Firearm Suicide Prevention Task Force 12/9/16

Agenda:

- Recap of last meeting
- Review of meeting minutes
- Presentation by Brian DiSabatino
- Presentation by Pete Rudoff
- Review of member input
- Wrap up & path forward
- Public comment

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 McLaughlin	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 Hague	Delaware State Sportsman Association
Member	Bill Farley	Commission on Veterans Affairs
Member	Sgt. John McDerby on behalf of Chief Drew Aydelotte	DNREC
Member	Emily Vera	Mental Health Association
Member	George Higgins	Delaware Coalition Against Gun Violence
Member	Amy Kevis	Division of Substance Abuse & Mental Health
Participant	Scott Bell	Firearm Dealer
Participant	Rick Armitage	NRA
Staff	Lauren Vella	Delaware House of Representatives
Staff	Alexa Scoglietti	Delaware House of Representatives

Firearm Suicide Prevention Task Force

Tuesday, November 15, 2016
10:00 a.m. – 12:00 p.m.
Legislative Hall, Senate Hearing Room
411 Legislative Ave.
Dover, DE 19901

Meeting Attendees:

Task Force Members:

Present:	Title/Organization
Lisa Goodman	Chair
Rep. Valerie Longhurst	Vice-Chair
Rep. Trey Paradee	State Representative
Rep. Kevin Hensley	State Representative
Sen. Margaret Rose Henry	State Senator
Sen. Ernie Lopez	State Senator
Pete Rudoff	Member of the Public
Cyndi McLaughlin	Foundation for a Better Tomorrow
Dr. Harvey Doppelt	DSCYF
Sec. Rita Landgraf	Dept. of Health and Social Services
Jeff Hague	Delaware State Sportsman Association
William Farley	Commission on Veterans Affairs
Emily Vera	Mental Health Association

Absent:	
Bryan Horsey	Member of the Public
Chief Drew Aydelotte	DNREC

Attendees:	Organization:
George Higgins	Delaware Coalition Against Gun Violence
Amy Kevis	DHSS on behalf of Bryan Horsey
Sgt. John McDerby	DNREC on behalf of Chief Drew Aydelotte
Rep. Daivd Bentz	State Representative

Staff:	
Lauren Vella	House of Representatives
Kay Wilson	House of Representatives
Stephanie Mantegna	House of Representatives
Samantha Hemphill	State Senate

Chair of the Firearm Suicide Prevention Task Force, Lisa Goodman, called the meeting to order at 10:06 a.m. She provided an introduction to the group and the intentions of the Task Force. She shared her background as President of Equality Delaware noting the increased risk of suicide in the LGBTQ community. She also shared her personal experience with the suicide of her father by a firearm.

She then asked the task force members and the public to provide a brief introduction. Many members of the group shared personal stories of suicides in their families or among friends as well as their related work experience.

Vice-Chair of the Firearm Suicide Prevention Task Force, State Representative Valerie Longhurst shared her thanks for the members' participation and shared her work with suicide prevention efforts during her tenure as a legislator. She shared her work on House Bill 90 in 2015 which requires training for public school personnel on the warning signs of suicide and requires prevention and response plans as well as her work with veteran suicide prevention with the '22 in 22' initiative.

Sen. Henry acknowledged the distinction between those suffering from mental illness and from end of life decisions regarding ending physical pain. She wanted to make it clear that senior suicides need to be looked at carefully to not misidentify an end of life decision with a mental illness induced suicide.

Chair Goodman reviewed the text of the Executive Order 63 and the charge of the task force to do the following:

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.

She discussed the importance of getting firearm dealers to the table to be a part of the discussion and noted the report due date is January 1st.

Dr. Harvey Doppelt reviewed the Center for Disease Control (CDC) data of suicides and firearms in Delaware from 1999 to 2014. The data shows that white men are much more likely than women or minorities to commit suicide by firearm. He discussed the youth clusters explaining that adolescents are more likely to commit suicide if other children have done so response to youth suicide needs to be very careful to address other children in the community. Women are more likely to use pills to attempt suicide and this is often not lethal, so intervention can be made. Dr. Doppelt noted that being widowed was a risk factor for white males. Firearm suicides are the most lethal method.

Jeff Hague remarked on the aging retiree population in Sussex County. Dr. Doppelt reviewed the firearm suicide rates as compared to other states. New Jersey had a significantly lower rate than Delaware. New Jersey is the second lowest state for gun ownership.

Vice-Chair Longhurst asked for an explanation on why New Jersey has such a lower rate of firearm suicide. Sec. Rita Landgraf offered to reach out to her counterparts in New Jersey to see what they are doing from a mental health perspective.

George Higgins and Dr. Doppelt discussed Delaware's participation in the National Violent Death Reporting System (NVDRS) which will improve the data collection for suicide. Dr. Doppelt shared that the state received the grant and is working on additional paperwork. NVDRS will be connected with law enforcement and the medical examiner's office.

The committee reviewed the article and legislation from Washington State. Vice-Chair Longhurst explained that the widow of the man who committed suicide by firearm reached out to the National Rifle Association to find a way to prevent these kinds of suicides. Chair Goodman pointed out that the legislation in Washington established a system of partners with the points of contact for people to obtain lethal means of suicide. Washington developed intervention strategies and materials at these locations in order to educate and intervene.

Sen. Henry asked if there have been any results or outcomes from Washington. Since the law was signing in 2016, outcomes are not yet available.

Chair Goodman reviewed the article about Dr. Gould, a professor of epidemiology at Columbia University and her work with suicide at the George Washington Bridge. Chair Goodman remarked that a take away would be from Dr. Gould's work is that the press needs to be engaged about how to cover suicides properly to not insight a suicide contagion.

Vice-Chair Longhurst asked the task force member to do some homework and review the materials provided at this meeting carefully. She also inquired about the current training law enforcement and first responders receive to handle calls.

William Farley shared that the Commission of Veterans Affairs provided training for law enforcement on post-traumatic stress disorder (PTSD). It was a onetime training.

Amy Kevis shared her experience as a New Castle County police officer for 20 years. It is difficult for officers to be prepared in practical ways to handle these types of cases. She saw this as an opportunity to review the training continuum that exists.

Sgt. John McDerby shared that officers within DNREC receive training but it is not annual and that bigger departments tend to have specialized officers. He noted that some training programs provide just a checklist but it is hard to make them meaningful and translate to the actual real situations officers will be responding to.

Amy Kevis shared about the training Division of Substance and Abuse and Mental Health (DSAMH) provides to crisis intervention teams for 40 hours. She would like to see more people

participate in that training given its significant time commitment. Emily Vera explained the training that the Mental Health Association provides at the Wilmington Policy Academy.

Chair Goodman noted that suicides can run in families and how important it is to educate family members.

Sen. Henry suggested that a commission be created to implement this work and to establish a collaborative effort providing the Child Protection Accountability Commission as an example.

William Farley noted that the training component in Washington's legislation brought consensus among gun owners and dealers.

Rep. Hensley pointed to the wellness centers in all of the Delaware public schools as a place for education and intervention with youth.

Cyndi McLaughlin suggested that efforts be implemented in steps to improve compliance and ease any concerns about the large undertaking. She also suggested that any recommendation include methods to help build up data.

Pete Rudoff asked if there was existing data on the signs of suicide to help inform the interventions. Cyndi McLaughlin share information about a 90 minute online training, Signs of Suicide.

George Higgins asked if the CDC had looked at suicide in the scientific way they recently looked at Wilmington's gun violence problem. Sec. Landgraf did not believe that they did; they look at just homicides.

The group discussed their goals for the next meeting which included each member submitting two proposals and disseminating the "Signs of Suicide" training module.

Chair Goodman opened the conversation to the public. Rep. Bentz remarked on the gender divide in suicide method and suggested modeling the Washington approach by addressing a in a holistic suicide methods including prescription drug overdoses. Vice-Chair Longhurst suggested that that be a recommendation for a commission to look at all methods.

Sen. Henry expressed her appreciation for firearm owners for their participation. She made it clear that she is not looking to take guns away but that there can be better ways to reach out to those in distress.

William Farley asked if this is a component of gun safety training and noted that the phrasing is really important to make suicide prevention a component of being a responsible gun owner.

Chair Goodman agreed that providing materials at gun shops is important but the content is equally as important. The meeting was adjourned at 11:46 a.m.

Respectfully submitted by: Lauren Vella

Firearm Suicide Prevention Task Force

Wednesday, November 30th
9:00am- 11:00am
Legislative Hall, Senate Hearing Room
411 Legislative Ave.
Dover, DE 19901

Meeting Attendees:

Task Force Members:

Present:	Title/Organization
Lisa Goodman	Chair
Rep. Valerie Longhurst	Vice-Chair
Rep. Trey Paradee	State Representative
Rep. Kevin Hensley	State Representative
Sen. Margaret Rose Henry	State Senator
Sen. Ernie Lopez	State Senator
Pete Rudoff	Member of the Public
Cyndi McLaughlin	Foundation for a Better Tomorrow
Dr. Harvey Doppelt	DSCYF
Sec. Rita Landgraf	Dept. of Health and Social Services
Jeff Hague	Delaware State Sportsman Association
William Farley	Commission on Veterans Affairs
Emily Vera	Mental Health Association
Bryan Horsey	Member of the Public
George Higgins	Delaware Coalition Against Gun Violence
Amy Kevis	DHSS
Sgt. John McDerby	DNREC on behalf of Chief Drew Aydelotte

Absent:	
Chief Drew Aydelotte	DNREC

Attendees:	
Scott Bell	Firearm Dealer
Rep. Daivd Bentz	State Representative
Rick Armitage	National Rifle Association
Mark Ostroski	DNREC, Div. of Fish & Wildlife
Maj. Vaughn Bond	NCCPD

Staff:	
Lauren Vella	House of Representatives
Alexa Scoglietti	House of Representatives

Chair of the Firearm Suicide Prevention Task Force, Lisa Goodman, called the meeting to order at 9:04 a.m. She went over the materials distributed at the beginning of the meeting. She then asked anyone not present at the first meeting to provide a brief introduction. Bryan Horsey, Rick Armitage of the National Rifle Association, firearms dealer Scott Bell, Mark Ostroski of DNREC, and Major Vaughn Bond from New Castle County Police Department made their introductions.

Chair Goodman reviewed several materials distributed at the beginning of the meeting including the minutes from the previous meeting. She then asked Major Bond to enlighten the group about New Castle County's approach to suicide prevention.

Major Bond said that he would make sure to provide them with relevant statistics gathered by NCCPD. He then explained that NCCPD officers receive over twenty-six hours of overall mental health training, above the twenty-hour training required by the Council on Police Training. A group of officers receive forty hours worth of intensive crisis intervention training from the National Alliance on Mental Illness (NAMI). About twenty-five officers across all units are used when needed as first responders for crisis intervention and potential suicide threats. Major Bond told the committee that the goal is to have NAMI training incorporated into police academy.

Chair Goodman asked if suicide is a daily issue for NCCPD. Major Bond confirmed that she was correct, and felt that methods in dealing with mental illness have thankfully progressed since the early 1990's. Simply providing resources or contacts to officers has improved response immensely.

Pete Rudoff asked about CAPES. Major Bond and Amy Kevis explained that it was the former partnership between Wilmington and the Division of Substance Abuse and Mental Health. Ms. Kevis explained that DHSS now uses crisis walk-in centers as a much more accessible policy to Delawareans facing a mental health issue. Wilmington Hospital still has psychiatric evaluation but is no longer working with DHSS.

Vice-Chair Longhurst asked if NAMI-trained officers were present at every potential suicide call. Major Bond responded that it is always a priority to have one of those specially trained officers there, but due to the sheer volume of calls they are often stretched thin. Vice-Chair Longhurst then asked if officers identify whether a potentially suicidal person has a firearm in their home. Major Bond responded that initial dispatchers do ask if weapons are in the house. He added that if the person is threatening to hurt themselves, they are able to take any firearms away or turn it over to a family member.

Vice-Chair Longhurst asked if the person threatening suicide is talked to about their firearms during their period of rehabilitation. Vice-Chair Longhurst expressed worry for the families involved. Ms. Kevis responded that the firearm is taken away for as long as a person is involuntary committed. If the person wants to become voluntarily committed, they may take the firearm back. Secretary Landgraf added that nothing is mandatory, but for some it may be a part of their commitment plan. Ms. Kevis added that police don't have any way to keep that firearm from a person threatening but cannot in good faith return the firearm.

Bryan Horsey agreed with Ms. Kevis' point, citing personal experiences with a family member who committed suicide by firearm. He recalled that no one had recommended taking the firearm away.

Rep. Trey Paradee focused on the idea of a "narrow window of opportunity", referencing that Caucasian males usually quickly and impulsive commit suicide by handgun. He felt that many people notice a potentially suicidal family member, but may be reluctant to give their guns to the government. He presented the idea of allowing gun shop owners to temporarily and discretely hold onto guns if asked by a customer struggling with suicidal thoughts.

Sen. Henry asked to hear from any gun shop owners present. Scott Bell stressed that liability would be a huge issue since gun shop owners would be reluctant to judge the mental health of a customer asking to retrieve their guns. He conceded that from a business perspective, this policy could be a potential source of income for dealers due to storage and transfer fees.

Dr. Harvey Doppelt pointed out that a large number of people do not continue their recommended treatment and follow their safety plan. Chair Goodman asked who writes up the safety plan and he responded that the therapist completes it. He also pointed out that a high percentage of people attempting suicide do so within ninety days of seeing their primary care doctor, stressing screenings at the primary care level.

Bryan Horsey cited his personal experiences in relation to his family member in relation to Dr. Doppelt's comments. Chair Goodman noted that a commonality among families is that they look back and recognize certain times when action could have happened. Hopefully the task force can identify these points and identify potential action at these times.

Pete Rudoff felt that the task force could help most with police training. He applauded the recommendation that police take firearms away from those struggling with suicide if there is immediate danger.

Mr. Rudoff and Mr. Bell also touched on the issue of the ATF form 4473, which has to be completed and sent to National Instant Criminal Background Check System (NICS) in order to purchase a firearm. Ms. Kevis clarified that safekeeping is not reported to NICS and informed the task force that the only thing sent to NICS is if a person changes their status to a voluntary commitment. She added that the only real factor in involuntary commitment which truly is not an adequate measure for suicide.

Secretary Landgraf emphasized that encouraging individuals to voluntary commit themselves is seen as a meaningful step towards optimizing their health and wellbeing. Mr. Rudoff talked about his experiences with taking guns away from potentially suicidal friends, but he was limited to holding onto these firearms for about two weeks. Mr. Bell noted that this may be where the Federal Firearms License could come in.

Cyndi McLaughlin was hesitant to approve of police instructing gun safety as a viable policy for helping families going through a crisis situation. Vice-Chair Longhurst clarified that she was simply trying to think of a way to provide resources to the families. Major Bond responded that

NCCPD has a victim services unit that speaks with families and provides resources. They primarily deal with domestic violence cases.

Chair Goodman asked if the victim services unit could be expanded to include families dealing with suicide attempts. Major Bond responded that they could potentially get involved with an unsuccessful threat of suicide.

Sen. Lopez was interested in hearing from DHSS to understand the clinical side of this issue. He felt that there was too large of focus on taking guns away and wanted to concentrate on helping individuals in crisis that had little access to the programs. Chair Goodman responded that there was a focus on firearm safety because the highest percentage of suicide is by firearm.

William Farley felt that the materials distributed at the beginning of the meeting affirmed his experiences dealing with suicides of veterans, in that there is always regret on someone's part if they did not know how to deal with a suicidal spouse. He felt that spouses needed to know if they had the right to take the guns out of the house, and agreed that a program needed to be established to provide more resources to families and caregivers.

Vice-Chair Longhurst referenced her legislation passed in the 148th General Assembly, which required ninety minutes of suicide training in schools. She did agree that more needed to be done to help veterans suffering from PTSD and that education is essential.

Chair Goodman requested Secretary Landgraf present to the Task Force. Secretary Landgraf gave a brief overview of the Centers for Disease Control study of youth suicide clusters. She then stated that Delaware does well with crisis intervention, but noted that the State needs to improve in prevention for youth suicide. Secretary Landgraf also told the committee that integration between primary care and mental health would help, and informed them of a new scorecard developed by DHSS that payers have committed to for mental health screenings. She also suggested that the Task Force recommend continuation of training in trauma informed care and harm reduction strategies.

Chair Goodman asked if the scorecard would last through the next administration. Secretary Landgraf was confident, and said she would provide Lauren Vella with a brief write-up on integration, the scorecard, and trauma-informed approaches.

George Higgins gave a brief presentation on the realm of suicide intervention, looking at all factors leading to suicide, specifics on Delaware's suicide rate, and state policies across the country. He looked at recommendations such as:

- Requiring a permit to purchase a handgun.
- Limiting the purchase of handguns to one per month.
- Allowing temporary suspension of firearm access for those found by a judge to be a danger to themselves or others.
- Adopting a "death with dignity" policy
- Forming partnerships in Delaware's communities.

William Farley questioned the death with dignity component included in the presentation. Chair Goodman stated that death with dignity policies are outside the scope of the task force.

Vice- Chair Longhurst thanked everyone present for their work and comments. She emphasized that the Task Force needs to have a thorough discussion of all potential policies and that everyone needs to feel comfortable with offering ideas and having respectful conversations.

Chair Goodman felt that everyone present was there with goodwill to help tackle a particularly heavy, complicated, and multifaceted issue.

Rick Armitage and Vice-Chair Longhurst discussed that there needs to be more conversation in connection to the gun dealers and law enforcement. Chair Goodman inquired if there was another dealer organization other than the NRA. Scott Bell informed Chair Goodman that there were a couple associations and he would reach out to them about this Task Force.

Pete Rudoff commended Mr. Higgins on his presentation. He asked if the CDC study was scalable to an older population, which he perceived to be the older target group. Secretary Landgraf noted that predictability of a suicide is common among all ages and demographics.

William Farley commended Mr. Higgins on his presentation, saying it helped place focus on the mission of the group.

Vice-Chair Longhurst stated that Chair Goodman and herself will put together some ideas and then vet each idea.

Cyndi McLaughlin commended Mr. Higgins on the outstanding presentation and stated her hope that the task force can consider accessibility to firearms, not just specific demographics.

Jeff Hague felt that the key solution would be finding a workable policy that upholds the constitutional right to bear arms.

Chair Goodman reminded members present that the next meeting would take place on Friday, December 9th, at 10 a.m. The meeting was adjourned at 10:56 a.m.

Respectfully submitted by: Alexa Scoglietti

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Advanced Search (/resources#samhsa-services)

Make the Connection (/) | What Is MTC? (/what-is-mtc) | About Your Privacy (/about/privacy)

(http://www.va.gov)

VA Suicide Prevention Program
Facts about Veteran Suicide
July 2016

Overview

VA believes every Veteran suicide is a tragic outcome. Regardless of the numbers or rates, one Veteran suicide is one too many. We continue to spread the word throughout VA that "Suicide Prevention is Everyone's responsibility." These new data about Veteran suicide will inform our Suicide Prevention programs and policies, especially for groups at elevated risk for suicide, including older and female Veterans. VA continues to address Veterans' needs through strategic partnerships with community and federal partners and seeks to enhance these partnerships. Meanwhile, we continue to serve as a leader in evidence-based care for suicide prevention.

VA relies on multiple sources of information to identify deaths that are likely due to suicide and has undertaken the most comprehensive analyses of Veteran suicide rates in the U.S. We have examined over 50 million Veteran records from 1979 to 2014 from every state in the nation. This effort extends VA's knowledge from the previous report issued in 2010, when over 3 million Veteran records from 20 states were available.

Veteran Suicide Statistics, 2014

- In 2014, an average of 20 Veterans died from suicide each day. 6 of the 20 were users of VA services.
- In 2014, Veterans accounted for 18% of all deaths from suicide among U.S. adults, while Veterans constituted 8.5% of the US population. In 2010, Veterans accounted for 22% of all deaths from suicide and 9.7% of the population.
- Approximately 66% of all Veteran deaths from suicide were the result of firearm injuries.
- There is continued evidence of high burden of suicide among middle-aged and older adult Veterans. In 2014, approximately 65% of all Veterans who died from suicide were aged 50 years or older.
- After adjusting for differences in age and gender, risk for suicide was 21% higher among Veterans when compared to U.S. civilian adults. (2014)
- After adjusting for differences in age, risk for suicide was 18% higher among male Veterans when compared to U.S. civilian adult males. (2014)
- After adjusting for differences in age, risk for suicide was 2.4 times higher among female Veterans when compared to U.S. civilian adult females. (2014)

Overview of data for the years between 2001-2014

- In 2014, there were 41,425 suicides among U.S. adults. Among all U.S. adult deaths from suicide, 18% (7,403) were identified as Veterans of U.S. military service.
- In 2014, the rate of suicide among U.S. civilian adults was 15.2 per 100,000.
    - Since 2001, the age-adjusted rate of suicide among U.S. civilian adults

has increased by 23.0%.

- In 2014, the rate of suicide among all Veterans was 35.3 per 100,000.
  - Since 2001, the age-adjusted rate of suicide among U.S. Veterans has increased by 32.2%.
- In 2014, the rate of suicide among U.S. civilian adult males was 26.2 per 100,000.
  - Since 2001, the age-adjusted rate of suicide among U.S. civilian adult males has increased by 0.3%.
- In 2014, the rate of suicide among U.S. Veteran males was 37.0 per 100,000.
  - Since 2001, the age-adjusted rate of suicide among U.S. Veteran males has increased by 30.5%.
- In 2014, the rate of suicide among U.S. civilian adult females was 7.2 per 100,000.
  - Since 2001, the age-adjusted rate of suicide among U.S. civilian adult females has increased by 39.7%.
- In 2014, the rate of suicide among U.S. Veteran females was 18.9 per 100,000.
  - Since 2001, the age-adjusted rate of suicide among U.S. Veteran females has increased by 85.2%.

VA Aggressively Undertaking New Measures to Prevent Suicide

Veterans Crisis Line Expansion

- The 24/7 Veterans Crisis Line (VCL) provides immediate access to mental health crisis intervention and support. Veterans call the national suicide prevention hotline number, 1-800-273-TALK (8255) and then "Press 1" to reach highly skilled responders trained in suicide prevention and crisis intervention. VCL also includes a chat service and texting option. We are continuing to modify phone systems to allow for direct connection to the VCL by dialing "7" when calling the VA medical center.
  - We are hiring over 60 new suicide intervention responders/counselors for the VCL
  - Each responder receives intensive training on a wide variety of topics in crisis intervention, substance use disorders, screening, brief intervention, and referral to treatment.
- Since the establishment of the VCL through May 2016 the VCL:
  - Has answered over 2.3 million calls, made over 289,000 chat connections, and over 55,000 texts;
  - Has initiated the dispatch of emergency services to callers in imminent suicidal crisis over 61,000 times;
  - Has provided over 376,000 referrals to a VA Suicide Prevention Coordinator (SPC) thus ensuring Veterans are connected to local care;

Using Predictive Analytics to identify those at risk and intervene early

- Screening and assessment processes have been set up throughout the system to assist in the identification of patients at risk for suicide.
- The VA will use predictive modeling to determine which Veterans may be at

highest risk of suicide, so providers can intervene early.

- Veterans in the top 0.1% of risk (who have a 43-fold increased risk of death from suicide within a month) are identified before clinical signs of suicide are evident in order to save lives before a crisis occurs.
- Patients who have been identified as being at high risk receive an enhanced level of care, including missed appointment follow-ups, safety planning, follow-up visits and individualized care plans that directly address their suicidality.

Bolstering Mental Health Services for Women

Since 2005, VA has seen a 154 percent increase in the number of women Veterans accessing VHA mental health services. In FY 2015, 182,107 women Veterans received VA mental health care.

- VA has enhanced provision of care to women Veterans by focusing on training and hiring Designated Women's Health Providers (DWHP) at every site where women access VA, with 100% of VA Medical Centers and 90% of Community-Based Outpatient Clinics having Designated Women's Health Providers.
- VA has trained nearly 2,500 providers in women's health and continues to train additional providers to ensure that every woman Veteran has the opportunity to receive her primary care from a DWHP.
- VA now operates a Women Veterans Call Center (WVCC), created to contact women Veterans to inform them about eligible services. As of February 2016, the WVCC received 30,399 incoming calls and made about 522,038 outbound calls, successfully reaching 278,238 women Veterans.

Expanding TeleMental Health Services

- VA is leveraging telemental health care by establishing four regional telemental health hubs across the VA healthcare system.
- In FY 2015, 12% of all Veterans enrolled for VA care received telehealth-based care, totaling more than 2 million telehealth visits that touched 677,000 Veterans, including 380,000 telemental health encounters.
- Since FY 2003, VHA has provided more than 2 million telemental health encounters, expanding its role as a world leader in telehealth and telemental health services, including services provided directly into the Veteran's home.

Free Mobile Apps to Help Veterans and their Families

VA has deployed a suite of 13 award-winning mobile apps to support Veterans and their families with tools to help them manage emotional and behavioral concerns. These include:

- PTSD Coach (released 2011; 233,000 downloads in 95 countries) is a VA and DoD joint project and is widely acclaimed, winning numerous awards. It is a tool for self-management of PTSD, and includes: a self-assessment tool; educational materials about PTSD symptoms, treatment, related conditions, and forms of treatment; relaxation and focusing exercises designed to address symptoms; and

immediate access to crisis resources, personal support contacts, or professional mental healthcare.

- CBT-i Coach for insomnia (released 2013; 86,000 downloads in 87 countries) was a collaborative effort between the Department of Veterans Affairs' National Center for PTSD (NCPTSD), Stanford University Medical Center, and the Department of Defense's National Center for Telehealth and Technology (T2). CBT-i Coach is a mobile phone app designed for use by people who are having difficulty sleeping and are participating in Cognitive Behavioral Therapy for Insomnia guided by a healthcare professional.
- ACT Coach for depression (released 2014; 23,000 downloads in 93 countries) supports people currently participating in Acceptance and Commitment Therapy (ACT) who want to use an app in conjunction with their therapist to bring ACT practice into daily life.
- Mindfulness Coach, (released 2014; 39,000 downloads in 95 countries) provides tools to assist users in practicing mindfulness meditation.
- Moving Forward (released 2014; 5,400 downloads in 54 countries) teaches problem solving skills and can be used in a stand-alone fashion or while participating in Problem Solving training.

Leveraging VA Vet Centers and Readjustment Counselors

Vet Centers are community-based counseling centers that provide a wide range of social and psychological services including professional readjustment counseling to Veterans and active duty Service members, including members of the National Guard and Reserve components who served on active military duty in any combat theater or area of hostility.

- There are 300 community-based Vet Centers, and 80 mobile Vet Centers located across the 50 states, the District of Columbia, American Samoa, Guam, Puerto Rico, and the US Virgin Islands (www.vetcenter.va.gov).
- In FY 2015, the Vet Centers Vet Centers provided over 228,000 Veterans, Service members and families with over 1,664,000 visits.
- To use Vet Center services, Veterans or Service members:
    - Do not need to be enrolled with VA Medical Centers;
    - Do not need a disability rating or service connection for injuries from either the VA or the DOD, and;
    - Can access Vet Center services regardless of discharge character.

- The Vet Center Combat Call Center is an around-the-clock confidential call center where combat Veterans and their families can talk with staff comprised of fellow combat Veterans from several eras. In FY 2015, the Vet Center Combat Call Center took over 113,000 calls from Veterans, Service members, their families, and concerned citizens.

Telephone Coaching for Families of Veterans

Coaching Into Care (www.va.gov/coachingintocare) assists family members and friends in helping a Veteran seek care. *Coaching Into Care* provides a motivational "coaching" service for family and friends of Veterans who see that a Veteran in their life needs help.

Coaching involves helping the caller figure out how to motivate the Veteran to seek services. The service is free and provided by licensed clinical social workers and psychologists. Since the inception of the service in January 2010 through November 2014, *Coaching Into Care* has logged 18,088 total initial and follow-up calls.

Innovative Public-Private Partnerships to Reach Veterans

VA is working with public and private partners across the country with the goal of ensuring that wherever a Veteran lives, he/she can access quality, timely mental health care.

VA is working with universities, colleges and health professional training institutions across the country to expand their curricula to address the new science related to meeting the mental and behavioral health needs of our Nation's Veterans, servicemembers, and their families.

- VA has recently partnered with the University of Michigan Health System and its Military Support Programs and Networks (M-Span) to support student Veterans as they transition from military to student life. Their Peer Advisors for Veteran Education (PAVE) program which is expanding to 42 campuses across the country and VA's Veterans Integration to Academic Leadership (VITAL) and VA's Peer Support Program will coordinate referrals, share resources and collaboratively help student Veterans successfully navigate college life and provide support.

VA is also supporting community provider organizations through innovative partnerships:

- VA recently partnered with the Bristol Myers Squibb Foundation (BMS-F) to share subject matter expertise across a range of topics relevant to Veterans and their families including: Student Veteran Programs, Caregiver Training Programs, Faith/Chaplain/Spirituality-based mental health Programs and other mental health and well-being programs.
- VA has also recently partnered with Give an Hour (GAH) to share training resources on various mental health topics to be disseminated to GAH's provider network, so more Veterans have access to evidence-based mental health care and are competent in military culture. In addition, VA's Make the Connection Veteran focused outreach campaign is collaborating with GAH's Change Direction Campaign to reduce negative perceptions associated with seeking mental health care and promote mental health literacy among Veterans and the general public.
- VA has also partnered with Psych Armor Institute (PAI) to share subject matter expertise on a range of mental health and caregiving topics to help civilians better serve Veterans through training that PAI is delivering free of charge to the public and VA.
- VA Campus Toolkit *(www.mentalhealth.va.gov/studentveteran)* is a resource for faculty, staff, and administrators to find resources to support student Veterans and learn about their strengths, skills, and needs.

- VA is hosting annual Community Mental Health Summits at each VAMC. Each facility will focus on building new partnerships and strengthening existing partners to meet the needs of Veterans and Veteran families residing in their catchment area.
- Each VAMC has appointed a Community Mental Health Point of Contact to provide ready access to information about VA eligibility and available clinical services, ensure warm handoffs at critical points of transition between systems of care, and provide ongoing liaison between VA and Community Partners.

Maintaining the High Quality of VA Mental Health Care

The Altarum/RAND report, Veterans Health Administration Mental Health Program Evaluation (2011) concluded that, "Timeliness for mental/behavioral healthcare in VHA is as good as or better than in commercial and public plans."

A recent publication comparing VA mental health care to private sector care examined medication treatment for mental disorders, finding:

- Across 7 performance indicators, VA "performance was superior to that of the private sector by more than 30%."
- The authors conclude that: "Findings demonstrate the significant advantages that accrue from an organized, nationwide system of care. The much higher performance of the VA has important clinical and policy implications." http://ps.psychiatryonline.org/doi/10.1176/appi.ps.201400537

Proactive Outreach to Reach Veterans Needing Care

- VA works proactively to connect Veterans and their families with the resources they need. In addition to VA's *Make the Connection* outreach campaign and extensive suicide prevention outreach, many specific mental health programs and services have outreach as part of their efforts. Suicide Prevention Coordinators are required to conduct at least five outreach activities per month in all of their local communities and are able to provide a Community version of Operation S.A.V.E. to Veterans and others.
- Partnering with community organizations has broadened VA's outreach efforts and promotes more positive outcomes from community providers.
- *Make the Connection* is VA's award-winning mental health public awareness campaign. Its primary objectives are to highlight Veterans' true and inspiring stories of mental health recovery, reduce negative perceptions about mental health and seeking mental health care and to connect Veterans and their family members with local, mental health resources.
- Over the past four years, *Make the Connection* has seen tremendous engagement with Veterans, Veteran family members, and supporters. Via MakeTheConnection.net, the campaign's outreach efforts, and social media properties including Facebook and YouTube pages, the following has been achieved (through May 2016):
    - 10.5 million website visits;
    - 333,000 resource locator uses (local VA and other community sources of support);
    - 14.4 million video views;

- 19,700 YouTube subscribers;
- 3.4 million likes on the MTC Facebook page, making it one of the largest government Facebook communities in the country;
- 39.8 million engagement actions on Facebook (likes, comments and/or shares);
- More than 2 billion impressions of the campaign's Public Service Announcements, earning more than $27M in free, donated airplay;
- Outreach has resulted in over 190 organizations broadcasting campaign messaging through their communication platforms and
- More than 730,000 pieces of material distributed nationwide

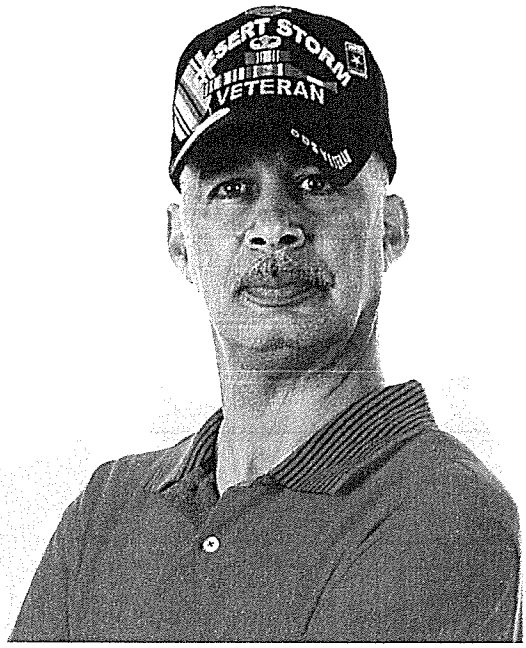
For more information, Veterans currently enrolled in VA health care can speak with their VA mental health or health care provider. Other Veterans and interested parties can find a complete list of VA health care facilities, Vet Centers, their local Suicide Prevention Coordinators, and other resources under the resource section of www.veteranscrisisline.net or at www.va.gov.

For more information about this Fact Sheet, contact Dr. Caitlin Thompson, National Mental Health Director for Suicide Prevention and Community Engagement at 202-461-4173.

MAKE THE CONNECTION (/)

Use the site filter to discover information and Veterans' stories of recovery tailored to you.

I served in Select your Service



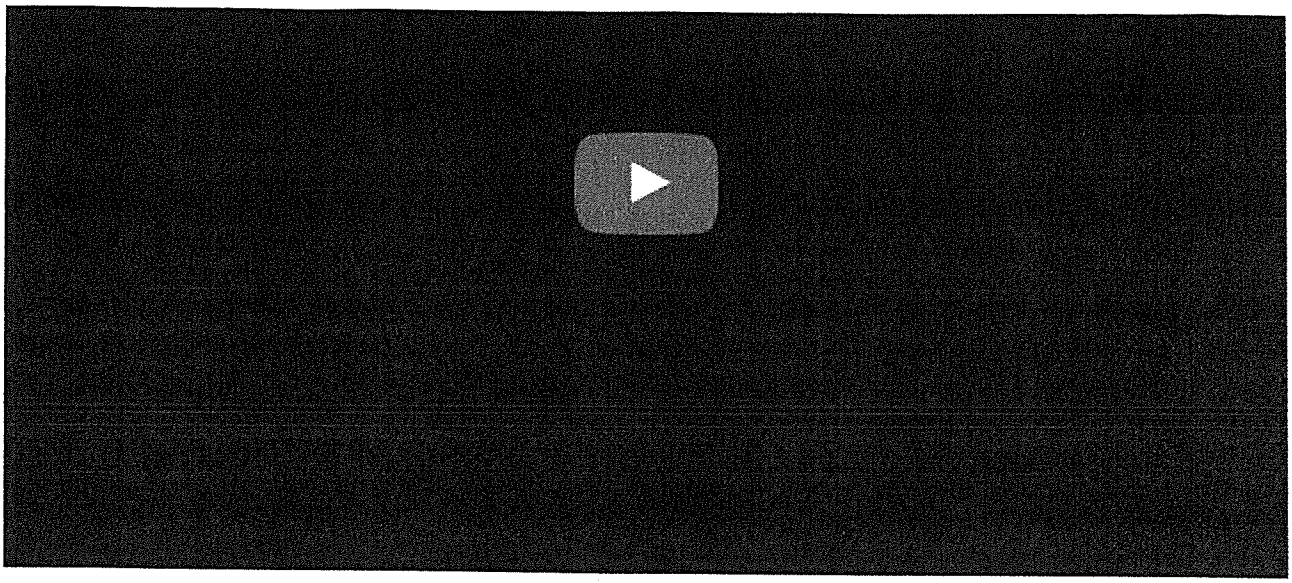
View Ben's story

(/stories/266)

Life Events & Experiences

Signs & Symptoms

Conditions



Veterans on taking steps to improve relationships

See Related Videos (/stories-of-connection?symptoms=8,14,21)

Family and Relationships (/events/family-relationships)

The experiences of military life can affect Veterans in ways that may impact their relationships. In this video, Veterans talk about working through problems with their friends and loved ones and finding solutions that benefit everyone.

Other life events and experiences

Transitioning from Service (/events/transitioning-from-service)

Jobs and Employment (/events/jobs-employment)

Death of Family or Friends (/events/death-family-friends)

Retirement and Aging (/events/retirement-aging)

U.S. Department of Justice
Bureau of Alcohol, Tobacco, Firearms and Explosives

OMB No. 1140-0020

Firearms Transaction Record Part I - Over-the-Counter

WARNING: You may not receive a firearm if prohibited by Federal or State law. The information you provide will be used to determine whether you are prohibited under law from receiving a firearm. Certain violations of the Gun Control Act, 18 U.S.C. §§ 921 *et. seq.*, are punishable by up to 10 years imprisonment and/or up to a $250,000 fine.

Prepare in original only. All entries must be handwritten in ink. Read the Notices, Instructions, and Definitions on this form. "PLEASE PRINT."

Transferor's Transaction Serial Number *(If any)*

Section A - Must Be Completed Personally By Transferee (Buyer)

1. Transferee's Full Name
Last Name | First Name | Middle Name *(If no middle name, state "NMN")*

2. Current Residence Address **(U.S. Postal abbreviations are acceptable. Cannot be a post office box.)**
Number and Street Address | City | County | State | ZIP Code

3. Place of Birth
U.S. City and State **-OR-** Foreign Country

4. Height
Ft. _____
In. _____

5. Weight *(Lbs.)*

6. Gender
☐ Male
☐ Female

7. Birth Date
Month | Day | Year

8. Social Security Number ***(Optional**, but will help prevent misidentification)*

9. Unique Personal Identification Number *(UPIN)* if applicable *(See Instructions for Question 9.)*

10.a. Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino

10.b. Race *(Check one or more boxes.)*
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

11. Answer questions 11.a. *(see exceptions)* through 11.l. and 12 *(if applicable)* by checking or marking ***"yes" or "no"*** in the boxes to the right of the questions.

a. Are you the actual transferee/buyer of the firearm(s) listed on this form? **Warning: You are not the actual buyer if you are acquiring the firearm(s) on behalf of another person. If you are not the actual buyer, the dealer cannot transfer the firearm(s) to you.** *(See Instructions for Question 11.a.) Exception: **If you are picking up a repaired firearm(s)** for another person, you are **not** required to answer 11.a. and may proceed to question 11.b.*	☐ Yes	☐ No
b. Are you under indictment or information in any court for a **felony**, or any other crime, for which the judge could imprison you for more than one year? *(See Instructions for Question 11.b.)*	☐ Yes	☐ No
c. Have you ever been convicted in any court of a **felony**, or any other crime, for which the judge could have imprisoned you for more than one year, even if you received a shorter sentence including probation? *(See Instructions for Question 11.c.)*	☐ Yes	☐ No
d. Are you a fugitive from justice?	☐ Yes	☐ No
e. Are you an unlawful user of, or addicted to, marijuana or any depressant, stimulant, narcotic drug, or any other controlled substance?	☐ Yes	☐ No
f. Have you ever been adjudicated mentally defective *(which includes a determination by a court, board, commission, or other lawful authority that you are a danger to yourself or to others or are incompetent to manage your own affairs)* **OR** have you ever been committed to a mental institution? *(See Instructions for Question 11.f.)*	☐ Yes	☐ No
g. Have you been discharged from the Armed Forces under **dishonorable** conditions?	☐ Yes	☐ No
h. Are you subject to a court order restraining you from harassing, stalking, or threatening your child or an intimate partner or child of such partner? *(See Instructions for Question 11.h.)*	☐ Yes	☐ No
i. Have you ever been convicted in any court of a misdemeanor crime of domestic violence? *(See Instructions for Question 11.i.)*	☐ Yes	☐ No
j. Have you ever renounced your United States citizenship?	☐ Yes	☐ No
k. Are you an alien **illegally** in the United States?	☐ Yes	☐ No
l. Are you an alien admitted to the United States under a nonimmigrant visa? *(See Instructions for Question 11.l.) If you answered "no" to this question, do **NOT** respond to question 12 and proceed to question 13.*	☐ Yes	☐ No
12. If you are an alien admitted to the United States under a nonimmigrant visa, do you fall within any of the exceptions set forth in the instructions? **(If "yes," the licensee must complete question 20c.)** *(See Instructions for Question 12.) If question 11.l. is answered with a "no" response, **then do NOT respond** to question 12 and proceed to question 13.*	☐ Yes	☐ No

13. What is your State of residence *(if any)*? *(See Instructions for Question 13.)*

14. What is your country of citizenship? *(List/check more than one, if applicable. If you are a citizen of the United States, proceed to question 16.)*
☐ United States of America
☐ Other *(Specify)* _____

15. If you are not a citizen of the United States, what is your U.S.-issued alien number or admission number?

Transferee (Buyer) Continue to Next Page
STAPLE IF PAGES BECOME SEPARATED

I certify that my answers to Section A are true, correct, and complete. I have read and understand the Notices, Instructions, and Definitions on ATF Form 4473. I understand that answering "yes" to question 11.a. if I am not the actual buyer is a crime punishable as a felony under Federal law, and may also violate State and/or local law. I understand that a person who answers "yes" to any of the questions 11.b. through 11.k. is prohibited from purchasing or receiving a firearm. I understand that a person who answers "yes" to question 11.l. is prohibited from purchasing or receiving a firearm, unless the person also answers "Yes" to question 12. I also understand that making any false oral or written statement, or exhibiting any false or misrepresented identification with respect to this transaction, is a crime punishable as a felony under Federal law, and may also violate State and/or local law. I further understand that the repetitive purchase of firearms for the purpose of resale for livelihood and profit without a Federal firearms license is a violation of law ***(See Instructions for Question 16).***

16. Transferee's/Buyer's Signature	17. Certification Date

Section B - Must Be Completed By Transferor (Seller)

18. Type of firearm(s) to be transferred *(check or mark all that apply)*:

☐ Handgun ☐ Long Gun *(rifles or shotguns)* ☐ Other Firearm *(Frame, Receiver, etc. See Instructions for Question 18.)*

19. If sale at a gun show or other qualifying event.

Name of Event _____

City, State _____

20a. Identification *(e.g., Virginia Driver's license (VA DL) or other valid government-issued photo identification.)* *(See Instructions for Question 20.a.)*

Issuing Authority and Type of Identification	Number on Identification	Expiration Date of Identification *(if any)* Month	Day	Year

20b. Alternate Documentation *(if driver's license or other identification document does not show current residence address)* *(See Instructions for Question 20.b.)*

20c. Aliens Admitted to the United States Under a Nonimmigrant Visa Must Provide: Type of documentation showing an exception to the nonimmigrant visa prohibition. *(See Instructions for Question 20.c.)*

Questions 21, 22, or 23 Must Be Completed Prior To The Transfer Of The Firearm(s) *(See Instructions for Questions 21, 22 and 23.)*

21a. Date the transferee's identifying information in Section A was transmitted to NICS or the appropriate State agency: *(Month/Day/Year)*

Month	Day	Year

21b. The NICS or State transaction number *(if provided)* was:

21c. The response initially provided by NICS or the appropriate State agency was:

☐ Proceed ☐ Delayed *[The firearm(s) may be transferred on _____ (Missing Disposition Information date provided by NICS) if State law permits (optional)]*
☐ Denied
☐ Cancelled

21d. If initial NICS or State response was *"Delayed,"* the following response was received from NICS or the appropriate State agency:

☐ Proceed _____ *(date)*
☐ Denied _____ *(date)*
☐ Cancelled _____ *(date)*
☐ No resolution was provided within 3 business days.

21e. *(Complete if applicable.)* After the firearm was transferred, the following response was received from NICS or the appropriate State agency on: _____ *(date).* ☐ Proceed ☐ Denied ☐ Cancelled

21f. The name and Brady identification number of the NICS examiner *(Optional)*

_____ *(name)* _____ *(number)*

22. ☐ No NICS check was required because the transfer involved only National Firearms Act firearm(s). *(See Instructions for Question 22.)*

23. ☐ No NICS check was required because the buyer has a valid permit from the State where the transfer is to take place, which qualifies as an exemption to NICS *(See Instructions for Question 23.)*

Issuing State and Permit Type	Date of Issuance *(if any)*	Expiration Date *(if any)*	Permit Number *(if any)*

Section C - Must Be Completed Personally By Transferee (Buyer)

If the transfer of the firearm(s) takes place on a different day from the date that the transferee *(buyer)* signed Section A, the transferee must complete Section C immediately prior to the transfer of the firearm(s). *(See Instructions for Question 24 and 25.)*

I certify that my answers to the questions in Section A of this form are still true, correct and complete.

24. Transferee's/Buyer's Signature	**25. Recertification Date**

Transferor (Seller) Continue to Next Page

STAPLE IF PAGES BECOME SEPARATED

Section D - Must Be Completed By Transferor (Seller)

26. Manufacturer and/or Importer *(If the manufacturer and importer are different, the FFL should include both.)*	27. Model	28. Serial Number	29. Type *(pistol, revolver, rifle, shotgun, receiver, frame, etc.) (See instructions for question 29)*	30. Caliber or Gauge

30a. Total Number of Firearms *(Please handwrite by printing e.g., one, two, three, etc.* ***Do not use numerals.)***

30b. Is any part of this transaction a Pawn Redemption? ☐ Yes ☐ No

30c. For Use by FFL *(See Instructions for Question 30c.)*

Complete ATF Form 3310.4 For Multiple Purchases of Handguns Within 5 Consecutive Business Days

31. Trade/corporate name and address of transferor *(seller) (Hand stamp may be used.)*	32. Federal Firearms License Number *(Must contain at least first three and last five digits of FFL Number X-XX-XXXXX.) (Hand stamp may be used.)*

The Person Transferring The Firearm(s) Must Complete Questions 33-36. For Denied/Cancelled Transactions, The Person Who Completed Section B Must Complete Questions 33-35.

I certify that my answers in Sections B and D are true, correct, and complete. I have read and understand the Notices, Instructions, and Definitions on ATF Form 4473. On the basis of: (1) the statements in Section A (and Section C if the transfer does not occur on the day Section A was completed); (2) my verification of the identification noted in question 20a (and my reverification at the time of transfer *if the transfer does not occur on the day Section A was completed)*; and (3) the information in the current State Laws and Published Ordinances, it is my belief that it is not unlawful for me to sell, deliver, transport, or otherwise dispose of the firearm(s) listed on this form to the person identified in Section A.

33. Transferor's/Seller's Name ***(Please print)***	34. Transferor's/Seller's Signature	35. Transferor's/Seller's Title	36. Date Transferred

NOTICES, INSTRUCTIONS AND DEFINITIONS

Purpose of the Form: The information and certification on this form are designed so that a person licensed under 18 U.S.C. § 923 may determine if he or she may lawfully sell or deliver a firearm to the person identified in Section A, and to alert the buyer of certain restrictions on the receipt and possession of firearms. This form should only be used for sales or transfers where the seller is licensed under 18 U.S.C. § 923. The seller of a firearm must determine the lawfulness of the transaction and maintain proper records of the transaction. Consequently, the seller must be familiar with the provisions of 18 U.S.C. §§ 921-931 and the regulations in 27 CFR Part 478. In determining the lawfulness of the sale or delivery of a long gun *(rifle or shotgun)* to a resident of another State, the seller is presumed to know the applicable State laws and published ordinances in both the seller's State and the buyer's State.

After the seller has completed the firearms transaction, he or she must make the completed, original ATF Form 4473 *(which includes the Notices, General Instructions, and Definitions)*, and any supporting documents, part of his or her permanent records. Such Forms 4473 must be retained for at least 20 years. Filing may be chronological *(by date)*, alphabetical *(by name)*, or numerical *(by transaction serial number)*, as long as all of the seller's completed Forms 4473 are filed in the same manner. FORMS 4473 FOR DENIED/CANCELLED TRANSFERS MUST BE RETAINED: If the transfer of a firearm is denied/cancelled by NICS, or if for any other reason the transfer is not complete after a NICS check is initiated, the licensee must retain the ATF Form 4473 in his or her records for at least 5 years. Forms 4473 with respect to which a sale, delivery, or transfer did not take place shall be separately retained in alphabetical *(by name)* or chronological *(by date of transferee's certification)* order.

If you or the buyer discover that an ATF Form 4473 is incomplete or improperly completed after the firearm has been transferred, and you or the buyer wish to make a record of your discovery, then photocopy the inaccurate form and make any necessary additions or revisions to the photocopy. You only should make changes to Sections B and D. The buyer should only make changes to Sections A and C. Whoever made the changes should initial and date the changes. The corrected photocopy should be attached to the original Form 4473 and retained as part of your permanent records.

Over-the-Counter Transaction: The sale or other disposition of a firearm by a seller to a buyer, at the seller's licensed premises. This includes the sale or other disposition of a rifle or shotgun to a nonresident buyer on such premises.

State Laws and Published Ordinances: The publication (ATF P 5300.5) of State firearms laws and local ordinances ATF distributes to licensees.

Exportation of Firearms: The State or Commerce Departments may require you to obtain a license prior to export.

Section A

Question 1. Transferee's Full Name: The buyer must personally complete Section A of this form and certify *(sign)* that the answers are true, correct, and complete. However, if the buyer is unable to read and/or write, the answers *(other than the signature)* may be completed by another person, excluding the seller. Two persons *(other than the seller)* must then sign as witnesses to the buyer's answers and signature.

When the buyer of a firearm is a corporation, company, association, partnership, or other such business entity, an officer authorized to act on behalf of the

business must complete Section A of the form with his or her personal information, sign Section A, and attach a written statement, executed under penalties of perjury, stating: (A) the firearm is being acquired for the use of and will be the property of that business entity and (B) the name and address of that business entity. If the buyer's name in question 1. is illegible, the seller must print the buyer's name above the name written by the buyer.

Question 2. Current Residence Address: U.S. Postal abbreviations are acceptable. *(e.g., St., Rd., Dr., PA, NC, etc.)*. Address cannot be a post office box. County and Parish are one and the same.

If the buyer is a member of the Armed Forces on active duty acquiring a firearm in the State where his or her permanent duty station is located, but does not reside at his or her permanent duty station, the buyer must list both his or her permanent duty station address and his or her residence address in response to question 2. If you are a U.S. citizen with two States of residence, you should list your current residence address in response to question 2 *(e.g., if you are buying a firearm while staying at your weekend home in State X, you should list your address in State X in response to question 2)*.

Question 9. Unique Personal Identification Number (UPIN): For purchasers approved to have information maintained about them in the FBI NICS Voluntary Appeal File, NICS will provide them with a Unique Personal Identification Number, which the buyer should record in question 9. The licensee may be asked to provide the UPIN to NICS or the State.

Question 11.a. Actual Transferee/Buyer: For purposes of this form, you are the actual transferee/buyer if you are purchasing the firearm for yourself or otherwise acquiring the firearm for yourself *(e.g., redeeming the firearm from pawn/retrieving it from consignment, firearm raffle winner)*. You are also the actual transferee/buyer if you are legitimately purchasing the firearm as a gift for a third party. **ACTUAL TRANSFEREE/BUYER EXAMPLES:** Mr. Smith asks Mr. Jones to purchase a firearm for Mr. Smith. Mr. Smith gives Mr. Jones the money for the firearm. Mr. Jones is **NOT THE ACTUAL TRANSFEREE/BUYER** of the firearm and must answer **"NO"** to question 11.a. The licensee may not transfer the firearm to Mr. Jones. However, if Mr. Brown goes to buy a firearm with his own money to give to Mr. Black as a present, Mr. Brown is the actual transferee/buyer of the firearm and should answer **"YES"** to question 11.a. However, you may not transfer a firearm to any person you know or have reasonable cause to believe is prohibited under 18 U.S.C. § 922(g), (n), or (x). **Please note: EXCEPTION:** If you are picking up a repaired firearm(s) for another person, you are not required to answer 11.a. and may proceed to question 11.b.

Question 11.b. - 11.l. Definition of Prohibited Person: Generally, 18 U.S.C. § 922 prohibits the shipment, transportation, receipt, or possession in or affecting interstate commerce of a firearm by one who: has been convicted of a misdemeanor crime of domestic violence; has been convicted of a felony, or any other crime, punishable by imprisonment for a term exceeding one year ***(this does not include State misdemeanors punishable by imprisonment of two years or less)***; is a fugitive from justice; is an unlawful user of, or addicted to, marijuana or any depressant, stimulant, or narcotic drug, or any other controlled substance; has been adjudicated mentally defective or has been committed to a mental institution; has been discharged from the Armed Forces under dishonorable conditions; has renounced his or her U.S. citizenship; is an alien illegally in the United States or an alien admitted to the United States under a nonimmigrant visa; or is subject to certain restraining orders. Furthermore, section 922 prohibits the shipment, transportation, or receipt in or affecting interstate commerce of a firearm by one who is under indictment or information for a felony, or any other crime, punishable by imprisonment for a term exceeding one year.

Question 11.b. Under Indictment or Information or Convicted in any Court: An indictment, information, or conviction in any Federal, State, or local court. An information is a formal accusation of a crime verified by a prosecutor.

***EXCEPTION to 11.c. and 11.i.*:** A person who has been convicted of a felony, or any other crime, for which the judge could have imprisoned the person for more than one year, or who has been convicted of a misdemeanor crime of domestic violence, is not prohibited from purchasing, receiving, or possessing a firearm if: (1) under the law of the jurisdiction where the conviction occurred, the person has been pardoned, the conviction has been expunged or set aside, or the person has had their civil rights *(the right to vote, sit on a jury, and hold public office)* taken away and later restored AND (2) the person is not prohibited by the law of the jurisdiction where the conviction occurred from receiving or possessing firearms. Persons subject to this exception should answer **"no"** to 11.c. or 11.i., as applicable.

Question 11.f. Adjudicated Mentally Defective: A determination by a court, board, commission, or other lawful authority that a person, as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease: (1) is a danger to himself or to others; or (2) lacks the mental capacity to contract or manage his own affairs. This term shall include: (1) a finding of insanity by a court in a criminal case; and (2) Those persons found incompetent to stand trial or found not guilty by reason of lack of mental responsibility.

Committed to a Mental Institution: A formal commitment of a person to a mental institution by a court, board, commission, or other lawful authority. The term includes a commitment to a mental institution involuntarily. The term includes commitment for mental defectiveness or mental illness. It also includes commitments for other reasons, such as for drug use. The term does not include a person in a mental institution for observation or a voluntary admission to a mental institution. Please also refer to Question 11.c. for the definition of a prohibited person.

***EXCEPTION to 11. f. NICS Improvement Amendments Act of 2007*:** A person who has been adjudicated as a mental defective or committed to a mental institution is not prohibited if: (1) the person was adjudicated or committed **by a department or agency of the Federal Government**, such as the United States Department of Veteran's Affairs ("VA") (as opposed to a State court, State board, or other lawful State authority); and (2) either: (a) the person's adjudication or commitment for mental incompetency was set-aside or expunged by the adjudicating/committing agency; (b) the person has been fully released or discharged from all mandatory treatment, supervision, or monitoring by the agency; or (c) the person was found by the agency to no longer suffer from the mental health condition that served as the basis of the initial adjudication. **Persons who fit this exception should answer "no" to Item 11.f.** This exception does not apply to any person who was adjudicated to be not guilty by reason of insanity, or based on lack of mental responsibility, or found incompetent to stand trial, in any criminal case or under the Uniform Code of Military Justice.

Question 11.h. Definition of Restraining Order: Under 18 U.S.C. § 922, firearms may not be sold to or received by persons subject to a court order that: (A) was issued after a hearing which the person received actual notice of and had an opportunity to participate in; (B) restrains such person from harassing, stalking, or threatening an intimate partner or child of such intimate partner or person, or engaging in other conduct that would place an intimate partner in reasonable fear of bodily injury to the partner or child; and (C)(i) includes a finding that such person represents a credible threat to the physical safety of such intimate partner or child; or (ii) by its terms explicitly prohibits the use, attempted use, or threatened use of physical force against such intimate partner or child that would reasonably be expected to cause bodily injury. An "intimate partner" of a person is: the spouse or former spouse of the person, the parent of a child of the person, or an individual who cohabitates or cohabitating with the person.

Question 11.i. Definition of Misdemeanor Crime of Domestic Violence: A Federal, State, local, or tribal offense that is a misdemeanor under Federal, State, or tribal law and has, as an element, the use or attempted use of physical force, or the threatened use of a deadly weapon, committed by a current or former spouse, parent, or guardian of the victim, by a person with whom the victim shares a child in common, by a person who is cohabitating with, or has cohabited with the victim as a spouse, parent, or guardian, or by a person similarly situated to a spouse, parent, or guardian of the victim. The term includes all misdemeanors that have as an element the use or attempted use of physical force or the threatened use of a deadly weapon *(e.g., assault and battery)*, if the offense is committed by one of the defined parties. *(See Exception to 11.c. and 11.i.)* A person who has been convicted of a misdemeanor crime of domestic violence also is not prohibited unless: (1) the person was represented by a lawyer or gave up the right to a lawyer; or (2) if the person was entitled to a jury, was tried by a jury, or gave up the right to a jury trial. Persons subject to this exception should answer **"no"** to 11.i.

Question 11.l. An alien admitted to the United States under a nonimmigrant visa includes, among others, persons visiting the United States temporarily for business or pleasure, persons studying in the United States who maintain a residence abroad, and certain temporary foreign workers. The definition does **NOT** include permanent resident aliens nor does it apply to nonimmigrant aliens admitted to the United States pursuant to either the Visa Waiver Program or to regulations otherwise exempting them from visa requirements.

An alien admitted to the United States under a nonimmigrant visa who responds "yes" to question 11.l. must provide a response to question 12 indicating whether he/she qualifies under an exception.

Question 12. Exceptions to the Nonimmigrant Alien Response: An alien admitted to the United States under a nonimmigrant visa is not prohibited from purchasing, receiving, or possessing a firearm if the alien: (1) is in possession of a hunting license or permit lawfully issued by the Federal Government, a State, or local government, or an Indian tribe federally recognized by the Bureau of Indian Affairs, which is valid and unexpired; (2) was admitted to the United States for lawful hunting or sporting purposes; (3) has received a waiver from the prohibition from the Attorney General of the United States; (4) is an official representative of a foreign government who is accredited to the United States Government or the Government's mission to an international organization having its headquarters in the United States; (5) is en route to or from another country to which that alien is accredited; (6) is an official of a foreign government or a distinguished foreign visitor who has been so designated by the Department of State; or (7) is a foreign law enforcement officer of a friendly foreign government entering the United States on official law enforcement business.

Persons subject to one of these exceptions should answer "yes" to questions 11.l. and 12 and provide documentation such as a copy of the hunting license or letter granting the waiver, which must be recorded in 20.c. If the transferee *(buyer)* answered "yes" to this question, the licensee must complete 20.c.

The seller should verify supporting documentation provided by the purchaser and must attach a copy of the provided documentation to this ATF Form 4473, Firearms Transaction Record.

Question 13. State of Residence: The State in which an individual resides. An individual resides in a State if he or she is present in a State with the intention of making a home in that State. If an individual is a member of the Armed Forces on active duty, his or her State of residence also is the State in which his or her permanent duty station is located.

If you are a U.S. citizen with two States of residence, you should list your current residence address in response to question 2 *(e.g., if you are buying a firearm while staying at your weekend home in State X, you should list your address in State X in response to question 2.)*

Question 16. Certification Definition of Engaged in the Business: Under 18 U.S.C. § 922 (a)(1), it is unlawful for a person to engage in the business of dealing in firearms without a license. A person is engaged in the business of dealing in firearms if he or she devotes time, attention, and labor to dealing in firearms as a regular course of trade or business with the principal objective of livelihood and profit through the repetitive purchase and resale of firearms. A license is not required of a person who only makes occasional sales, exchanges, or purchases of firearms for the enhancement of a personal collection or for a hobby, or who sells all or part of his or her personal collection of firearms.

Section B

Question 18. Type of Firearm(s): Check all boxes that apply. "Other" refers to frames, receivers and other firearms that are not either handguns or long guns (rifles or shotguns), such as firearms having a pistol grip that expel a shotgun shell, or National Firearms Act (NFA) firearms.

If a frame or receiver can only be made into a long gun *(rifle or shotgun)*, it is still a frame or receiver not a handgun or long gun. However, they still are "firearms" by definition, and subject to the same GCA limitations as any other firearms. See Section 921(a)(3)(b). 18 U.S.C. Section 922(b)(1) makes it unlawful for a licensee to sell any firearm other than a shotgun or rifle to any person under the age of 21. Since a frame or receiver for a firearm, to include one that can only be made into a long gun, is a "firearm other than a shotgun or rifle," it cannot be transferred to anyone under the age of 21. Also, note that multiple sales forms are not required for frames or receivers of any firearms, or pistol grip shotguns, since they are not "pistols or revolvers" under Section 923(g)(3)(a).

Question 19. Gun Shows: If sale at gun show or other qualifying event sponsored by any national, State, or local organization, as authorized by 27 CFR § 478.100, the seller must record the name of event and the location *(city and State)* of the sale in question 19.

Question 20a. Identification: List issuing authority *(e.g., State, County or Municipality)* and type of identification presented *(e.g., Virginia driver's license (VA DL), or other valid government-issued identification)*.

Know Your Customer: Before a licensee may sell or deliver a firearm to a nonlicensee, the licensee must establish the identity, place of residence, and age of the buyer. The buyer **must** provide a valid government-issued photo identification to the seller that contains the buyer's name, residence address, and date of birth. The licensee must record the type, identification number, and expiration date *(if any)* of the identification in question 20.a. A driver's license or an identification card issued by a State in place of a license is acceptable. Social Security cards are not acceptable because no address, date of birth, or photograph is shown on the cards. A combination of government-issued documents may be provided. For example, if a U.S. citizen has two States of residence and is trying to buy a handgun in State X, he may provide a driver's license *(showing his name, date of birth, and photograph)* issued by State Y and another government-issued document *(such as a tax document)* from State X showing his residence address. If the buyer is a member of the Armed Forces on active duty acquiring a firearm in the State where his or her permanent duty station is located, but he or she has a driver's license from another State, you should list the buyer's military identification card and official orders showing where his or her permanent duty station is located in response to question 20.a.

Question 20.b. Alternate Documentation: Licensees may accept a combination of valid government-issued documents to satisfy the identification document requirements of the law. The required valid government-issued photo identification document bearing the name, photograph, and date of birth of transferee may be supplemented by another valid, government-issued document showing the transferee's residence address. This alternate documentation should be recorded in question 20.b., with issuing authority and type of identification presented. A combination of government-issued documents may be provided. For example, if a U.S. citizen has two States of residence and is trying to buy a handgun in State X, he may provide a driver's license *(showing his name, date of birth, and photograph)* issued by State Y and another government-issued document *(such as a tax document)* from State X showing his residence address.

Question 20c. Documentation for Aliens Admitted to the United States Under a Nonimmigrant Visa: See instructions for Question 11.l. Types of acceptable documents would include a valid hunting license lawfully issued in the United States or a letter from the U.S. Attorney General granting a waiver.

Question(s) 21, 22, 23, NICS BACKGROUND CHECKS: 18 U.S.C. § 922(t) requires that prior to transferring any firearm to an unlicensed person, a licensed importer, manufacturer, or dealer must first contact the National Instant Criminal Background Check System (NICS). NICS will advise the licensee whether the system finds any information that the purchaser is prohibited by law from possessing or receiving a firearm. For purposes of this form, contacts to NICS include contacts to State agencies designated to conduct NICS checks for the Federal Government. **WARNING:** Any seller who transfers a firearm to any person they know or have reasonable cause to believe is prohibited from receiving or possessing a firearm violates the law, even if the seller has complied with the background check requirements of the Brady law.

After the buyer has completed Section A of the form and the licensee has completed questions 18-20, and before transferring the firearm, the licensee must contact NICS *(read below for NICS check exceptions.)* However, the licensee should NOT contact NICS and should stop the transaction if: the

buyer answers "no" to question 11.a.; the buyer answers "yes" to any question in 11.b.-11.l., unless the buyer only has answered "yes" to question 11.l. and also answers "yes" to question 12; or the buyer is unable to provide the documentation required by question 20.a, b, or c.

At the time that NICS is contacted, the licensee must record in question 21.a-c: the date of contact, the NICS *(or State)* transaction number, and the initial response provided by NICS or the State. The licensee may record the Missing Disposition Information (MDI) date in 21.c. that NICS provides for delayed transactions *(States do not provide this number)*. If the licensee receives a *"delayed"* response, before transferring the firearm, the licensee must record in question 21.d. any response later provided by NICS or the State or that no resolution was provided within 3 business days. If the licensee receives a response from NICS or the State after the firearm has been transferred, he or she must record this information in question 21.e. **Note:** States acting as points of contact for NICS checks may use terms other than *"proceed," "delayed," "cancelled,"* or *"denied."* In such cases, the licensee should check the box that corresponds to the State's response. Some States may not provide a transaction number for denials. However, if a firearm is transferred within the three business day period, a transaction number is required.

NICS Responses: If NICS provides a *"proceed"* response, the transaction may proceed. If NICS provides a *"cancelled"* response, the seller is prohibited from transferring the firearm to the buyer. If NICS provides a *"denied"* response, the seller is prohibited from transferring the firearm to the buyer. If NICS provides a *"delayed"* response, the seller is prohibited from transferring the firearm unless 3 business days have elapsed and, before the transfer, NICS or the State has not advised the seller that the buyer's receipt or possession of the firearm would be in violation of law. (See 27 CFR § 478.102(a) for an example of how to calculate 3 business days.) If NICS provides a *"delayed"* response, NICS also will provide a Missing Disposition Information (MDI) date that calculates the 3 business days and reflects when the firearm(s) can be transferred under Federal law. States may not provide an MDI date. *Please note State law may impose a waiting period on transferring firearms.*

EXCEPTIONS TO NICS CHECK: A NICS check is not required if the transfer qualifies for any of the exceptions in 27 CFR § 478.102(d). Generally these include: (a) transfers where the buyer has presented the licensee with a permit or license that allows the buyer to possess, acquire, or carry a firearm, and the permit has been recognized by ATF as a valid alternative to the NICS check requirement; (b) transfers of National Firearms Act weapons approved by ATF; or (c) transfers certified by ATF as exempt because compliance with the NICS check requirements is impracticable. See 27 CFR § 478.102(d) for a detailed explanation. If the transfer qualifies for one of these exceptions, the licensee must obtain the documentation required by 27 CFR § 478.131. A firearm must **not** be transferred to any buyer who fails to provide such documentation.

Section C

Question 24 and 25. Transfer on a Different Day and Recertification: If the transfer takes place on a different day from the date that the buyer signed Section A, the licensee must again check the photo identification of the buyer at the time of transfer, and the buyer must complete the recertification in Section C at the time of transfer.

Section D

Immediately prior to transferring the firearm, the seller must complete all of the questions in Section D. In addition to completing this form, the seller must report any multiple sale or other disposition of pistols or revolver on ATF Form 3310.4 (see 27 CFR § 478.126a).

Question(s) 26, 27, 28, 29 and 30, Firearm(s) Description: These blocks should be completed with the firearm(s) information. Firearms manufactured after 1968 should all be marked with a serial number. Should you acquire a firearm that is not marked with a serial number; you may answer question 28 with "NSN" (No Serial Number), "N/A" or "None."

If more than five firearms are involved in a transaction, the information required by Section D, questions 26-30, must be provided for the additional firearms on a separate sheet of paper, which must be attached to the ATF Form 4473 covering the transaction.

Types of firearms include: pistol, revolver, rifle, shotgun, receiver, frame and other firearms that are not either handguns or long guns (rifles or shotguns), such as firearms having a pistol grip that expel a shotgun shell or National Firearms Act (NFA) firearms.

Additional firearms purchases by the same buyer may not be added to the form after the seller has signed and dated it. A buyer who wishes to purchase additional firearms after the seller has signed and dated the form must complete a new ATF Form 4473. The seller must conduct a new NICS check.

Question 30c. This box is for the FFL's use in recording any information he or she finds necessary to conduct business.

Question 32 Federal Firearms License Number: Must contain at least the first three and last five digits of the FFL number, for instance X-XX-XXXXX.

Question 33-35 Transferor/Sellers Information: For "denied" and "cancelled" NICS transactions, the person who completed Section B must complete Section D, questions 33-35.

Privacy Act Information

Solicitation of this information is authorized under 18 U.S.C. § 923(g). Disclosure of the individual's Social Security number is voluntary. The number may be used to verify the buyer's identity.

Paperwork Reduction Act Notice

The information required on this form is in accordance with the Paperwork Reduction Act of 1995. The purpose of the information is to determine the eligibility of the transferee to receive firearms under Federal law. The information is subject to inspection by ATF officers and is required by 18 U.S.C. §§ 922 and 923.

The estimated average burden associated with this collection is 30 minutes per respondent or recordkeeper, depending on individual circumstances. Comments about the accuracy of this burden estimate and suggestions for reducing it should be directed to Reports Management Officer, Document Services Section, Bureau of Alcohol, Tobacco, Firearms and Explosives, Washington, DC 20226.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Confidentiality is not assured.

(5) For purposes of this subsection, the term "juvenile" means a person who is less than 18 years of age.

(6) (A) In a prosecution of a violation of this subsection, the court shall require the presence of a juvenile defendant's parent or legal guardian at all proceedings.

(B) The court may use the contempt power to enforce subparagraph (A).

(C) The court may excuse attendance of a parent or legal guardian of a juvenile defendant at a proceeding in a prosecution of a violation of this subsection for good cause shown.

18 U.S.C. 924(a)(6)

(6) (A) (i) A juvenile who violates section 922(x) shall be fined under this title, imprisoned not more than 1 year, or both, except that a juvenile described in clause (ii) shall be sentenced to probation on appropriate conditions and shall not be incarcerated unless the juvenile fails to comply with a condition of probation.

(ii) A juvenile is described in this clause if--

(I) the offense of which the juvenile is charged is possession of a handgun or ammunition in violation of section 922(x)(2);and

(II) the juvenile has not been convicted in any court of an offense (including an offense under section 922(x) or a similar State law, but not including any other offense consisting of conduct that if engaged in by an adult would not constitute an offense) or adjudicated as a juvenile delinquent for conduct that if engaged in by an adult would constitute an offense.

(B) A person other than a juvenile who knowingly violates section 922(x)--

(i) shall be fined under this title, imprisoned not more than 1 year, or both; and

(ii) if the person sold, delivered, or otherwise transferred a handgun or ammunition to a juvenile knowing or having reasonable cause to know that the juvenile intended to carry or otherwise possess or discharge or otherwise use the handgun or ammunition in the commission of a crime of violence, shall be fined under this title, imprisoned not more than 10 years, or both.

If you have any questions, contact:

Bureau of Alcohol, Tobacco, Firearms and Explosives
99 New York Avenue, NE
Washington, DC 20226
Phone: (202) 648-7090
OR
Visit our web site at www.atf.gov

U.S. Department of Justice
Bureau of Alcohol, Tobacco, Firearms and Explosives

YOUTH HANDGUN SAFETY ACT NOTICE

ATF Information 5300.2
Revised July 2004

YOUTH HANDGUN SAFETY ACT NOTICE

(1) The misuse of handguns is a leading contributor to juvenile violence and fatalities.

(2) Safely storing and securing firearms away from children will help prevent the unlawful possession of handguns by juveniles, stop accidents, and save lives.

(3) Federal law prohibits, except in certain limited circumstances, anyone under 18 years of age from knowingly possessing a handgun, or any person from selling, delivering, or otherwise transferring a handgun to a person under 18.

(4) A knowing violation of the prohibition against selling, delivering, or otherwise transferring a handgun to a person under the age of 18 is, under certain circumstances, punishable by up to 10 years in prison.

FEDERAL LAW

The Gun Control Act of 1968, 18 U.S.C. Chapter 44, provides in pertinent part as follows:

18 U.S.C. 922(x)

(x) (1) It shall be unlawful for a person to sell, deliver, or otherwise transfer to a person who the transferor knows or has reasonable cause to believe is a juvenile—

(A) a handgun; or

(B) ammunition that is suitable for use only in a handgun.

(2) It shall be unlawful for any person who is a juvenile to knowingly possess--

(A) a handgun; or

(B) ammunition that is suitable for use only in a handgun.

(3) This subsection does not apply to--

(A) a temporary transfer of a handgun or ammunition to a juvenile or to the possession or use of a handgun or ammunition by a juvenile if the handgun and ammunition are possessed and used by the juvenile-

(i) in the course of employment, in the course of ranching or farming related to activities at the residence of the juvenile (or on property used for ranching or farming at which the juvenile, with the permission of the property owner or lessee, is performing activities related to the operation of the farm or ranch), target practice, hunting, or a course of instruction in the safe and lawful use of a handgun;

(ii) with the prior written consent of the juvenile's parent or guardian who is not prohibited by Federal, State, or local law from possessing a firearm, except--

(I) during transportation by the juvenile of an unloaded handgun in a locked container directly from the place of transfer to a place at which an activity described in clause (i) is to take place and transportation by the juvenile of that handgun, unloaded and in a locked container directly from the place at which such an activity took place to the transferor; or

(II) with respect to ranching or farming activities as described in clause (i), a juvenile may possess and use a handgun or ammunition with the prior written approval of the juvenile's parent or legal guardian and at the direction of an adult who is not prohibited by Federal, State or local law from possessing a firearm;

(iii) the juvenile has the prior written consent in the juvenile's possession at all times when a handgun is in the possession of the juvenile; and

(iv) in accordance with State and local law;

(B) a juvenile who is a member of the Armed Forces of the United States or the National Guard who possesses or is armed with a handgun in the line of duty;

(C) a transfer by inheritance of title (but not possession) of a handgun or ammunition to a juvenile; or

(D) the possession of a handgun or ammunition by a juvenile taken in defense of the juvenile or other persons against an intruder into the residence of the juvenile or a residence in which the juvenile is an invited guest.

(4) A handgun or ammunition, the possession of which is transferred to a juvenile in circumstances in which the transferor is not in violation of this subsection shall not be subject to permanent confiscation by the Government if its possession by the juvenile subsequently becomes unlawful because of the conduct of the juvenile, but shall be returned to the lawful owner when such handgun or ammunition is no longer required by the Government for the purposes of investigation or prosecution.

GPO U.S. GOVERNMENT PRINTING OFFICE: 2009—353–589

Firearm Suicide Prevention Task Force

Recommendations for Consideration

Submitted by

Secretary Rita Landgraf

Department of Health and Social Services

December 7, 2016

Recommendation - Continue to promote, support and advance trauma informed practices throughout systems and within communities

A growing body of research shows that adversity is so common as to be nearly universal. The prevalence of trauma is one of the reasons we suggest that when working with someone, you assume the presence of current or past trauma. A crisis may cause a level of trauma. **Trauma** is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives

In order to maximize the impact of trauma informed practices, they need to be provided in an organizational or community context that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing. These program or system practices and policies often interfere with achieving the desired outcomes in these systems.

That's why it is so important to adhere to that guiding principle: "First, does no harm."

Trauma Informed Practices are those that

- Understand the cumulative impact of trauma
- Creates environments of safety
- Promotes resilience and healing
- Promotes non-judgmental communication – what happened to you rather then what is wrong with you
- Learn about the impact of trauma.
- Assess how it affects the children and adults you serve, and how it is manifested in them.
- Embrace trauma-informed care as a fundamental principle for your organization – a principle that needs to appear in your mission, vision and values statements.
- Implement trauma-focused interventions appropriate to your setting

Guiding Principles of Trauma-Informed Care

1. **Safety** - Throughout the organization, staff and the people they serve feel physically and psychologically safe.
2. **Trustworthiness and transparency** - Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.
3. **Peer support and mutual self-help (Victim/Survivor Services need to include those with lived experience)** - These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.
4. **Collaboration and mutuality** - There is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. One does not have to be a therapist to be therapeutic.
5. **Empowerment, voice, and choice** - Throughout the organization and among the public served, individuals' strengths are recognized, built on, and validated and new skills developed as necessary. The organization aims to strengthen the staff's, public members' experience of choice and recognize that every person's experience is unique and requires an individualized

approach. This includes a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. This builds on what individuals and communities have to offer, rather than responding to perceived deficits.

6. **Cultural, historical, and gender issues** - The organization actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma

Increasing examples of local level efforts are being documented throughout the country. For example, the City of Tarpon Springs in Florida has taken significant steps in becoming a trauma-informed community. The city made it its mission to promote a widespread awareness of the costly effects of personal adversity upon the wellbeing of the community and how to become a trauma informed community which promotes healing and overall well-being.

Recommendation - Support the work of the Delaware Center for Health Innovation relative to

- **Clinical Scorecard (adding to the assessment for depression, include assess for suicide and method)**

Goal - Primary care practices will document a plan for patients with behavioral health needs.

– Identification criteria: The practice sets specific criteria for identifying patients with behavioral conditions. They may include:

- Diagnosis of a behavioral issue based on behavioral health visits or medications
- Two or more psychiatric hospitalizations in the past year
- Counseling or treatment for substance abuse
- A positive screening result from a standardized behavioral health screen including substance abuse.
- Care plan: The practice has documented approach to developing and

- Updating an individual care plan that includes integration with behavioral health care.

- **Support integration of behavioral health with primary care**

– Access to a behavioral health provider:
The practice can take one of three approaches to ensuring access to behavioral health care:

A documented plan to maintain at least one agreement with a behavioral health provider. A practice must hold an agreement if it shares a facility or campus with the mental health professional but has separate practice management and clinical information systems

A documented plan to integrate with a behavioral health care provider, either partially, such as though co-location with some shared practice management and clinical information systems, or fully, with all systems shared.

Integration of behavioral health care services, such as through colocation with a behavioral health provider with at least some shared

Current Status
More than 30% of primary care providers in Delaware are participating in practice transformation support funded by the State Innovation Models federal grant.

Relative to behavioral health integration with primary care, a one year testing program is scheduled to launch in early 2017, followed by evaluation. The goal of the testing program is proof of concept for behavioral health integration and creation of a best practices resource document that other primary care and behavioral health practices can use to guide future integration.

For More Information
Consensus paper “Integration of Behavioral Health and Primary Care”
http://www.choosehealthde.com/Providers

Delaware Suicide Task Force 12-7-16 By: Peter Rudloff

When evaluating the materials we received at the task force meetings and then doing online research on suicide and firearms, my research path led me overseas to countries that have different fundamental firearm philosophies and laws as compared to the USA.

In the United Kingdom, there is near zero ownership of personal firearms, yet the country has a higher rate of suicides per 100,000 people when compared to the USA. Likewise, Australia has very restrictive gun ownership laws that include registration of every firearm in the country and, like the United Kingdom, has a rate of suicides per 100,000 that is higher than the USA. In the United Sates, firearm ownership is the highest per capita of any country.

An interesting correlation of the three countries is that men successfully complete suicide at a significantly higher rate than women do, but women attempt suicide at a higher rate than men do.

When the task force initially looked the data in the USA we assumed this difference was because firearm ownership and firearm availability is higher with men because, in the USA, completed suicide by firearm account for the largest means to complete a suicide, a reasonable hypothesis when looking at only USA data.

In order for this hypothesis to be proven true, we would be able to apply similar logic to the higher rate of completed suicides in other countries where the greatest means to complete suicide is done without firearms.

The equation would look like this in USA:

Higher availability of firearms = greater number of completed suicides

OR

Lower availability of firearms = fewer completes suicides

To perform a similar equation utilizing the primary method of suicide completion in the UK or Australia the same equation looks like this:

Higher availability of rope = greater number of completed suicides

OR

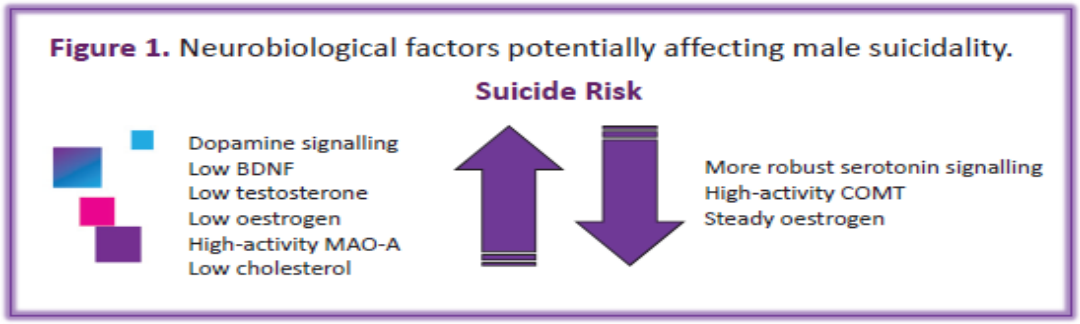
Lower availability of rope = fewer completes suicides

It is unlikely anyone will find the second equation rational. If we cannot reasonably swap out the leading means when other criteria are similar it is difficult to argue in favor that access to means is the link on why adult males complete suicide more often even though they attempt it less often than females.

An additional problem with firearm availability is that in the USA women have an equal opportunity to purchase, own and utilize firearms. In fact, the number of female firearm owners is at an all time high both in actual numbers and percentage compared to men (roughly 25% of firearm owners are women).

When looking at the data it is clear that adult males are completing suicide at a significantly greater rate than adult females. Looking at commonality in adult males is the most probable area that a solution to suicide prevention will be found.

Australian Institute for Suicide Research and Prevention has found compelling evidence that the reason males complete suicide at a higher rate has to do with neurobiological factors.



Additionally, the Interpersonal Theory of Suicide brings to light the fact that in order to complete suicide a person must first overcome their primal instinct of survival. Society influences on how males are raised and how they are expected to conform in society may actually be a contributing factor when looking at completed suicides.

Males often grow up being told to “suck it up” and “don’t cry”. This upbringing could lead to males placing higher value on other’s lives and less on their own. This may also explain why veterans have a very high suicide completion rate. The mindset of a person who is trained to go to war is one that they must confront the possibility of their demise during service to their country.

Dr. Silvia Sara Canetto, Department of Psychology, Colorado State University has released a paper titled: “Suicide: Why Are Older Men So Vulnerable?” 10.1177/1097184X15613832 . I have not figured out how to access this paper, but my research keeps pointing me to this document as one that should be accessed. I have reached out to Dr. Canetto, but have not heard back from her at the time of writing this.

I have noticed that some of the information provided to the task force so far has come from non-neutral sources. For example David Hemenway is a known anti-gun activist and some of the works submitted are heavily disputed by his peers. When looking for research on a sensitive subject like suicide or firearms I choose to specifically look for information that was not driven by an agenda on either side of the firearm debate as it relates to the second amendment. I specifically discounted NRA backed research for this reason. Further, much of the task force supplied data focused on youth even though our demographic has clearly indicated that completed suicides of all means happen in the adult white male category. Understanding the motivations behind the largest demographic should benefit the smaller demographics.

From reviewing the task force materials combined with my own investigation, I have concluded that the most practical area where improvement and near immediate positive impact can be made is on the front lines by law enforcement. The task force has discovered a deficiency in resources being available to our law enforcement team. Law enforcement is our first and most often contact with individuals whom are at risk. Secondary to improving law enforcement, resources should be appropriated to research into the neurobiological factors.

The most probable place a true solution will be likely found is in the science behind the neurobiological factors that entities like Griffith University and Colorado University are pursuing.

In closing I have not seen a credible evidence that suggests firearm availability increases or reduces completed suicides. I further suspect that firearms is a red herring, the data in the UK and Australian studies suggest any USA efforts chasing firearm restrictions will put the overall goal of solving suicide back.

Recommended path forward:

- Research with focus on the neurobiological factors that are driving males to break the self preservation barrier.
- Improve the lack of resource issue that today's law enforcement are dealing with in regard to victim services geared towards people who demonstrate suicidal tendencies and families of those dealing with a potential suicides.
- Research Griffith Universities training program that addresses all age groups, not just youth
- Procure and review the Colorado document # 10.1177/1097184X15613832

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Griffith UNIVERSITY
Australian Institute for
Suicide Research and Prevention

Male Suicide: What biological factors make men so vulnerable?

Eeva-Katri Kumpula, Kairi Kõlves and Diego De Leo

Background

Male completed suicide rates exceed those of women in many countries[1]. As many as 98% of suicide completers may have some underlying psychopathology, but not all people with mental disorders become suicidal[2]. Both psychological and biological factors affect moods, and environmental factors can exert their effects through both of these[3]. According to the stress-diathesis model, acute or chronic stressors such as primary psychiatric disorders or psychosocial crisis (e.g. unemployment, separation, somatic illness, bullying etc.) may lead to suicidal ideation, which in vulnerable persons with diathesis (genetic predisposition) can lead to a suicidal act[4]. Diathesis affects to which degree a person's neurobiological signalling may be disrupted through adversity, leading to hopelessness or pessimism and impulsivity, which increase a person's risk of suicide. Men and women differ in the obvious chromosomal and sex hormone aspects, and the female X and male Y chromosomes exert different effects leading to somewhat different brain structure and function in the two sexes[5], but what other biological factors may in part explain some of the differences observed in male and female suicidality? In this literature study we review current knowledge of biological factors affecting suicide, specifically attempting to find possible differences between the two sexes that might in part help explain the sex differences in suicide rates.

Methodology

A systematic literature search of publications in English without any publication time constraints was performed in Scopus, PubMed, and Web of Science databases. Search terms used in the title search field were: suicid* and gender or sex; combined with terms in all search fields: difference, men, male, biolog*. The titles and abstracts of the articles found in these searches were scanned and duplicates eliminated. Reference lists of articles found through the searches were also scanned for additional articles. Relevant articles were obtained and a synthesis made.

Results

From the review of the literature it can be deduced that no single gene, hormone, or other factor should be examined separately as we try to understand the biological processes contributing to suicide, but rather a bigger picture, such as co-regulated gene groups in several brain areas[6]. Coordinated expression of several genes has been implicated, and chronic shifts in all of the affected biological factors will likely lead to an altered, pathological new homeostatic state, e.g. a mental disorder.

Serotonin and dopamine signalling

Serotonin concentration fluctuates, going up and down with gonadal hormones, but day-to-day fluctuation is smaller in men[7]. There is some evidence suggesting that men generally have higher serotonin synthesis rates than women[8,9], even up to 50% higher[8], but methodological problems have been implicated in these studies[10,11]. Suicidal men had higher peripheral blood platelet serotonin levels than suicidal women in one study[12], but serotonin synthesis rate measurements in brain tissues by Positron Emission Tomography (PET) have shown conflicting results, possibly depending on differences in studied subject groups[11]. Synthesis patterns may also vary in different brain areas[13]. If the serotonin synthesis rate is in fact higher in men, this would to some degree protect them from effects of changes in serotonin levels and low serotonin (depression, impulsivity, possibly aggression), as transient changes could potentially be corrected more rapidly. However, men tend to be more sensitive to the negative effects of altered dopamine levels (increased aggression and impulsivity), possibly because the beneficial effects of estrogens on dopamine signalling are less prominent than those in women[14].

A high-activity allele of the MAO-A enzyme which breaks down monoamines (e.g. serotonin and dopamine) appeared to be a suicidality risk factor for men[15], while other studies have not found such an effect[16], and some have found only a connection to more violent methods of suicide[17]. A high-activity allele of the COMT enzyme which breaks down only catecholamines (e.g. dopamine) on the other hand appears to protect men from suicide[18].

Other biological factors

The neurotrophin BDNF which improves neuron signalling and adaptation to stress and adversity seems to be down-regulated in male suicide victims, with about 4 times less BDNF in males compared to females[19].

Low cholesterol and violent behaviour appear to be linked[20], and a group of male suicide attempters had very low blood cholesterol values, while no such effect was found for women [21].

High testosterone has traditionally been linked to aggression and may explain some of the violence in suicides[22], with one study finding no association between testosterone and suicide but rather with higher suicide attempt lethality[23]. However, low testosterone was found in a group of male suicide attempters, and the higher lethality, the lower the testosterone levels[24]. Oestrogen hormones are also present in men, and usually have anxiolytic effects in physiological concentrations[25]. Testosterone is continuously converted to oestrogens by the enzyme aromatase until old age, keeping oestrogen levels fairly steady in men compared to women whose levels fluctuate with their menses and then drop after menopause[26]. Men may therefore be better protected against e.g. anxiety disorders for their steadier oestrogen levels.

Brain-wide or structure-specific gene[27] and protein[28] expression profiling of causes and effects of suicidal behaviour is still in developmental stages, as there have been difficulties in replicating results in different patient samples, and therefore a more complete picture of the multiple pathways leading to suicide is still lacking. However, some possible aspects are summarised in Figure 1.

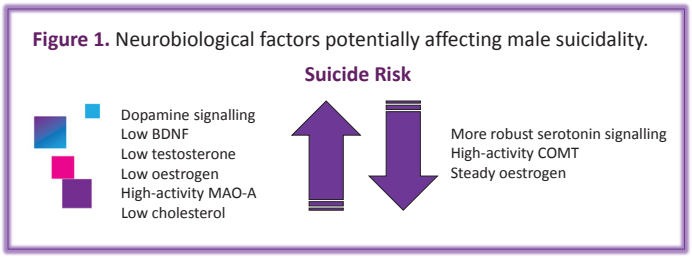

Figure 1. Neurobiological factors potentially affecting male suicidality.

Conclusions

A more resistant serotonin system may protect men from depression and suicidality to some extent, while a less resistant dopamine system may expose men to impulsive, aggressive behaviour, which may lead to suicidal behaviour. Crudely simplified, these effects may mean that men are less likely to suffer from depression (low serotonin), but may be more sensitive to increased impulsivity and aggression (high dopamine). High activity MAO-A enzyme appears to be a risk factor for suicidality in men, while a high activity COMT enzyme that does not break down serotonin but only catecholamines seems to protect men from suicide. This may imply that catecholamines dopamine, noradrenaline, and adrenaline need to be more effectively controlled in men to avoid suicidality, while serotonin may be important but less critical. Oestrogen in general protects from suicidality and depression, and since male bodies can synthesize it with a steady rate from testosterone, it may better protect them from suicidality. However, male oestrogen concentrations are lower than those in women, therefore offering less protection. These biological effects may explain some of the differences between male and female suicidal behaviour, and future genomics and proteomics research will likely offer more insight.

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George Higgins
Tuesday, December 6, 2016

Firearm Suicide Prevention Task Force Discussion Proposal

Follow up from review of comments presented during, and subsequent to, our previous meeting:

- There is an abundance of Peer-reviewed research on the topic of firearm-related suicide, some of which I provide here, categorized as follows:
  - Public Health Approach
  - Statistics
  - Lethal Means
  - Veterans & Active Military
  - Homicide-Suicide
  - Youth
  - Women
  - Emergency Responders
  - Prison Inmates
  - Education & Training
- Gun shop and firing range owners in other states are actively participating in the Gun Shop Project:
  - The video [5:44], Suicide Prevention - A Role for Gun Shops and Ranges illustrates the practical benefit for gun shop and firing range owner engagement.
  - Our neighboring Maryland Licensed Firearms Dealers Association is engaged as a point of distribution for a brochure containing safe practice and crisis line information.
- CALM: Counseling on Access to Lethal Means is a comprehensive workshop that is immediately available to provide awareness and skills training to key professionals:
  - Clinicians
  - First Responders (police, fire, and EMS)
- State-specific university research can be provided as illustrated by the recent California initiative to charter the Firearm Violence Research Center now established on the UC Davis Sacramento Campus
- Laws to temporarily remove lethal means from persons at risk have been determined both constitutional and effective.

RESEARCH:

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FINDINGS:

Education & Training:

CALM: Counseling on Access to Lethal Means

a 2 hour workshop developed by Elaine Frank and Mark Ciocca, of the Injury Prevention Center at Children's Hospital at Dartmouth, Lebanon, NH. This workshop helps providers implement counseling strategies to help clients at risk for suicide and their families reduce access to lethal means, particularly (but not exclusively) firearms. The workshop provides background on suicide data and lethal means; an introduction to firearms; video presentation that models the counseling strategy; a presentation and discussion on conducting a counseling session; optional role plays; and course evaluation.

The train-the-trainer workshop adds time for questions and exploration of experiences and runs about 6 hrs total. Cost includes a certificate and access to materials through DropBox.

CALM for Clinicians Train the Trainer

Provides participants with the materials and information needed to provide a 90 – 120 workshop to clinicians (and others) who work with suicidal individuals and/or their families in a counseling capacity. This could include: mental and physical health providers, school and youth counselors, VA and EAP personnel, clergy and others. The workshop focuses on how to address the need for and practical ways to reduce their access to lethal means to prevent suicide deaths. A major focus of the training is on how to approach this topic in a collaborative and respectful way that focuses on increasing safety.

CALM for First Responders Train the Trainer

Provides participants with needed information and materials to provide a 90 to 120 minute workshop to First Responders (police, fire, and EMS) who are often called out in cases of suicidal behavior. This workshop focuses on how they can address access to lethal means in the home environment with the at risk individual or their family as well as how to ensure that communications regarding them are clear among services as well as with hospital personnel and others. Finally, this session looks at addressing the issue of suicidal thoughts among First Responders themselves.

CALM in action

In August 2016, during a single trip to Oregon, under the guidance of Donna Noonan, the suicide prevention coordinator for state, who obtained funding for a big push on access to lethal means; Elaine Frank provided a

train-the-trainer for clinicians on the front-end, did 4 CALM workshops covering 3 counties, who in coalition, put together a meeting of stake holders of 20-60 people, as "technical assistance" workshops, then closed the tour with a train-the-trainer workshop for first responders on back end. During each workshop, someone locally presented suicide data for the county; then Elaine did presentation on Means Matter and gun shops, which led to break-out sessions to explore what they were doing now and what they could be doing. In addition to creating a vibrant program across the state, County Sheriff's wrote on the topic and the state mailed materials to all concealed carry permit holders.]

Workshops will require someone in DE to coordinate, define audience, and enroll a minimum of 10, maximum of 40 people in each session for good interaction. Cost is $4000 + travel for train-the-trainer; public workshops are $1000 + travel (reduced for multiple trainings during a single trip).

References:

Oregon:

- Donna Noonan (soon to retire) State Suicide Prevention Coordinator - donna.noonan@state.or.us
- Meghan Crane - Washington County SP Coordinator - Meghan.crane@co.washington.or.us

Texas:

- Merily Hodge Keller - hodgekeller@yahoo.com

Colorado

- Jarrod Hindman - jarrod.hindman@state.co.us

University Research:

- In 1997, a freeze on federal funds for gun violence research has been in place for two decades.
- in 2013, the National Academy of Sciences published Priorities for Research to Reduce the Threat of Firearm-Related Violence as approved by the Governing Board of the National Research Council, whose members are drawn from the councils of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine.
- In 2014, the American Psychological Association (APA) adopted a Resolution on Firearm Violence Research and Prevention that defines principles to guide APA in public education and policy advocacy regarding firearms violence research and prevention.
- In 2016, California passed CA SB1006 to create the Firearm Violence Research Center now established on the UC Davis Sacramento Campus.

Limiting Lethal Means:

Temporary Removal of Lethal Means:

- CA – Gun Violence Restraining Order:
    - Speak For Safety campaign empowers families and law enforcement to utilize this mechanism and educate the public to empower loved ones to intervene before it is too late.
    - In California, the courts have specifically held that "the state may ensure that firearms are not in the hands of someone who may use them dangerously" and dangerous people may be prohibited from possessing firearms consistent with their Second Amendment rights, as long as they are afforded adequate due process. See City of San Diego v. Boggess, 216 Cal. App. 4th 1494 (2013).

- CT – Risk-warrant Gun Removal CONN. GEN. STAT. § 29-38c(a) ; key findings:
  1. Police found firearms in 99 percent of instances when a risk-warrant was issued, removing an average of seven guns per warrant.
  2. People in Connecticut subject to risk-warrants had an annual suicide rate 40 times higher than the general population, showing the increase risk among this population.
  3. Nearly one-third of all risk warrant subjects received mental health and substance abuse treatment after a risk-warrant was issued.
  4. At least one life is saved for every 20 risk-warrants issued, an estimated 38 to 76 people are alive today.
- IN – Proceedings for the Seizure and Retention of a Firearm [Ind. Code Ann. § 35-47-14] upheld on 2nd Amendment Challenge:
  - The Indiana constitutional provision guarding the right to bear arms appears near the end of article 1's Bill of Rights. The provision states that the "people shall have a right to bear arms, for the defense of themselves and the State." Like other provisions in the Bill of Rights, the right to bear arms limits the State's police power. In Price v. State, the Indiana Supreme Court established that the State's police power may not "materially burden" the "preserves of human endeavor" embodied in the Bill of Rights. The General Assembly may qualify the "cluster of essential values" provided in Indiana's Bill of Rights but it may not entirely alienate those rights.

    In Redington v. State [992 N.E.2d 823 (Ind. Ct. App.)], the court addressed whether an Indiana statute allowing the seizure of an individual's firearms was constitutional as applied. After a hearing, the trial court found that the State proved by clear and convincing evidence that Redington was dangerous as defined by the statute and ordered the police to retain Redington's fifty-one firearms. The provision defines dangerousness in two general categories. A person is dangerous if she presents "an imminent risk of personal injury to the individual or to another individual." Alternatively, the individual is dangerous if he presents not an imminent risk, but a general risk the same injury and either (A) has a statutorily defined mental illness that medication cannot effectively control or (B) evidence gives "rise to a reasonable belief that the individual has a propensity for violent or emotionally unstable conduct."
- WA – Extreme Violence Protection Order (Ballot Initiative 1491) overwhelmingly adopted:
  - 70% YES to 30% NO.

Harvey Doppelt:
Areas for intervention would include:

1. At sale of gun or purchase of ammunition – training of person selling on suicidal signs would help
2. When a person is being trained to use a gun
3. Having information available at gun ranges where you might reach long time gun owners. A gun owner might not be suicidal but a friend might be and if the gun owner knows about suicide he might be able to help
4. Primary Care Physicians – screen I am offering for free to primary care physicians under my suicide grant includes a question about guns. Glad to demonstrate it to the task force
    - In month prior to suicide 45% (range 20 to 76%) of people had contact with primary care physician
    - 77% (range 57 to 90%) had contract in year prior to suicide
    - Age 55 and over 58% (range 43 to 70%) had contact with PCP in month prior to suicide

Guns owners might fear that if they come forward with being suicidal that the person will be hospitalized and have his guns taken away forever. Most suicidal people don't need to be hospitalized and from our discussion last week the only issue would be if a person is involuntarily committed to a psychiatric hospital.

The issue of governmental involvement in taking away guns can be a lightning rod for the gun dealers/owners. This can be sidestepped if the goal after identification of a suicidal person is to have that person evaluated by a mental health professional. The mental health professional's job is to work with the client to have the client agree to have the guns taken away. This might include (with the client's permission when needed) the help of family members and friends.

Amy Kevis:
Working in both the law enforcement and mental health fields has helped me realize how valuable information sharing can be – with that being said, I would suggest some type of *informational handout on crisis services be made available at all gun retailers in the state*. For those that work out of their homes, they would be asked to provide the relevant material upon transfer of the firearm. This would not be anything cumbersome, but merely a small (3 x 8) piece of paper with the information for the Crisis Hotline and the two Crisis walk-in centers. I think that several folks at the table spoke of the humiliation that their loved ones felt over the need to explain themselves to their family doctor or an emergency room physician whom did little in providing an intervention that may have resulted in a different outcome. This is not to suggest that emergency rooms and family doctors do not do their best to assist individuals, but typically these resources do not exist in emergency rooms and must be accessed in alternate settings. By providing this printed information, individuals will know that they can access crisis services 24/7 on their own terms, whenever they are ready and with confidentiality.

Second, I would recommend a formal, *scripted training portion of the law enforcement mental health training (which already exists via the Council On Police Training, COPT) for Delaware*

police officers on dealing with suicide/suicide awareness. If this recommendation is accepted, the content of the training would be decided by committee members and those designated individuals would be invited to a COPT meeting to discuss content with board members. Although this topic is included in the current COPT mandate, I believe that the police would benefit from additional awareness and understanding of the complexities of the act of suicide. There should also be a referral to the victim services staff to provide outreach and support to surviving family members after a completed suicide - the larger police agencies employ specialized Victim's Services staff to assist with critical incidents.

Third, I would recommend a more formalized outreach process be developed for physician's offices with patients that present and express suicidal ideations. A referral to an emergency room for assistance with thoughts of suicide is not the most encouraging referral for an individual that is actively suicidal. While emergency rooms will perform psychiatric assessments, there are typically long wait times and other interventions may provide support more readily. Options could be provided for either a direct referral for an assessment at one of the three Delaware psychiatric hospitals or an on-site phone call to the Crisis hotline to provide outreach which would provide immediate support for the individual. During the phone call, trained psychiatric staff would be able to determine the best intervention for the individual and provide the most clinically appropriate intervention based on the individual's verbalized need.

There should also be some type of mechanism by which firearms can be held for individuals that are expressing suicidal thoughts. I think the GVRO process should be explored more thoroughly for Delaware's needs.

As a side note, I have realized the lack of awareness of the State's Crisis Hotline which is staffed 24/7 by clinical staff and also available to make visits to individuals in the community needing support. As a result, I have employed two senior staff to assist in promoting the existence of these services for all Delawareans. My Crisis staff provides clinical support via telephone in excess of 3,000 phone calls monthly and also via many face to face visits with individuals in the community. I am appreciative of this awareness via the opportunity to be a member of this task force.

Elevated Rates of Urban Firearm Violence and Opportunities for Prevention—Wilmington, Delaware

Final Report

Prepared By:

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November 3, 2015

Submitted to:
Secretary Rita Landgraf
Delaware Department of Health and Social Services

Background of the Field Investigation:

In 2013, Wilmington, Delaware, experienced 127 shooting incidents resulting in 154 victims.[1] This represented nearly a 45% increase in the number of shootings over the preceding two years.[1] Furthermore, rates of violent crime in Wilmington are higher than in nearby cities of Dover, Newark, and Philadelphia.[2] Indeed, although Wilmington is a moderately-sized city of approximately 71,525 residents, when compared to all large cities in the United States, its homicide rate in recent years has been reported to be as high as 4th overall.[3] In fact, in recent years, the growth in Delaware's homicide rate (Wilmington is the largest city in Delaware) has outpaced that of every other state (see Figure 1 below).

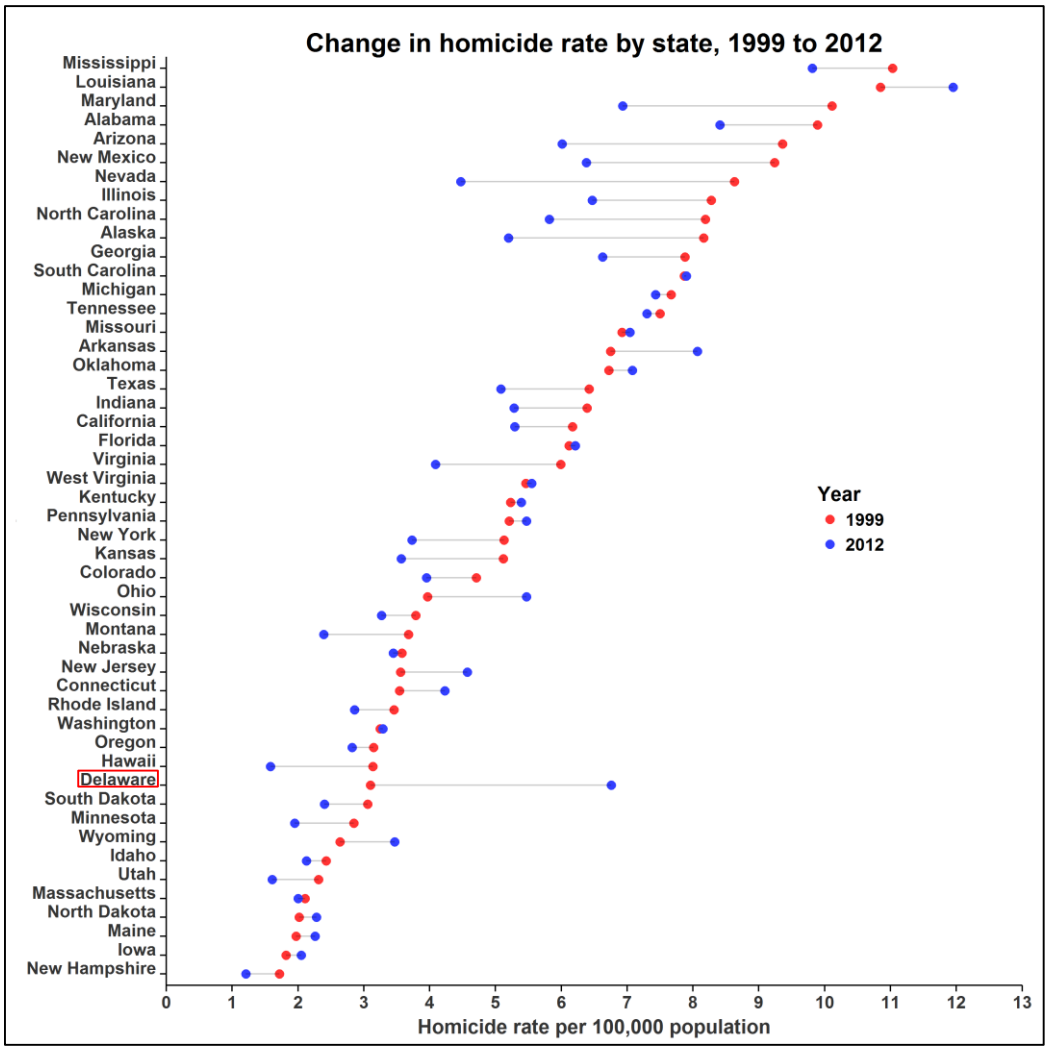


Figure 1. Note: Vermont not included as rates not reported for 2012

1. Delaware Online. Wilmington Shootings: Incidents by year. 2015. http://data.delawareonline.com/webapps/crime/.
2. Nolan J. Aggravated Assault and Homicide Incidents in Wilmington: 2010-2013. 2013.
3. Cornish A. Wilmington, Del., Struggles With Outsized Murder Rate January 1, 2014. http://www.npr.org/2014/01/01/258889969/wilmington-del-struggles-with-outsized-murder-rate

As a result of persistently elevated urban firearm violence rates, the Wilmington City Council passed a resolution to request the Centers for Disease Control and Prevention (CDC) to assist in an investigation and provide recommendations for preventive action.[4] The Delaware Division of Public Health, with concurrence from the City Council and Mayor's office, issued a formal invitation to CDC to provide epidemiologic assistance and make programmatic recommendations for a public health response.

Investigation Rationale and Objectives:

Urban firearm violence results in a substantial degree of fear among city residents, slowing of business growth, straining of city resources, and suffering among victims' families. However, in spite of the tremendous impacts of such violence on a city, only a relatively small number of individuals are actually responsible for committing these particular crimes. For example, in 2013, Wilmington experienced a reported 127 shooting incidents. If we assume one person committed each shooting, this equates to 127 individuals committing firearm violence out of a total population of about 71,000 residents, which is less than 1 out of every 500 residents. Because only a relatively small proportion of individuals are involved in firearm crimes, accurately focusing prevention efforts could have a significant impact on lethal violence in urban city centers and be an important component to a larger comprehensive approach to violence prevention.

CDC's investigation sought to utilize several Delaware administrative data sources to explore the feasibility of using public health resources in a more efficient manner, focusing comprehensive wrap-around services to individuals at the highest risk of violent crime involvement. Such services might include peer outreach/mentorship, medical care or counseling, educational support, economic assistance, or other services.

The objectives of this investigation were:

1. To assist the Delaware Division of Public Health and the City of Wilmington in examining the characteristics of persons involved in urban firearm crimes.

2. To provide epidemiologic information that can help the Delaware Division of Public Health focus educational, social, medical, and other assistance to populations at risk.

3. To identify strategies for Delaware officials to help monitor and prevent future violence.

Scientific Methods:

Individuals involved in firearm crimes

The primary analysis sought to develop a pilot tool that could potentially better identify the multiple risk factors of individuals at the highest risk of involvement in firearm crimes so that appropriate public health and social services could be provided more efficiently. To understand these characteristics, investigators first examined Delaware law enforcement records.

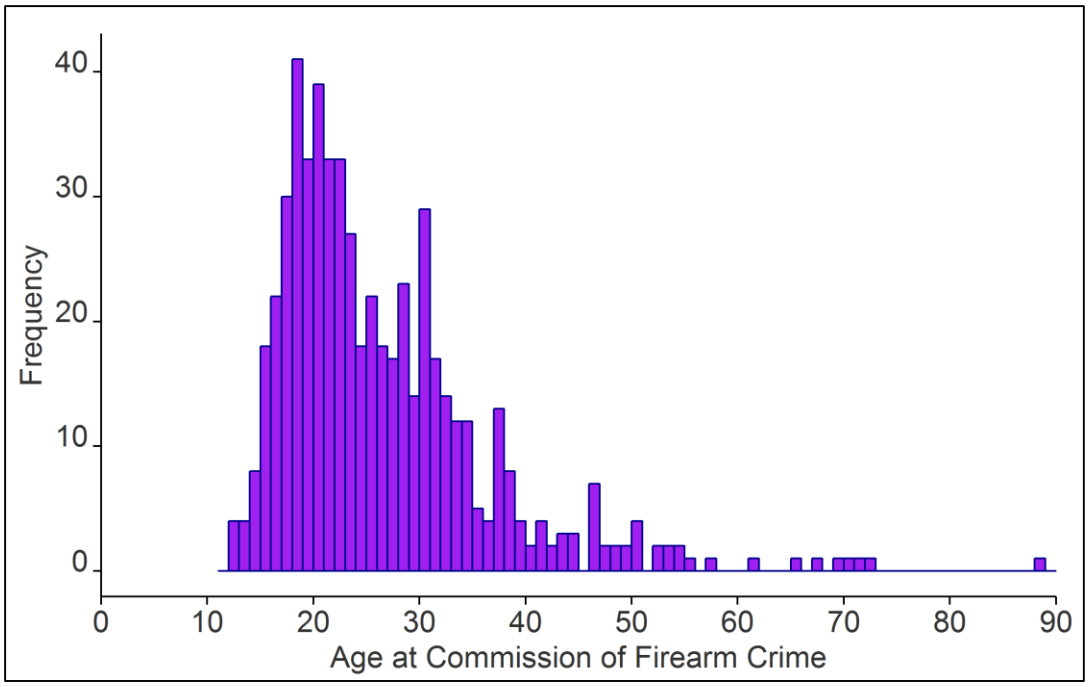
From a police database, Wilmington residents arrested for a violent firearm crime in the city of Wilmington between January 1st, 2009, and May 21st, 2014, were identified. A violent firearm crime was defined as homicide, attempted homicide, aggravated assault, robbery with a firearm, or possession of a firearm during the commission of a felony. Such events were identified based on crime codes and state statue violations.

This search yielded 569 individuals. Approximately 95% of these individuals were male. The age of individuals involved in firearm crimes at the time of the offense is as follows (totals may sum to more than 100% due to rounding):

- under age 18: 15.1%
- age 18 to <25: 39.4%
- age 25 to <30: 16.5%

- age 30 to <35: 14.8%
- age 35 to <40: 6.0%
- age 40 and older: 8.3%

Figure 2. Age distribution of individuals committing firearm crimes



Identification of risk factors for firearm crime involvement

To focus prevention services, risk factors for firearm crime involvement must be understood in Wilmington. Consequently, several local administrative data sources were used to explore preceding patterns of events in individuals' lives before they committed a firearm crime. These administrative data sources included the Delaware Department of Services for Children, Youth and their Families, Delaware Criminal Justice Information System, Delaware Department of Education, Delaware Department of Labor, and Christiana Care Health Care System. The prevalence of several major risk factors were examined for each of the individuals involved in

firearm crimes. The percent of individuals experiencing these risk factors are shown in table 1 below:

Table 1. Proportion of 569 individuals involved in firearm crimes who experienced each risk factor

Type of Risk Factor	Number	Percent (%)
Emergency Department Visit History		
Gunshot wound	72	13
Stabbing	27	5
Blunt weapon injury	36	6
Physical fight	107	19
Suicidal ideation/attempt, self-inflicted injury	46	8
Clinical encounter involves police(a)	113	20
Any emergency department event listed above	271	48
Labor Indicators		
Unemployed in quarter preceding the crime(b)	410	86
Application filed for unemployment benefits	100	18
Child Welfare Investigation History		
Investigated as victim of child maltreatment	159	28
Out of home placement	39	7
Any child welfare event listed above	167	29
State Juvenile Services Participation		
Community probation	284	50
Residential detention	215	38
Behavioral health services	91	16
Managed care services	160	28
Any juvenile service listed above	308	54
School System Events(c)		
Recipient of social assistance programs ever	327	73
Prior suspension/expulsion	186	42
Dropped out prior to high school graduation	105	24
≥10 unexcused absences in school year preceding crime(d)	57	58

(a) Injury from legal intervention or patient brought in/discharged to police
(b) Among those with wage data available
(c) Among those for whom school enrollment was confirmed
(d) Among individuals enrolled in school year preceding crime date

Note: Each risk factor or category is not mutually exclusive (an individual may have multiple risk factors in multiple categories). Emergency room data available since 2000; child welfare/juvenile services data available since 1992; labor data available since 2006; education data available since 2002

Using risk factors to focus efforts

Although some risk factors may be common in the lives of individuals involved in firearm crimes, they may not be the strongest signals of risk of firearm violence involvement. This is because some risk factors may also be very common in the general population. To further explore what are the strongest risk factors, investigators also examined the prevalence of the major risk factors among the Wilmington general population by randomly sampling approximately three non-firearm crime records for each firearm crime record. The strength of each risk factor was then assessed through logistic regression, a standard mathematical technique for examining risk factors.

Logistic regression provides an estimate of the strength of the association between a risk factor and an outcome, controlling for all other risk factors being considered. Consequently, scoring systems can be developed in medicine and public health using this technique that take into account a number of risk factors. As an example, a logistic regression model of the risk factors shown in Table 1 produces the following risk scoring system (Table 2). Point values are obtained by multiplying all regression coefficients by 5 and rounding to the nearest integer (multiplication by a factor of 5 is chosen as it makes the smallest regression coefficient [0.4] an integer after multiplication). Risk factors with more points indicate a stronger association with firearm violence involvement. This kind of procedure is used widely in medicine and public health to create scoring systems for conditions such as diabetes, heart attack, HIV, and many other conditions.

(Continued with table, next page)

Table 2. Example risk factor scoring system

Type of Risk Factor	Regression coefficient	Point value for risk score
Emergency Room Visit History		
Gun shot wound	2.4	12
Stabbing	2.3	12
Blunt weapon injury	1.0	5
Physical fight	0.6	3
Suicidal ideation/attempt, self-inflicted injury	0.4	2
Clinical encounter involves police	2.2	11
Labor Indicators		
Unemployed in quarter preceding the crime	1.1	6
Application filed for unemployment benefits	0.5	3
Child Welfare Investigation History		
Investigated as potential victim of child maltreatment	0.5	3
Out of home placement	0.8	4
State Juvenile ServicesParticipation		
Community probation	1.0	5
Residential detention	1.1	6
Behavioral health services	0.8	4
Managed care services	0.5	3
School System Events		
Recipient of social assistance programs ever	1.4	7
Prior suspension/expulsion	0.7	4
Dropped out prior to high school graduation	1.0	5
≥10 unexcused absences in school year preceding crime	0.6	3

Note: Point values are obtained by multiplying all regression coefficients by 5 and rounding to nearest integer. The model constitutes an example scoring system based on Wilmington data; further model refinement is needed before any actual implementation.

In clinical or public health settings, practitioners can assess the number of risk factors an individual has, add up the individual point values, and thereby determine risk of a particular outcome. For example, using just the sample point values from Table 2, a score for each person in our sample can be calculated. Higher scores are clearly associated with a higher risk of committing a firearm crime in our investigation sample (Table 3).

Table 3: Total point score and percent of individuals committing a firearm crime within investigation sample

Total point score	Percent committing a firearm crime
0	4.2%
1 to 10	8.2%
11 to 20	26.8%
21 to 30	43.4%
31 to 40	67.8%
41 to 50	83.3%
> 50	89.8%

Although calculating risk scores has often been done manually by doctors, counselors, or other practitioners, risk assessment tools can be automated when only administrative data are used, such as in our investigation in Wilmington. Automation allows more factors to be considered in the risk score, can incorporate more complex factors (such as timing of events), and permits the risk assessment tool to be low cost, so that the majority of project resources can be allocated to service provision.

Further increases in classification accuracy can be achieved by restricting analyses to the highest risk populations. We see that the majority of individuals involved in firearm crimes are young males. As a test of potential population level estimates, we now focus on males approximately age 15-29, the highest risk population for violence involvement. Incorporating all of the factors in Table 2 as well as census tract yields excellent risk classification ability.

Figure 3. Estimated Risk of Firearm Crime Involvement Based on Risk Factors and Subsequent Involvement in Firearm Crimes

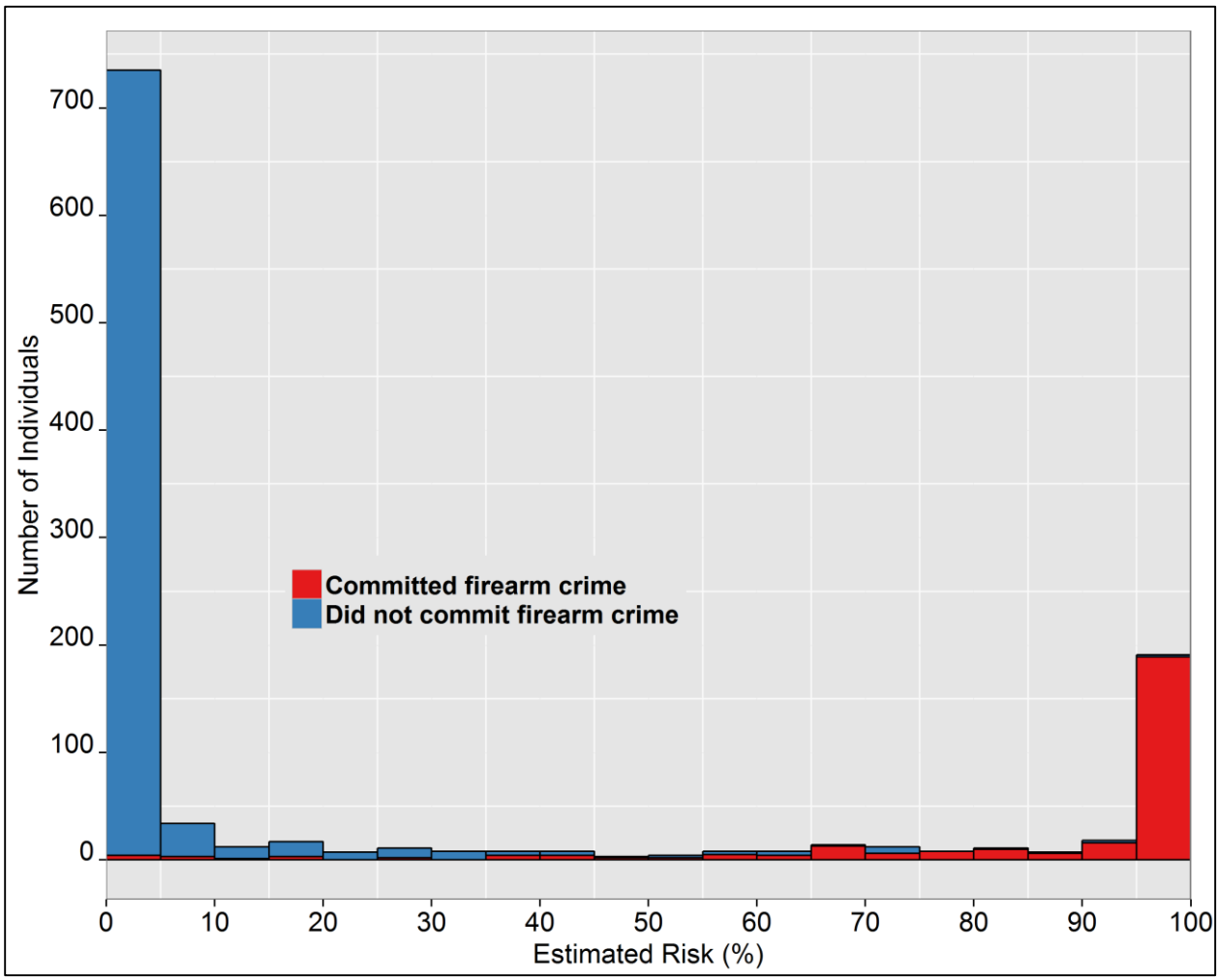


Figure 3 demonstrates that considering multiple risk factors does lead to excellent classification accuracy within our sample—individuals with a high, estimated risk for violence involvement based on the presence of multiple, strong risk factors were often subsequently involved in firearm crimes. For example, in our sample of 15-29 year old males, there were 209 individuals who had an estimated risk of 90% or greater based on multiple risk factors. Ultimately, 205 of these young men were involved in firearm crimes over the study period.

Because the total population of males age 15 to 29 can be estimated from census data, we can attempt to extrapolate from our sample to make rough population level estimates of how useful such a risk assessment tool could be. Using a risk level of 90% or greater could have up to

an approximate 66% accuracy (i.e., 66% of those having a greater than 90% risk would subsequently be involved in firearm crimes in the time period we assessed). Another important metric to consider is sensitivity, which refers to the proportion of individuals committing firearm crimes that the risk assessment tool identifies among our population of 15-29 year old males. Estimated sensitivity could be up to 73% (i.e., out of all male youth committing firearm crimes in Wilmington over the 5 year period studied, this risk assessment tool could have allowed an estimated 73% to receive social services they may have been lacking). For example, these young men have often experienced multiple exposures to violence and challenges in their family, educational, and employment backgrounds. Assistance in multiple areas could help reduce risk for violence involvement and a range of other health and social problems.

Our fieldwork demonstrates that data across Delaware agencies can be linked and that linking data has value in allowing service providers to better understand the multiple risk factors for violence involvement that need to be addressed, particularly among young men. Linked data systems have the potential to allow practitioners to provide more comprehensive services to youth at the highest risk of violence involvement and coordinate services to a greater degree with other agencies. Linked data systems also provide a valuable feedback loop which allows local governments to better assess the impact of programs.

Limitations

This investigation provides a proof-of-concept of the powerful risk classification ability of certain risk factors and the potential for the development of a low-cost risk assessment tool using administrative data. This information can then be used to improve programs and services. However, several steps would need to occur before actual implementation of such a tool. First, this test was conducted using a limited sample; further testing and refinement of the risk scores should occur with the full administrative datasets. The mathematical procedures used to control for the matching in the study design may affect estimates; the population level estimates provided should only be considered a rough approximation. Many factors will affect actual population estimates. However, it should be noted that the population estimates

provided here may be an underestimate. The risk scoring system demonstrated here is a basic model and in the real-world context, many additional items should be included in the scoring system, such as other risk factors, the frequency/magnitude of risk factors, and timing of risk factors. These adjustments would increase classification accuracy. Further increases in classification accuracy can be achieved by setting point values or cut-off scores even higher. With additional testing on a larger dataset, an optimal risk assessment tool can be developed and evaluated. Lastly, it should be noted that certain data systems may have unique legal requirements to be considered; partners may benefit from consulting with other cities or states who have already linked diverse data systems to improve programs. Nonetheless, scoring systems, such as the one we have demonstrated, are widely used in medicine and public health and provide marked improvements in risk classification ability and subsequent care for individuals.

Risk assessment tool implementation and violence prevention services

This investigation was focused on determining the feasibility of linking data across administrative data sources to develop an accurate risk assessment tool that would facilitate violence prevention efforts in Wilmington. Further testing can help determine optimal implementation of such a tool, such as timing and location of service provision, but the potential value of such a tool is clear. For example, imagine a 17 year old boy who is suspended for carrying a knife at school. A linked data system could help service providers see that 2 months ago the boy was treated for a gunshot wound at a local hospital; at the age of 14 the boy spent 6 months in a juvenile detention facility for a violent crime; and now the boy lives in the census tract of the city with the highest rate of violent crime. With this information, social service providers better understand this young man's elevated risk for violence involvement and can better provide comprehensive services to prevent future violence involvement and to promote positive and healthy development. The tool is to be used by social service providers to inform violence prevention efforts, and provisions should be established to preclude use as a

tool for law enforcement action. Implementation and management of such a tool should likely be performed by the Delaware Department of Health and Social Services.

For youth and individuals who are at an elevated risk of violence involvement, multiple programs and services exist to help enhance skills, promote opportunities for success, and prevent future violence involvement. These range from jobs programs, peer outreach/mentorship, educational or school-based programs, counseling, family focused programs, or other approaches. Resources to help communities understand the full spectrum of violence prevention programs include:

- CDC's STRYVE program selector tool: https://vetoviolence.cdc.gov/apps/stryve/strategy_selector.html
- CDC's Opportunities for Action publication: http://www.cdc.gov/violenceprevention/youthviolence/opportunities-for-action.html
- Washington State Institute for Public Policy cost/benefit: http://www.wsipp.wa.gov/BenefitCost?topicId=
- The University of Colorado Blueprints program registry: http://www.blueprintsprograms.com/
- National Institute of Justice's program reviews: http://www.crimesolutions.gov/
- The Community Guide to Preventive Services reviews: http://www.thecommunityguide.org/index.html

It is important for communities to focus resources on evidence-based practices that have demonstrated or promising results. The table below provides examples of demonstrated or promising approaches, though should not be considered a complete or proposed package; program selection will need to be tailored to priorities and local factors demonstrated from city data.

Problem Focus	Approach	Example program
• Emergency department visits for violence	• Street outreach • Linkage to social services through hospital interactions	• Cure Violence • Hospital-based violence intervention programs (HVIP)

• Unemployment	• Job placement and assistance • Conditional cash transfers	• Individual Placement and Support (IPS)
• Trauma from child abuse victimization	• Therapeutic support / counseling	• Trauma-focused cognitive behavioral therapy
• Juvenile criminal involvement	• Individual or family-focused programs and placement strategies	• Multidimensional Treatment Foster Care • Functional Family Therapy
• School problems	• Individual or group school-based social and emotional learning (SEL) and other programs	• Coping Power • Life Skills Training

Summary and Recommendations

This investigation highlights the potential of a risk assessment tool and linked data systems to guide violence prevention efforts. The majority of individuals involved in urban firearm violence are young men with substantial violence involvement preceding the more serious offense of a firearm crime. Our findings suggest that integrating data systems could help these individuals better receive the early, comprehensive help that they need to prevent violence involvement. This could potentially help prevent the subsequent violent crime that affects individuals, families, and neighborhoods throughout Wilmington. Such an approach can be an important component of community-wide efforts to prevent multiple forms of violence. Improved information systems can also help communities measure the impact of other strategies, such as interventions to address poverty, housing, education, or other underlying risk factors. Linked

administrative data systems have the potential to improve the efficiency and impact of social service provision in Delaware. Our primary recommendations include:

1. Increase collaboration between Delaware social service agencies in preventing violence by developing the capacity to link and share data between Delaware's various social service agencies in an ongoing fashion. This should involve consultation of agency technical and legal counsel to develop the appropriate policies and procedures to protect the privacy of individuals and data. Delaware partners may also consider consulting with other cities/states who have created local inter-agency data sharing agreements to learn from best practices.

2. Further refine the pilot risk assessment tool by using the full administrative dataset. Focusing the risk assessment on youth is likely to be the most feasible approach and youth are most likely to experience lifelong benefits from prevention programs. The proposed tool is to be used by social service providers to inform violence prevention efforts, and provisions should be established to preclude use by law enforcement. Use of the tool and program delivery should be managed by a Delaware social service/health agency.

3. Establish a community advisory board to provide recommendations on proposed evidence-based, wrap-around services/programs to be provided for high risk youth in conjunction with the recommended risk assessment tool.

Acknowledgements

- Delaware Department of Health and Social Services and Division of Public Health
- City of Wilmington
- Delaware Department of Safety and Homeland Security
- Delaware Criminal Justice Information System
- Delaware Department of Services for Children, Youth and their Families
- Delaware Department of Education
- Delaware Department of Labor
- Christiana Care Health Care System
- University of Delaware, Center for Drug and Health Studies
- Delaware Statistical Analysis Center, Criminal Justice Council

Firearm Suicide Prevention Task Force

Meeting #3 Notice

Friday, December 9
10am to noon
Legislative Hall, House Hearing Room
411 Legislative Ave,
Dover, DE 19901

Agenda

- Approval of minutes

TBD

Contact: Lauren CW Vella, 302-577-5190

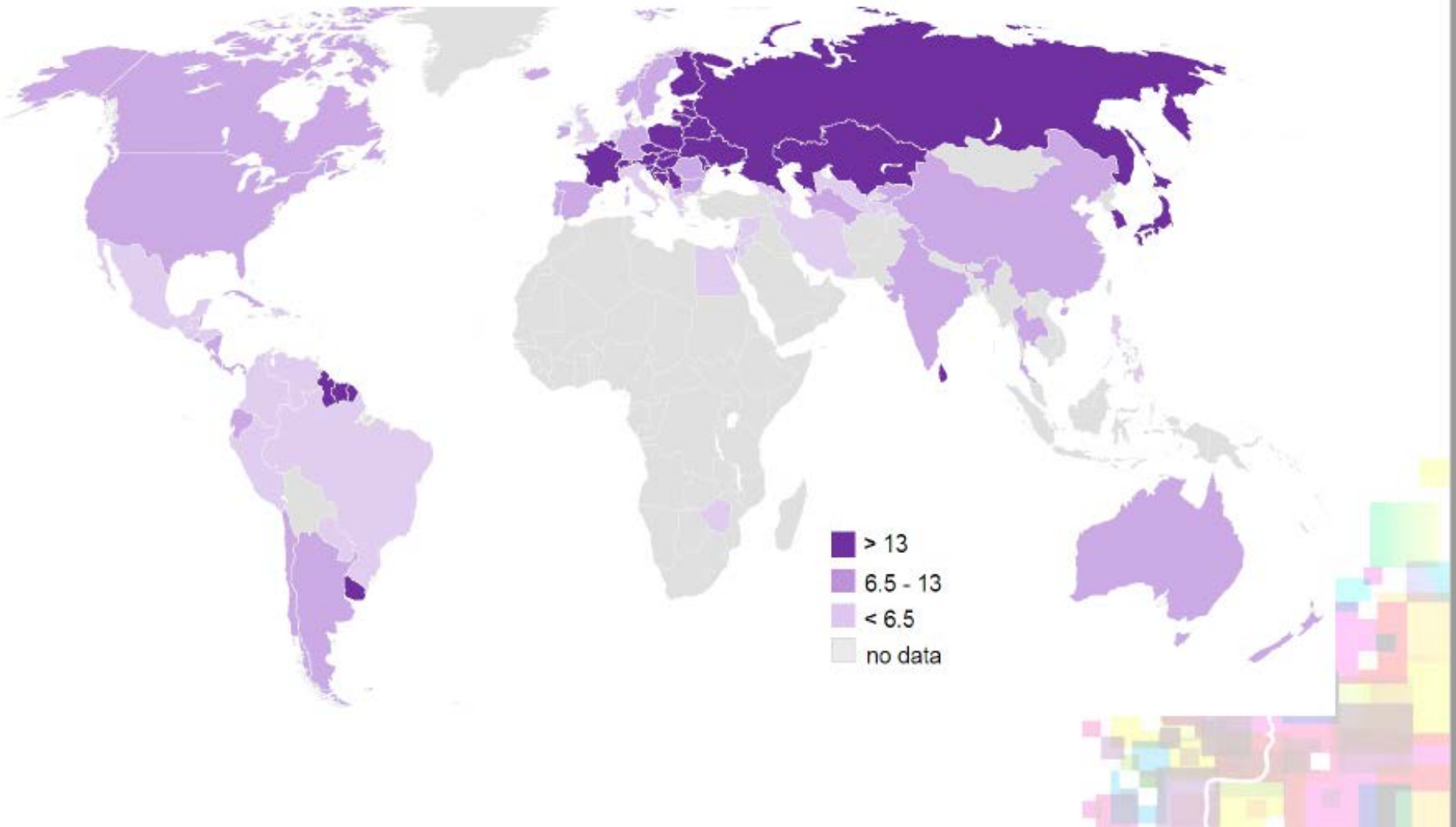
Suicide in Australia

Review of Griffith University data
December 2016

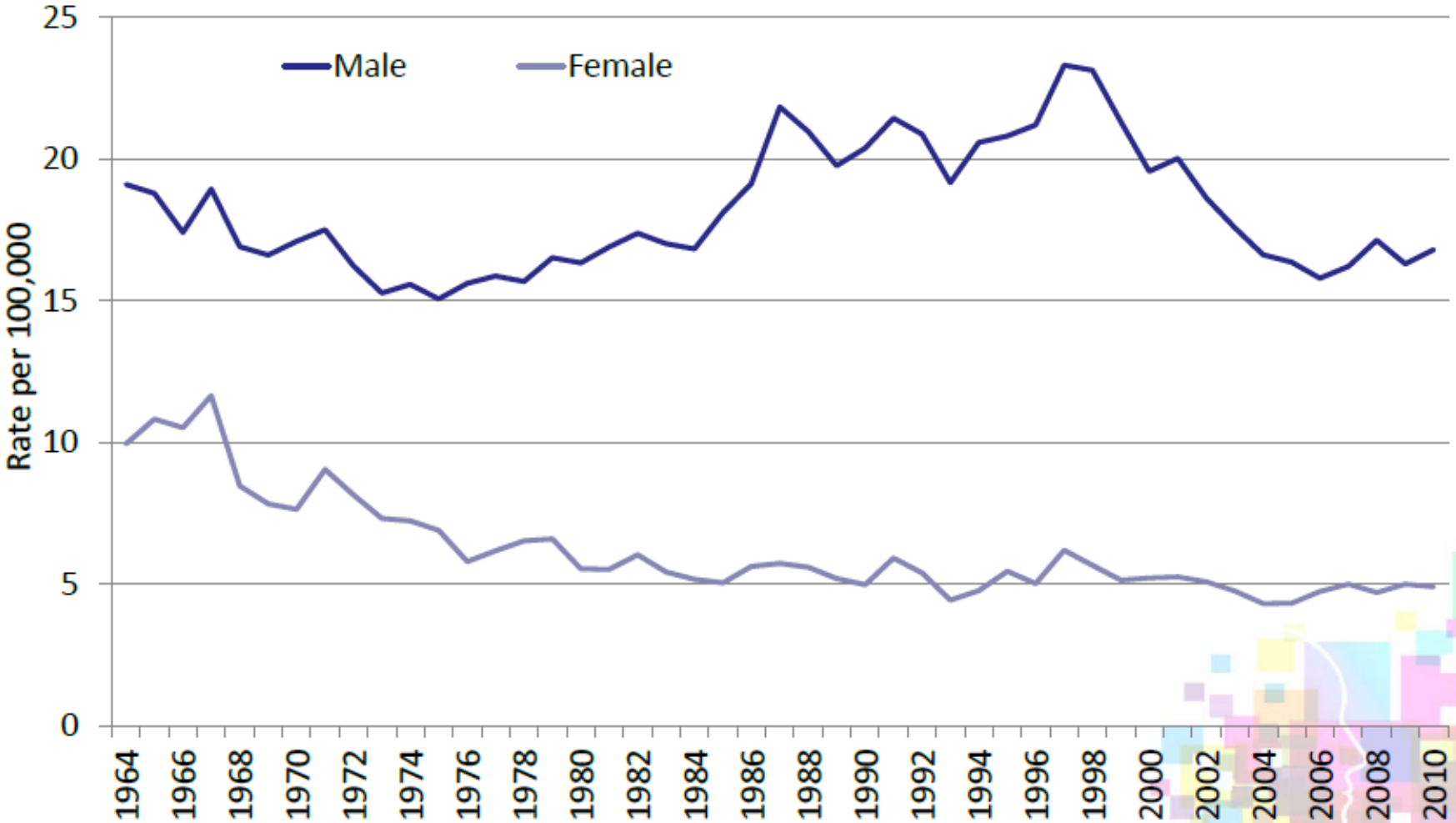
By: Peter Rudloff

World map of suicide rates in males

(latest year available on WHOSIS in 2011)

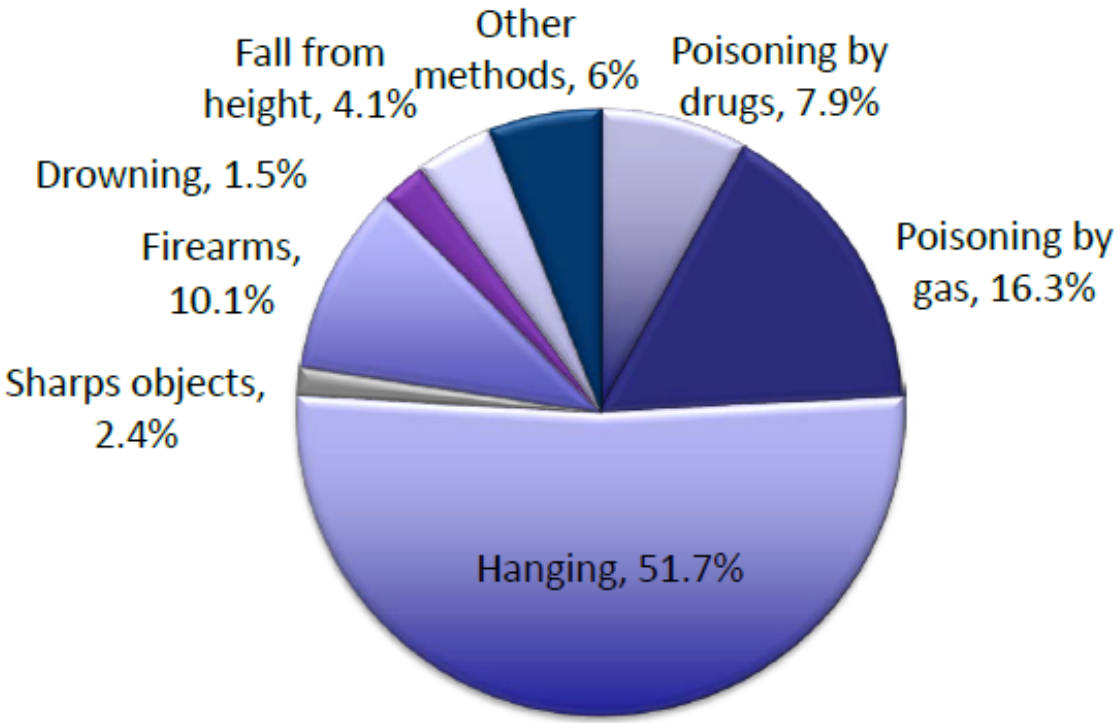


Suicide rates by year and sex, Australia, 1964–2010



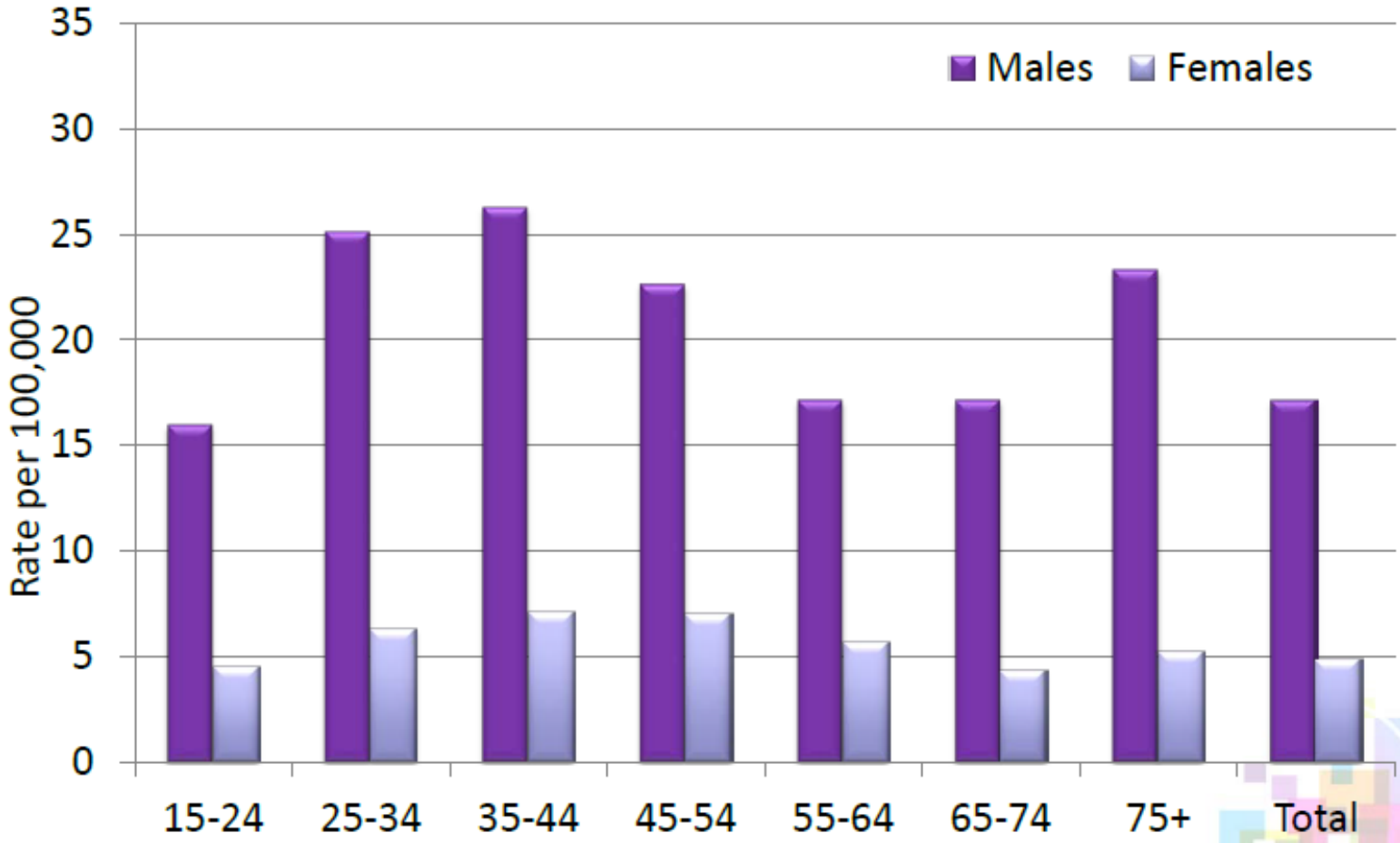
Data source: ABS

Distribution of suicide methods used by males, 2001-2010



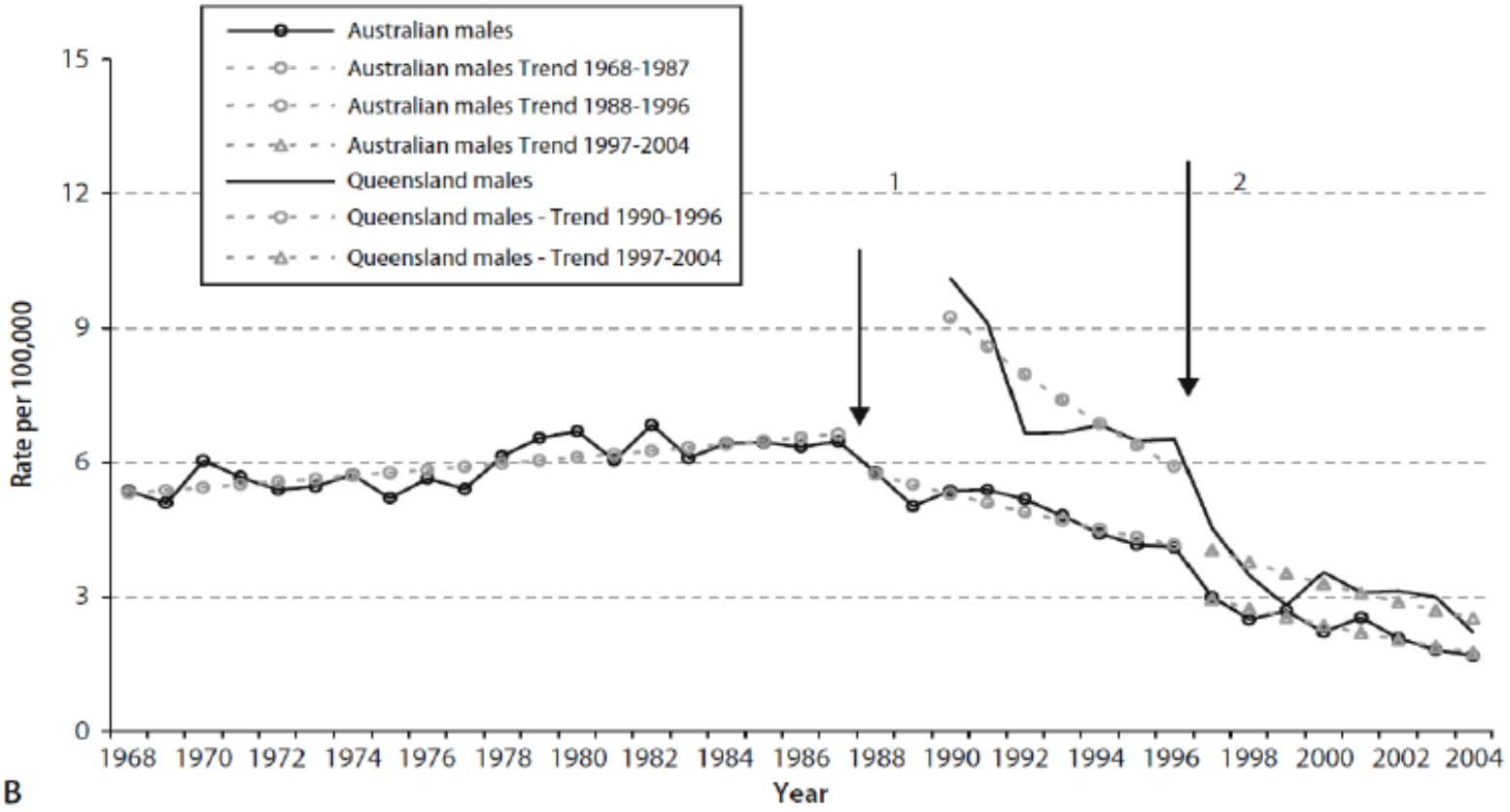
Data source: ABS

Suicide rates by age group and sex, Australia, 2001-2010



Data source: ABS

Australian and Queensland male firearm suicide trends



B

Two important events have been marked in the graph:

(1) establishment of the National Committee on Violence and

(2) the National Firearms Agreement

Source: Klieve et al., 2009b, p. 288

Aboriginal and Torres Strait Islander males

- ✓ In Australia, suicide rates among Aboriginal and Torres Strait Islander Peoples are higher than the other Australian population; males have higher rates of suicide while females engage more in non-fatal suicidal behaviour.
- ✓ Aboriginal and Torres Strait Islander males aged 25-34 years have the highest rates of suicide.
- ✓ Hanging is the most common suicide method among Aboriginal and Torres Strait Islander males in Australia.
- ✓ *Alcohol and substance abuse, under-utilisation of health services, as well as disadvantages in social and health conditions* put Aboriginal and Torres Strait Islander males at high risk of suicide.
- ✓ Aboriginal and Torres Strait Islander males are at a high risk of *contagion* or imitation of suicidal behaviours in their communities.

Males in Rural and Remote areas

- ✓ Male suicide rates are higher in rural and remote areas of Australia than in metropolitan areas.
- ✓ Vulnerable groups in the rural and remote areas include *farmers, Aboriginal and Torres Strait Islander Peoples*, and *migrants*.
- ✓ Identified suicidal risk factors for rural and remote males include climatic variability, political issues related to the farming industry, economic fluctuations, and the impact of mining.

Biological factors

- ✓ Recent research has shown that women and men are different in many fundamental ways, however, there are still many questions and a lot is unclear.
- ✓ *Dopamine* signalling disturbances may increase impulsivity and aggression. Men may be more vulnerable to this which, in turn, may increase their suicide risk.
- ✓ Low *testosterone* may be connected to suicidality. However, high testosterone, in association with aggression, has also been implicated.

Psychological theories & factors

The **Interpersonal Theory of Suicide** by Joyner (2005) suggests that the key is the presence of capability, defined as a combination of acquired fearlessness and competency (those who kill themselves not only have a desire to die, they have learned to overcome the instinct for self-preservation).

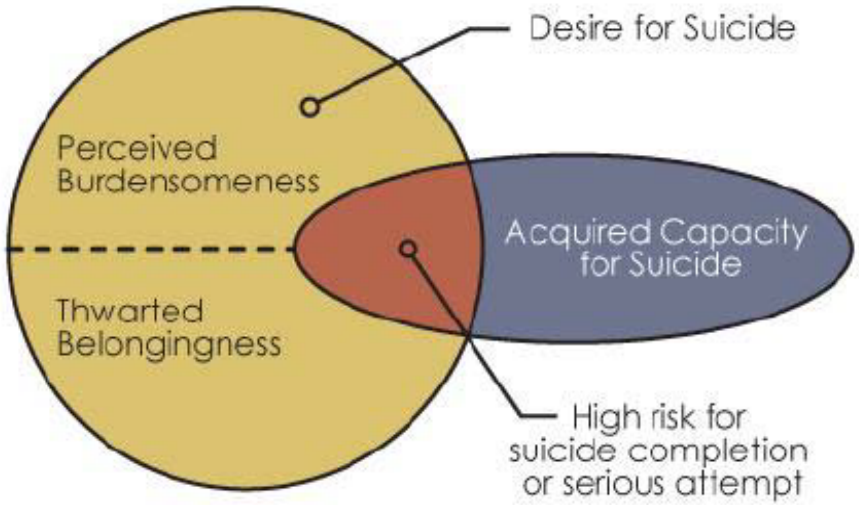


Figure 1: Thomas Joiner's model of suicide risk, 2006

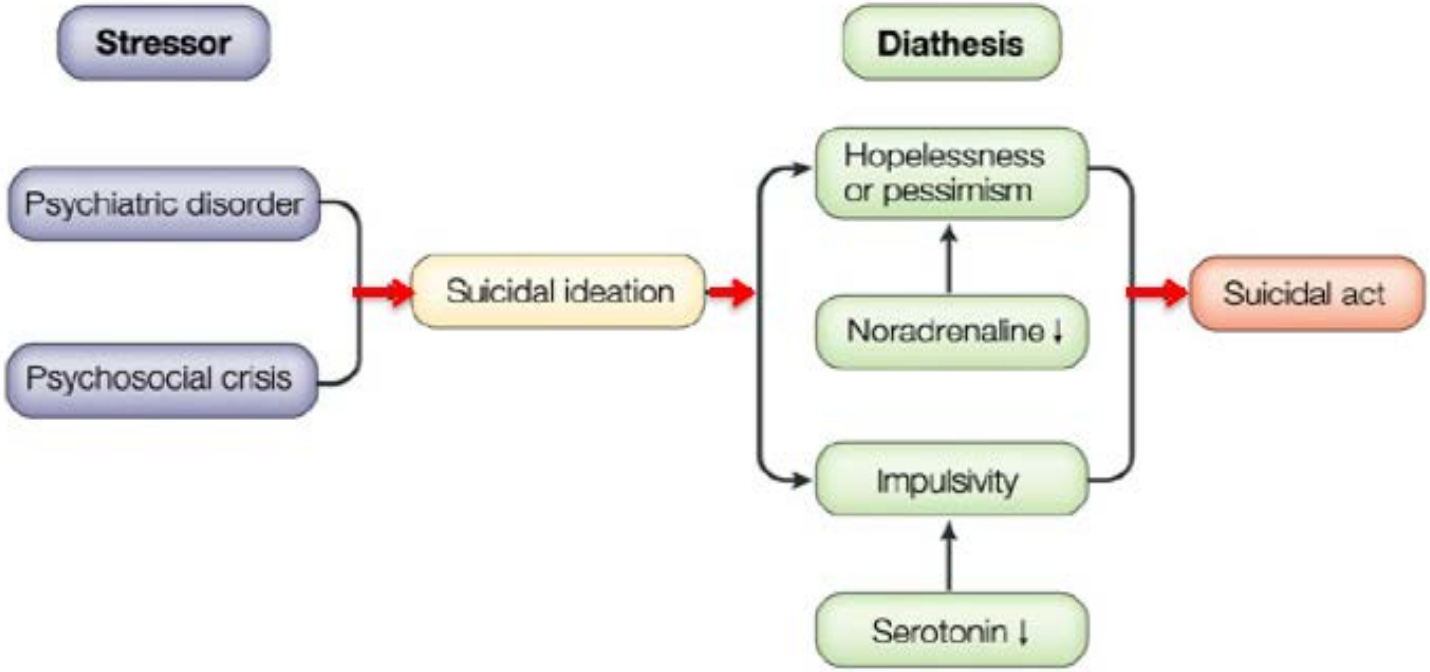
Wanting death is composed of two psychological experiences:

✓a perception of being a burden to others - *perceived burdensomeness*

✓social disconnection to something larger than oneself - *thwarted belongingness*

In general, males and older adults tend to have experiences that prepare them to tackle barriers of self-preservation in ways females and younger people do not.

Stress-Diathesis Model of suicidal behaviour



Nature Reviews | Neuroscience

Source: Mann, 2003

Restriction of means

- ✓ Restricting means to suicide is an effective suicide prevention method. It helps to ensure suicide methods such as firearms, drugs, or jumping sites are not readily available; it may also consequently affect whether these methods are eventually considered to be less socially acceptable.
- ✓ Restrictions on alcohol consumption have been associated with decreased suicide rates in high consumption countries.

  International studies have demonstrated that restricting access to alcohol has had a positive effect on suicide rates in Russia, Estonia, Slovenia, the United States, Denmark, Iceland

Peer support

- ✓ Help from within the *community or a peer group* may be preferable to contacting professionals.
- ✓ The mental (as well as physical) wellbeing of young men can be improved through activities attractive to this target group such as *sport*, where peer-to-peer support can work well.
- ✓ Older men may benefit most from suicide prevention efforts that allow them to be *more social* and spend time with, and talk to their peers, as well as doing things that make them feel more useful to the community.
- ✓ Gay and bisexual men are at increased risk of suicide due to issues, including discrimination and feelings of isolation, and would benefit from peer support.
- ✓ Peer support appears to be beneficial when dealing with *loss and grief*.

Help seeking

- ✓ Australian males' help-seeking behaviours are negatively influenced by *masculine stereotypes*. This is particularly so in young males aged 16-24 years.
- ✓ Negative attitudes towards help seeking and a perceived need for autonomy are strong barriers to help seeking among young males.
- ✓ Australian males compared to females who had suicide plan are less likely to perceive the need for help.

Conclusion

- Men are more likely to commit suicide due a combination of:
  - They are more likely to acquire the capacity to capable of following through with suicide
  - Less likely to seek help due to masculine stereotypes created by society
  - Neurobiological factors, likely compounded by the use of a depressant drug
  - Changes in relationship or employment
  - Feelings of being burdensome or incompatible with society.

Continued Conclusion

- USA and Australia have similar metrics of suicide:
  - Australia trends higher per 100,000 in successful suicides (approx 16) versus the USA (approx 11) even though it is one of the strictest firearm countries in the world
  - Rates of suicide seem to be higher in areas where it is harder to live (rural) in both Australia and the USA
- A minor trend upwards in firearm suicides started in 1987(approx) when the National committee on Violence was commissioned, previous to this a slight trend upwards was noted, followed by a new trend down until 2006 where a trend up appears to be starting
- Firearm restrictions of 1997 correlate with a sharp uptick in firearm suicides during the buyback/registration period, but otherwise overall trend in suicide frequency did not change. Firearm specific suicides did decline slightly but were replaced with other means.

Continued Conclusion

- Rural living is a factor
- Access to firearms does not appear to be a factor in suicides other than it is utilized when available.

How to Help?

- More research is needed, specifically in the areas of:
  - Rural living
  - Neurobiological factors
  - Overcoming the instinct for survival
    - Does this equate to Veterans?
    - Does this equate to public service like Police/ Fire?
- Create funding towards education and treatment for those whom demonstrate suicidal tendencies.
- Create funding to get education to the loved ones of people whom demonstrate suicidal tendencies.

Suicide in England

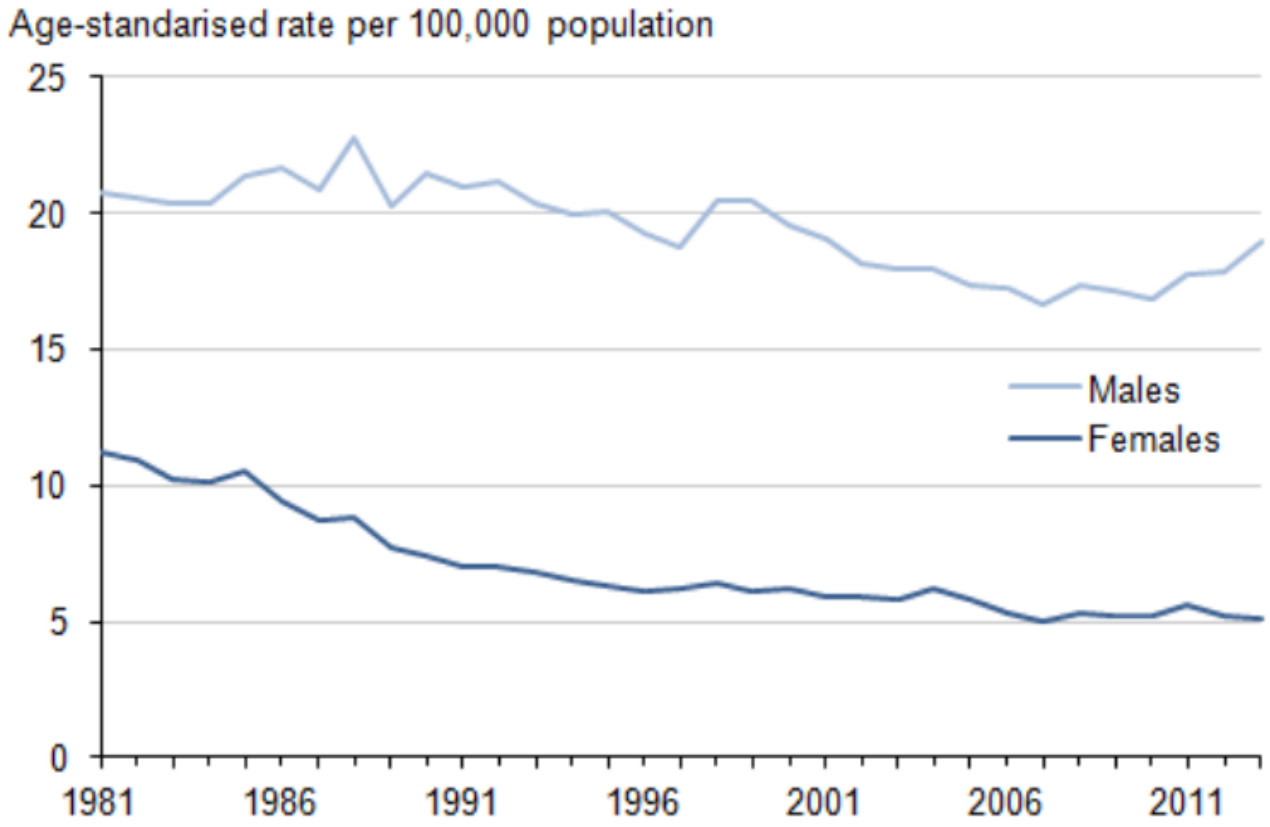
Short review suicide statistics realeased by England's Office of National Statistics

By: Peter Rudloff

England

2013

United Kingdom



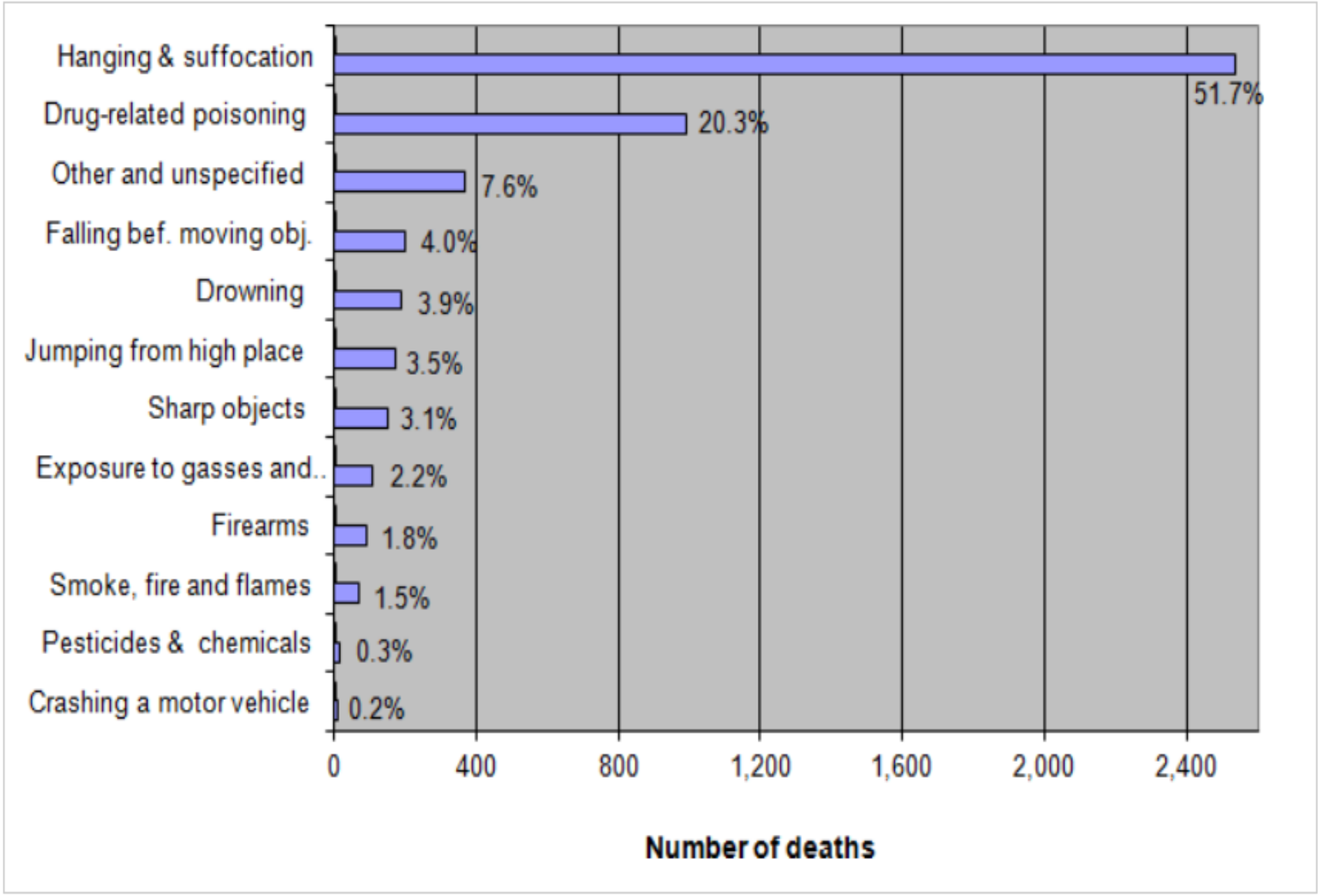
Source: Office for National Statistics, Northern Ireland Statistics and Research Agency, National Records of Scotland

Age standardised suicide rate						
By gender and age group, United Kingdom (2006–2010), rate per 100,000 people						
	Male			Female		
Year	15-44	45-74	75+	15-44	45-74	75+
2006	17.7	17.3	14.9	4.4	6.6	4.5
2007	17.6	16.0	15.2	4.2	6.2	4.3
2008	18.6	17.0	13.9	4.9	6.1	4.5
2009	18.0	17.4	13.6	4.9	5.8	4.7
2010	16.7	17.7	14.6	4.8	6.0	4.2

Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency[2]

Suicide rate		
By gender; United Kingdom (2006–2013), rate per 100,000 people		
Year	Male	Female
2006	17.4	5.3
2007	16.8	5.0
2008	17.7	5.4
2009	17.5	5.2
2010	17.0	5.3
2011	18.2	5.6
2012	18.2	5.2
2013	19.0	5.1
Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency[2]		

Deaths by self harm and undetermined intent in England & Wales 2011



English regions

In 2013, the suicide rate was highest in the North East at 13.8 deaths per 100,000 population and lowest in London at 7.9 per 100,000 (see table 1). Reference table 5 shows that over the last 16 years (1998 to 2013) suicide rates have tended to be highest in the North East, the North West and South West; the lowest rates tend to be in London and the East of England. The age-standardised all persons rate of 7.9 deaths per 100,000 population in London in 2013 was the lowest rate of any region since 1981.

Conclusion

- England combined suicide rate is approx 12 per 100,000, compared to USA's rate of 6 per 100,000
- England's male suicide rate is currently near 19 per 100,000 versus USA rate of approx 11per 100,000
- Hanging is the most effective means of suicide in England, over 50% reported

Conclusion continued

- In 1997 England enacted a law that basically eliminated firearm ownership from all citizens
- Previous to this law, suicides were trending down at a slight rate
- Firearm suicides spiked during the confiscation period then continued a slow trend down until about 2010 where an upward trend started

Noted Correlations

- When the USA, United Kingdom and Australia are compared, areas of commonality are:
  - Males are more successful at suicide than females
  - Females attempt suicide more often
  - Rural living is a factor
- Firearm availability did not correlate to successful attempts per 100,000 people, in fact in countries where firearms are heavily restricted successful attempts are higher
- Neurobiological factors have great potential to unlocking causes of suicides
- What doesn't work overseas is unlikely to work here in the USA

How to Help

- More research is needed, specifically in the areas of:
  - Rural living
  - Neurobiological factors
- Create funding towards education and treatment for those whom demonstrate suicidal tendencies.
- Create funding to get education to the loved ones of people whom demonstrate suicidal tendencies.