner licensed under chapter 18.59 RCW;

(vi) A psychologist licensed under chapter 18.83 RCW;

(vii) An advanced social worker or independent clinical social worker licensed under chapter 18.225 RCW; and

(viii) A social worker associate—advanced or social worker associate—independent clinical licensed under chapter 18.225 RCW.

(b) The requirements in (a) of this subsection apply to a person holding a retired active license for one of the professions in (a) of this subsection.

(c) The training required by this subsection must be at least six hours in length, unless a disciplining authority has determined, under subsection ((~~(9)~~)) (10)(b) of this section, that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length.

(d) Beginning July 1, 2017, the training required by this subsection must be on the model list developed under subsection (6) of this section. Nothing in this subsection (1)(d) affects the validity of training completed prior to July 1, 2017.

(2)(a) Except as provided in (b) of this subsection, a professional listed in subsection (1)(a) of this section must complete the first training required by this section by the end of the first full continuing education reporting period after January 1, 2014, or during the first full continuing education reporting period after initial licensure or certification, whichever occurs later.

(b) A professional listed in subsection (1)(a) of this section applying for initial licensure may delay completion of the first training required by this section for six years after initial licensure if he or she can demonstrate successful completion of the training required in subsection (1) of this section no more than six years prior to the application for initial licensure.

(3) The hours spent completing training in suicide assessment, treatment, and management under this section count toward meeting any applicable continuing education or continuing competency requirements for each profession.

(4)(a) A disciplining authority may, by rule, specify minimum training and experience that is sufficient to exempt an individual professional from the training requirements in subsections (1) and (5) of this section. Nothing in this subsection (4)(a) allows a disciplining authority to provide blanket exemptions to broad categories or specialties within a profession.

(b) A disciplining authority may exempt a professional from the training requirements of subsections (1) and (5) of this section if the professional has only brief or limited patient contact.

(5)(a) ((~~Beginning January 1, 2016,~~)) Each of the following professionals credentialed under Title 18 RCW shall complete a one-

time training in suicide assessment, treatment, and management that is approved by the relevant disciplining authority:

(i) A chiropractor licensed under chapter 18.25 RCW;

(ii) A naturopath licensed under chapter 18.36A RCW;

(iii) A licensed practical nurse, registered nurse, or advanced registered nurse practitioner, other than a certified registered nurse anesthetist, licensed under chapter 18.79 RCW;

(iv) An osteopathic physician and surgeon licensed under chapter 18.57 RCW, other than a holder of a postgraduate osteopathic medicine and surgery license issued under RCW 18.57.035;

(v) An osteopathic physician assistant licensed under chapter 18.57A RCW;

(vi) A physical therapist or physical therapist assistant licensed under chapter 18.74 RCW;

(vii) A physician licensed under chapter 18.71 RCW, other than a resident holding a limited license issued under RCW 18.71.095(3);

(viii) A physician assistant licensed under chapter 18.71A RCW; ((~~and~~))

(ix) A pharmacist licensed under chapter 18.64 RCW; and

(x) A person holding a retired active license for one of the professions listed in (a)(i) through ((~~(viii)~~)) (ix) of this subsection.

(b)(i) A professional listed in (a)(i) through (viii) of this subsection or a person holding a retired active license for one of the professions listed in (a)(i) through (viii) of this subsection must complete the one-time training by the end of the first full continuing education reporting period after January 1, 2016, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between June 12, 2014, and January 1, 2016, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(ii) A licensed pharmacist or a person holding a retired active pharmacist license must complete the one-time training by the end of the first full continuing education reporting period after January 1, 2017, or during the first full continuing education reporting period after initial licensure, whichever is later.

(c) The training required by this subsection must be at least six hours in length, unless a disciplining authority has determined,

under subsection ((~~(9)~~)) (10)(b) of this section, that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length.

(d) Beginning July 1, 2017, the training required by this subsection must be on the model list developed under subsection (6) of this section. Nothing in this subsection (5)(d) affects the validity of training completed prior to July 1, 2017.

(6)(a) The secretary and the disciplining authorities shall work collaboratively to develop a model list of training programs in suicide assessment, treatment, and management.

(b) The secretary and the disciplining authorities shall update the list at least once every two years.

(c) By June 30, 2016, the department shall adopt rules establishing minimum standards for the training programs included on the model list. The minimum standards must require that six-hour trainings include content specific to veterans and the assessment of issues related to imminent harm via lethal means or self-injurious behaviors and that three-hour trainings for pharmacists include content related to the assessment of issues related to imminent harm via lethal means. When adopting the rules required under this subsection (6)(c), the department shall:

(i) Consult with the affected disciplining authorities, public and private institutions of higher education, educators, experts in suicide assessment, treatment, and management, the Washington department of veterans affairs, and affected professional associations; and

(ii) Consider standards related to the best practices registry of the American foundation for suicide prevention and the suicide prevention resource center.

(d) Beginning January 1, 2017:

(i) The model list must include only trainings that meet the minimum standards established in the rules adopted under (c) of this subsection and any three-hour trainings that met the requirements of this section on or before July 24, 2015;

(ii) The model list must include six-hour trainings in suicide assessment, treatment, and management, and three-hour trainings that include only screening and referral elements; and

(iii) A person or entity providing the training required in this section may petition the department for inclusion on the model list.

The department shall add the training to the list only if the department determines that the training meets the minimum standards established in the rules adopted under (c) of this subsection.

(7) The department shall provide the health profession training standards created in this section to the professional ((~~education [educator]~~)) educator standards board as a model in meeting the requirements of RCW 28A.410.226 and provide technical assistance, as requested, in the review and evaluation of educator training programs. The educator training programs approved by the professional educator standards board may be included in the department's model list.

(8) Nothing in this section may be interpreted to expand or limit the scope of practice of any profession regulated under chapter 18.130 RCW.

(9) The secretary and the disciplining authorities affected by this section shall adopt any rules necessary to implement this section.

(10) For purposes of this section:

(a) "Disciplining authority" has the same meaning as in RCW 18.130.020.

(b) "Training in suicide assessment, treatment, and management" means empirically supported training approved by the appropriate disciplining authority that contains the following elements: Suicide assessment, including screening and referral, suicide treatment, and suicide management. However, the disciplining authority may approve training that includes only screening and referral elements if appropriate for the profession in question based on the profession's scope of practice. The board of occupational therapy may also approve training that includes only screening and referral elements if appropriate for occupational therapy practitioners based on practice setting.

(11) A state or local government employee is exempt from the requirements of this section if he or she receives a total of at least six hours of training in suicide assessment, treatment, and management from his or her employer every six years. For purposes of this subsection, the training may be provided in one six-hour block or may be spread among shorter training sessions at the employer's discretion.

(12) An employee of a community mental health agency licensed under chapter 71.24 RCW or a chemical dependency program certified

under chapter 70.96A RCW is exempt from the requirements of this section if he or she receives a total of at least six hours of training in suicide assessment, treatment, and management from his or her employer every six years. For purposes of this subsection, the training may be provided in one six-hour block or may be spread among shorter training sessions at the employer's discretion.

NEW SECTION. **Sec. 6.** The schools of pharmacy at the University of Washington and Washington State University shall convene a work group to jointly develop a curriculum on suicide assessment, treatment, and management for pharmacy students. The curriculum must include material on identifying at-risk patients and limiting access to lethal means. When developing the curriculum, the schools shall consult with experts on suicide assessment, treatment, and management, and with the safe homes task force created in section 2 of this act on appropriate suicide awareness and prevention messaging. The schools of pharmacy shall submit a progress report to the governor and the relevant committees of the legislature by December 1, 2016.

NEW SECTION. **Sec. 7.** By January 1, 2017, the department of health and the pharmacy quality assurance commission shall jointly develop written materials on suicide awareness and prevention that pharmacies may post or distribute to customers. When developing the written materials, the department and the commission shall consult with experts on suicide assessment, treatment, and management, and with the safe homes task force created in section 2 of this act on appropriate suicide awareness and prevention messaging.

NEW SECTION. **Sec. 8.** Section 5 of this act takes effect January 1, 2017.

NEW SECTION. **Sec. 9.** Section 3 of this act expires January 1, 2024.

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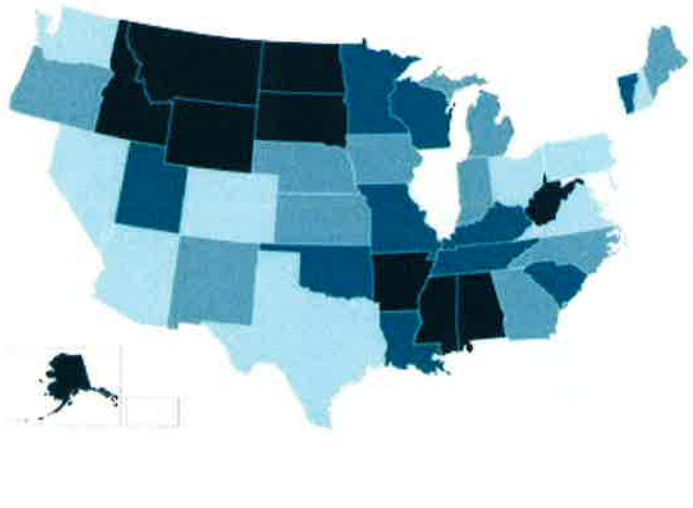
News

Gun prevalence and suicide rank by state

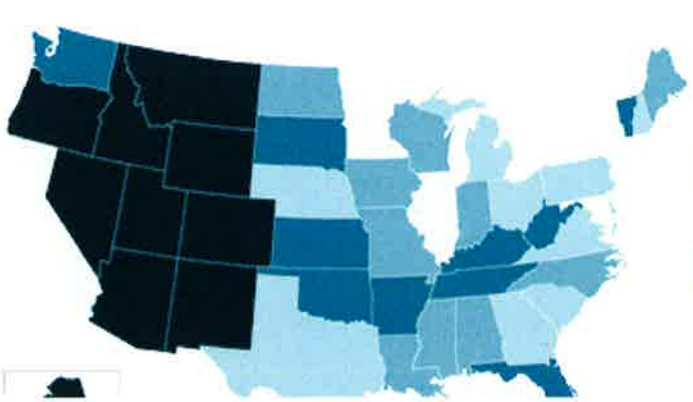
Mapping the Overlap As these maps show, the correlation between guns and suicide is strong but inexact, since both are influenced by poverty, population density, and crime. The nine states that rank lowest in terms of gun prevalence are the very same nine that rank lowest for suicide rates. Similarly, the three states top-ranked for gun prevalence can be found among the four states ranking highest for suicide rates.



State rank by gun prevalence

median % of households with guns, 2002

1 Wyoming	6 West Virginia		58%
2 Montana	7 Alabama		
3 Alaska	8 Idaho		
4 South Dakota	9 Mississippi		
5 Arkansas	10 North Dakota		
11 Kentucky	16 South Carolina		46%
12 Tennessee	17 Utah		
13 Louisiana	18 Oklahoma		
14 Missouri	19 Minnesota		
15 Vermont	20 Wisconsin		
21 Iowa	26 Georgia		42%
22 Kansas	27 Michigan		
23 Nebraska	28 Oregon		
24 North Carolina	29 New Mexico		
25 Maine	30 Indiana		
31 Arizona	36 Colorado		36%
32 Pennsylvania	37 Nevada		
33 Washington	38 Ohio		
34 Virginia	39 New Hampshire		
35 Texas	40 Delaware		
41 Florida	46 Connecticut		17%
42 Maryland	47 Rhode Island		
43 Illinois	48 Massachusetts		
44 California	49 New Jersey		
45 New York	50 Hawaii		



State rank by suicide deaths

median rate per 100,000, 2002–04

1 Alaska	6 Idaho		17.6
2 Wyoming	7 Colorado		
3 Nevada	8 Utah		
4 Montana	9 Arizona		
5 New Mexico	10 Oregon		
11 West Virginia	16 Kentucky		13.4
12 Oklahoma	17 Washington		
13 Vermont	18 Tennessee		
14 South Dakota	19 Florida		
15 Arkansas	20 Kansas		
21 North Dakota	26 Wisconsin		11.6
22 Mississippi	27 Maine		
23 Missouri	28 Alabama		
24 Indiana	29 Iowa		
25 North Carolina	30 Louisiana		
31 South Carolina	36 Michigan		10.7
32 Georgia	37 New Hampshire		
33 Texas	38 Ohio		

34 Virginia
35 Pennsylvania
41 Minnesota
42 California
43 Hawaii
44 Maryland
45 Illinois
39 Delaware
40 Nebraska
46 Rhode Island
47 Connecticut
48 New Jersey
49 Massachusetts
50 New York

8.0

News

Removing guns from distraught individuals may help curb suicide rate

Friends of distressed individuals can have a role in helping to reduce the nation's rising suicide rate by showing compassion, optimism, and coaxing the distraught person to store any household guns or medications that they might use to kill themselves inaccessably until they're feeling better, said Catherine Barber, director of the Means Matter Campaign at the Harvard Injury Control Research Center at Harvard T.H. Chan School of Public Health, in a April 21, 2016 *Los Angeles Times* article.*

Barber was commenting on a new report from the Centers for Disease Control and Prevention (CDC), which showed a 24% increase in suicides in the U.S. between 1999 and 2014, including increases among white women and Native Americans. About 42,773 Americans died of suicide in 2014, making it the 10th leading cause of death for all ages. Many who attempt suicide act with little or no planning—and if they have access to a gun, they are much more likely to die in the attempt. Firearms claimed about half of the male suicide victims and about one-third of female suicides in 2014.

Nine out of 10 people who attempt suicide and survive—even very serious attempts—do not go on to later take their lives. "Often, the moment for a friend to intervene is related to a crisis that is going to resolve, like a divorce," said Barber.

Read the *Los Angeles Times* article: U.S. suicides have soared since 1999, CDC report says

Read the CDC report: Increase in Suicide in the United States, 1999–2014

This article was updated on April 27, 2016