New York State Bridge Authority

In Partnership With

Hudson River Coalition for the Prevention of Suicide

Utilizing

National Suicide Prevention Lifeline Network

A Comprehensive Plan for Suicide Prevention, Education and Awareness

A Comprehensive Plan for Suicide Prevention
New York State Bridge Authority

New York State Bridge Authority

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Executive Summary

Of all the challenges posed by suicide, one of the most difficult is the widely-held belief that we can do little to prevent or control such destructive behavior.

Depression is a primary cause of suicidal behavior. Depression is treatable in 80% of cases which means most suicides are preventable. Educating the public to this truth is critical to the efforts at making our communities safe from suicidal behavior.

The Golden Gate Bridge is the most studied bridge in the world as it relates to suicide risk management. Many years of study at the Golden Gate conclude that if a suicidal person can be helped through his/her crises, one at a time, chances are extremely good that he/she won't die by suicide later. The difference between entertaining suicidal thoughts and acting on them can be as basic as having a casual encounter with a person - anyone - who exhibits concern and empathy.

The ambivalence of bridge jumpers and survivors points to a key strategy for saving lives:

Maintaining a human connection with a suicidal individual is the best way to ensure that person's survival.

These findings underscore the need for a universal hotline service able to reach individuals in remote locations, including the walkways on bridges, and provide emotional support and advice to those in danger of harming themselves.

Constructing a 'Human Barrier' against Suicide

Preventing suicides on NYSBA's bridges will most likely occur if we recognize the situation for what it is: a mental health problem that won't be solved by a technical 'quick fix' in the form of a 'curtain of steel' twenty miles long (the approximately length of all the spans of the five bridges).

Rather, it will only be solved by addressing the needs of the people who are drawn to these bridges out of desperation by partnering with mental health professionals who know how to assess, refer and treat those in danger of self-harm.

NYSBA can instead construct a 'human barrier' that will outperform any physical barrier and save more lives. Moreover, it will do so without posing dangers to the motoring public as a physical barrier on the bridges could do.

A System-Wide Solution

Based on the advice of mental health professionals, the most appropriate approach for the NYSBA is to implement a comprehensive package that utilizes technology, awareness and informed intervention.

It is neither appropriate nor sufficient to deny access to the bridges by pedestrians. These spans are historic and integral components of the federally designated Hudson River Heritage Area. Previous discussions about limiting access have resulted in strong opposition from historic, environmental and cultural institutions.

The NYSBA also must keep its primary function, the efficient and safe passage of vehicles across the Hudson River, in mind. Certain barriers will significantly impact regular inspection and maintenance operations, cause extensive delays and costs in implementation, and divert the Authority from its primary task.

In addition, limiting access might temporarily defer a potential suicide attempt, but does nothing towards the desired outcome of long-term suicide prevention. Getting appropriate help to those who need it is the best approach.

Every feasible effort to prevent a potential suicide should be made. To this end and after extensive review of suicide mitigation efforts by bridge and transportation agencies both nationally and internationally, the following summarizes the results of the investigation.

In addition, this solution may serve as a prototype for other entities in similar situations. Results of our study have been requested by the International Bridge, Tunnel & Turnpike Association (IBTTA) and several individual facility operators around the nation.

This analysis keeps in focus two primary points:

- Incidents of suicide (attempts and completions)are low;

- However, the Authority recognizes the emotional and public impact of this type of suicide and desires to take all reasonable actions available to uphold its public stewardship and responsibility.

The NYSBA Plan for Suicide Prevention & Saving Lives

- Implementing A Suicide Prevention Hotline Service On Every Bridge
- Conduct Education & Awareness Campaigns For The Community
- Emergency Call Training For Personnel
- Re-Emphasize Random Patrols
- CCTV Cameras Will Continue To Be Added To Bridges

Suicide Prevention Hotline Services

Professionals in the field of mental health overwhelmingly agree that qualified intervention is the best way to try to stop a potential suicide and establish a process for long-term prevention of suicide.

Getting the potential victim to make the call or seek help is an ongoing challenge. Awareness of the option and the ability to make the call are additional factors.

The most significant change since the last time this issue was examined by the NYSBA is that a centralized, nation-wide suicide prevention hotline now exists. **Lifeline** will provide a connection/referral service to a qualified suicide prevention counselor from anywhere in the country via a 1-800 phone number. The issue of where to send the call for locations other than the MHB has been solved.

NYSBA will implement a direct communication system to Lifeline on the Bear Mountain Bridge (BMB), Newburgh-Beacon Bridge (NBB), Kingston-Rhinecliff Bridge (KRB) and Rip Van Winkle (RVW) Bridge as soon as possible, starting with the KRB. The successful system on the Mid-Hudson Bridge (MHB) will be maintained.

Education & Awareness

While not detracting from our primary mission, the Authority, as a public entity with extensive contact with the community, will also play a role in education and awareness by making use of its facilities and resources to inform the public that suicide is a serious, and largely preventable, act.

NYSBA will also partner with the Hudson River Coalition for the Prevention of Suicide to increase awareness and assist their efforts to address this serious issue.

A combination of signage, access to Lifeline and assistance in promotion of the help available to potential suicide victims are all aspects that the NYSBA will implement.

Media coverage of potential suicide on bridges can have a significant impact. The "copycat" syndrome is well documented. Media awareness of their impact on suicide prevention is important.

In addition, the media can serve a vital role in making the public aware of the real issues involving suicide and the alternatives available.

With the assistance of the Hudson Valley Suicide Prevention Coalition and St. Francis Hospital, the NYSBA will sponsor an educational seminar, hopefully in partnership with media outlets throughout the Hudson Valley, to increase public awareness that suicide is largely preventable and that preventative help for those in mental distress is available

Emergency Call training for personnel

Whether it's a potential suicide, security threat, bomb threat, traumatic accident or any other emergency situation, how our personnel respond is important. Whether it is by motorist aid call box, cell phone call or physical encounter – our personnel will receive additional training in procedures for receiving an emergency call.

The New York State Police have an effective training program for their civilian dispatchers. They are given the primary do's and don'ts, a protocol to be followed and some basic techniques that allow the call to be taken and fully trained emergency services to be dispatched in the most professional and expeditious manner possible.

In addition, basic protocol exists should any person encounter a potentially suicidal individual. Mental health professionals will assist NYSBA in developing this protocol specifically for the type of situations a bridge employee might face.

NYSBA will make it clear that our employees are not crisis intervention specialists and will not be tasked with a role more appropriately accomplished by trained emergency response personnel.

Our personnel will be given the same level of emergency call response training and guidelines should they personally encounter a situation on one of our structures.

Patrols

Patrols are regularly conducted by law enforcement agencies and bridge personnel. These patrols are random. Patrols will be re-emphasized and additional training will be sought for bridge personnel (see above).

CCTV

Monitoring by remote cameras is already available on a number of the spans. These cameras are used primarily for internal traffic information. They may also be used as an emergency response and security tool.

The multi-year project to add security cameras will continue.

Key Points

NYS Bridge Authority Action

Because suicide from a Bridge Authority facility has a public impact beyond the individual tragedy, the Authority will act to try to prevent even these very low incidences.

We have conducted extensive research and sought the best advice from mental health professionals on how to address the issue. We have also worked to solved technical issues that prevented the system used at the Mid-Hudson Bridge from being used at other facilities.

The Comprehensive Plan is the culmination of the 'best practices' conclusions of our technology department and advice and direction of state and national experts in the field of suicide prevention.

The objective is to implement a plan to construct a 'Human Barrier' by providing immediate mental health services to anyone in crisis at an Authority facility.

Incidents of Suicide at NYS Bridge Authority Facilities

Incidents are few and rare. For the last year in which suicide statistics are available (2004), suicides at Authority facilities comprise less than 1/20th of 1% of suicides in NYS, and NYS has one the lowest suicide rate of any state in the nation.

Until the two recent incidents at the one facility in late 2006, there had been no suicide at any Authority facility in more than 2 years. (The NYS Bridge Authority has not kept specific statistics regarding suicide incidents; the following data is compiled from a variety of news reports):

2006	Kingston-Rhinecliff Bridge (2)	2004	Bear Mountain Bridge (1)
2003	Rip Van Winkle Bridge (1)	2003	Kingston-Rhinecliff Bridge (1)
2002	Mid-Hudson Bridge (1)		

Beginning with the installation of the Lifeline Network, the Bridge Authority will keep data on bridge incidents that we are made aware of.

Public Comment & Discussion of Suicide

Long-standing written policy of the NYS Bridge Authority is to not comment on specific instances of suicide in concurrence with the advice of mental health professional that such discussion could lead to further tragedy and the well documented "copycat syndrome".

The Bridge Authority has been advised to and will continue to follow this sound advice in any discussion of suicide prevention measures. We will discuss these measures at an appropriate time and place with the focus on preventative action. The Bridge Authority will not indulge any effort to sensationalize the issue or otherwise jeopardize the lives of vulnerable individuals.

A COMPREHENSIVE PLAN TO PREVENT SUICIDES AND SAVE LIVES ON NYSBA BRIDGES

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New York residents complete suicide by jumping from heights more than those of any other state besides California, and they do it at nearly three times the national rate. (CDC: 2004) Many of these jumping deaths occur in New York City, mostly Manhattan, from the rooftops and parapets of high-rise buildings, and especially among the elderly, from the windows of their homes. (Abrams et al.: 2005)

The Dutchess County Mental Health Commissioner has characterized jumps from area bridges as "a low frequency method" of a "low frequency occurrence" (suicide) (1/31/07). The statistics on suicide at the Mid-Hudson Bridge indicate seven people exited this way from 1984 to 2006, an average of one death every three years. At the same time, 74 people were potentially saved; 60 were transported to St. Francis Hospital: 38 required in-patient care and 7 others out-patient care as a result of using the crisis phones installed on the bridge for that purpose. Of the 8 individuals who jumped from 1984-2006, only 1 had used the phone previously.

Suicide statistics are often considered suspect, because there are powerful cultural and personal reasons for under-counting suicides to spare the family the stigma that attaches to suicide. Even so, more people kill themselves than each other by a wide margin in New York: 1,187 vs. 860. (CDC: 2004) Most people find that statistic surprising; however, most mental health professionals do not. There is a powerful association of mental illness and suicide. For every completed suicide, there are 25 attempts. Each attempt makes a succeeding one more likely.

Although suicides are a "low frequency occurrence", numbers alone do not convey the impact on the community created by a leap from a structure as imposing as a bridge spanning the Hudson River, where thousands of vehicles pass each day. A personal tragedy in such a setting can become a public spectacle. Such an act can and often does create copycat suicides, or "suicide contagion". A single suicide can prey on the vulnerability the public senses when they view the site on the bridge where the suicide originated. Some people memorialize the location with flowers; others look the other way. Either way, it has an impact on people.

The recent fatal jumps from the Kingston-Rhinecliff Bridge and the near-attempt on the Newburgh-Beacon Bridge have raised concerns regarding the safety and security of the bridges operated by the New York State Bridge Authority. The following plan addresses these concerns and sets forth a comprehensive strategy designed to reassure the public while saving lives. The Bridge Authority cannot solve a human problem - suicide - by blind reliance on technology alone. The strategy that follows is comprehensive, prevention-oriented and emphasizes "human factors" combined with the latest communication tools.

The approach advocated takes full advantage of recent advances in suicide prevention; developments that didn't exist before 2005. In that year, the state completed drafting of its comprehensive statewide prevention plan, based on a three-year study by some of the leading experts on the subject. The report confirmed that suicide and mental illness are closely linked, especially mood disorders that go undiagnosed and untreated. It established that suicide is preventable and that several evidence-based practices exist and are available. Based on this plan, last year, for the very first time, the Governor and Legislature, allocated $1.5 million to fight suicide. Governor Spitzer has continued this funding in the 2007-08 Executive Budget.

Also, in 2005, **Lifeline** came into existence with the full support of the federal and state government, suicide prevention advocates, experts, and survivors. **Lifeline** makes possible an integrated, state of the art communications system to reach suicidal individuals on NYSBA bridges and maximize the chances of their safe rescue. Without these three key advances: a written statewide plan, supported by real state dollars, and featuring **Lifeline**, we would be addressing the challenges of bridge safety alone. Now, NYSBA has partners and we want this partnership to flourish. The end result will be safer bridges and fewer lives lost.

Suicide Prevalence

Each year nearly 1,200 New Yorkers lose their lives to suicide, a number that is 38 percent higher than the number of lives claimed by homicide. Between 25,000 and 30,000 individuals require medical treatment in emergency rooms and even more are seen in doctors' offices and clinics for self-inflicted injuries. Thousands of family members, friends, co-workers and neighbors are left behind to grieve their loss, in an atmosphere of stigma, shame and frequently guilt. Even when suicide acts are not completed, the injuries inflicted can be long-lasting and permanently disfiguring.

While the rate of suicide in New York is below the national average, New York ranks fifth among the states in the numbers of lives lost to suicide each year. Suicide claims victims as young as eight years old and as old as 85, and few communities are completely spared its pain. The typical New York suicide victim is a white male who is 35 years or older who lives alone, upstate, suffers from depression and ends his life by means of a firearm. Men comprise nearly 80% of suicide victims, while women make more attempts by a ratio of 3:2. A major reason for this difference is that men tend to use more violent and lethal means to end their lives. A psychiatric disorder is involved in approximately 90% of suicide cases, especially mood disorders (major depression, bipolar disorder, dysthmia) that remain untreated in 80% of cases.

Ethnically, the suicide rate of is significantly higher for white New Yorkers than for persons of color (Native Americans, Hispanics, African Americans and Asian Americans). For all race and ethnic groups, the suicide rate rises with age and Asian women over 65 are at elevated risk. However, the numbers of suicide attempts peak in the 15-24 age group, with females typically using self-inflicted poisons, usually over-the-counter drugs or by cutting themselves. While these attempts are rarely fatal, once an individual has attempted suicide, he/she is much more likely to attempt it again. Still, 70% of those who die from suicide do it on the very first attempt. This epidemiological finding underscores the need for preventing every suicide attempt. We may get only one chance to save that person's life.

Suicide Methods

Of all the ways people use to end their lives, firearms and suffocation are the most common in New York (33.3% for each), followed by poisoning (12%), falls/jumps (10.2%), cut/pierce (3.3%), drowning (1.9%), and burns from fire (.2%). Although suicide from a bridge structure comprises a small percentage of the total, it is significant for the New York State Bridge Authority that suicide by falls, including jumps from heights, occurs much more frequently in New York than the rest of the country. In 2004, 121 New Yorkers - or 10.2% of all suicides - died this way, a rate that is three times the national average and nearly three times the average in California, the state best known for bridge-jumping.

In fact, according to the Centers for Disease Control and Prevention, fully one in six Americans (17.8%) who took their life in 2004 by falls/jumps was a New York resident. This figure stands out because New Yorkers comprise just 4% of all Americans who will die by suicide this year. (1,200/31,000). This means death from intentional jumping from heights is involved in a disproportionate number of suicides by a factor greater than 4.

While bridge jumping is not specified on most coroners' reports as a cause of death, it is reasonable to infer that such structures pose an elevated risk as do residential skyscrapers in New York City, NYU dormitories and the gorges near the Cornell University campus in Ithaca. (Abrams et al.: 2005; Arneson: 2005; Blum: 2005) All of these locations have been the scene of multiple suicides in recent years.

Figure 1. Suicide by falls/jumps in New York also varies by age:
(Both Sexes, All Ages, 2004)

Age-Group	# of Deaths by falls/jumps	% of all Suicides/age-group
15-24	20	11.9
25-34	11	6.0
35-44	28	12.1
45-54	17	7.1
55-64	14	8.9
65-85+	31	15.7
All Age-Groups TOTAL	121	10.2

Source: Centers for Disease Control and Prevention, ***WISQARS***, retrieved January 29, 2007

One explanation for the higher rate of falls/ jumps among the elderly is that they tend to use more lethal means of suicide, they are less likely to be revived from an attempt; and it requires less manual dexterity to open a window in a high-rise residence than to concoct a lethal cocktail or obtain a handgun and ammunition in the City of New York.

Location

When it comes to the prevalence of suicide, geography matters. Across New York, there are significant regional differences in completed and attempted suicides, irrespective of ethnicity, religion, age, culture or gender. Specific places also matter. Locations of suicidal acts can evolve into 'magnets' for future acts of self-destruction as the 'fatal attraction' of the Golden Gate Bridge in San Francisco demonstrates. (Friend: 2003)

Geographically, the Hudson River region ranks in the middle of the state's regions with respect to the numbers of adolescent and general population suicides and self-inflicted injuries. As the ***Saving Lives in New York*** report on suicide (2005) documented, across the state Central and Northeastern New York experience the most completed and attempted suicides, and New York City and Long Island the least. This follows a national and worldwide trend which links suicidal behavior with rural life. In effect, the sparser the population in a given geographic area, the greater the prevalence of suicidal behavior.

Following is a breakdown of completed suicides for the past five years (2000-04) for which data is available in the eleven counties comprising the mid-and lower- Hudson River region, arranged in alphabetical order, and containing (1) the number of suicides and (2) the annual rate expressed in # per 100,000.

Figure 2. Suicide deaths and rates per 100,000 in mid- and lower Hudson River counties, 2000-2004.

County	2004	2003	2002	2001	2000
Albany	18 (6.0)	19 (6.4)	30 (10.1)	17 (5.8)	19 (6.5)
Columbia	4 (6.3)	7 (11.0)	6 (9.4)	7 (11.1)	6 (9.5)
Dutchess	16 (5.5)	12 (4.1)	15 (5.2)	16 (5.6)	23 (8.2)
Greene	3 (6.1)	6 (12.3)	5 (10.3)	4 (8.3)	5 (10.4)
Orange	28 (7.6)	14 (3.9)	25 (7.0)	27 (7.7)	28 (8.2)
Putnam	8 (8.0)	6 (6.0)	5 (5.1)	7 (7.2)	4 (4.2)
Rensselaer	19 (12.3)	13 (8.4)	14 (9.1)	11 (7.2)	10 (6.6)
Rockland	6 (2.0)	9(3.1)	14 (4.8)	18 (6.2)	10 (3.5)
Sullivan	8 (10.5)	4 (5.3)	13 (17.5)	9 (12.2)	12 (16.2)
Ulster	8 (4.4)	9 (5.0)	14 (7.8)	19 (10.7)	18 (10.1)
Westchester	38 (4.0)	38 (4.0)	49 (5.2)	62 (6.6)	52 (5.6)
TOTALS	156 (6.6)	137 (6.3)	190 (8.3)	197 (8.1)	187 (8.1)

Source: NYSDOH: New York State County Health Indicator Profiles, 2000-04 (Revised: July 2006)

The data shows there has been an overall decline in suicides region-wide over the past five years and the smaller the county population, the higher the suicide rate: the average rate for the three most populous counties (Westchester, Orange, Albany) in the Hudson Valley over this period is 6.3 deaths per 100,000; for the three least populated counties (Greene, Columbia, and Sullivan) it is 10.4 deaths per 100,000.

Fatalism

Of all the challenges posed by suicide, one of the most difficult is the widely-held belief that little can be done to prevent or control such destructive behavior. So long as this belief is widely held in the public mind; the task of focusing attention and resources on the problem is much more difficult. The stigma in our culture attached to both mental illness and suicide provides a "rationale" for ignoring both. Silence, reinforced by stigma and shame, and suicide go hand-in-hand.

Efforts at the state and federal level in the past ten years, combined with a citizens' movement and enlightened individuals, have contributed much to countering the belief that we are powerless to prevent suicides and other life-threatening behaviors. Suicide was once regarded as an individual/family tragedy that occurred unpredictably and could not be prevented. This view has been challenged by developments in neurobiology, psychopharmacology and psychotherapy. The link between mental illness, especially mood disorders and suicide, is well-established. Reductions in the rate of suicide are partially attributable to the development and use of antidepressant medications and cognitive-behavioral and other "talk therapies." Depression is treatable in 80% of cases, which means most suicides are preventable.

Educating the public to this truth is critical to the state's efforts at making our communities safe from suicidal behavior. To this end, the Office of Mental Health launched a statewide campaign, Suicide Prevention Education and Awareness Kit (**SPEAK**), in 2004 to counter the myths around suicide, help people recognize the danger signs that portend self-destructive behavior in family and acquaintances and instruct them how and when to take action to save a life.

Differences between men and women and sociality are real. Women are more likely to be "early adopters" of healthy behaviors than men. One reason why fewer women die by suicide, compared to men, despite more of them being diagnosed with depression, is that women are much more likely to see their health care providers more regularly, accept the diagnosis they receive and follow the prescribed therapies that have proven to be effective. Men are much more likely to be ignorant of the symptoms of depression, or regard them as a sign of weakness or a failure of will. (***Saving Lives in New York,*** vol. 2: 2005)

Instead of consulting a health care provider, men are more likely to "tough it out" and endure the misery of untreated depression or self-medicate with alcohol or recreational drugs in the search for relief. Far too often they spiral down into a desperate state and seek relief from a pain so unbearable that death itself is seen as the only means of relief. To address the problem, the Surgeon General of the United States has launched a public education campaign (***Real Men, Real Depression***). Its goal is to encourage men to recognize depressive symptoms and seek treatment.

Lessons from the Golden Gate Bridge

The Golden Gate Bridge is the most studied bridge in the world as it relates to suicide risk management. One of its lessons is powerful evidence that some suicides are impulsive. A classic study of 515 persons prevented from jumping from the Golden Gate Bridge found that 94% of those had died from natural causes or were still alive 25 years later. The belief that Golden Gate bridge attempters will simply go elsewhere to kill themselves was clearly unsupported by the data. The 1978 study, *Where Are They Now?* "confirmed previous observations that suicidal behavior is crisis-oriented and acute in nature. It concluded that if a suicidal person can be helped through his/her crises, one at a time, chances are extremely good that he/she won't die by suicide later." (Friend: 2003) Accordingly, "The justification for prevention and intervention...is warranted and the prognosis for suicide attempters is...on balance, relatively hopeful." (Seiden: 1978)

Research has shown that many suicide attempters are deeply conflicted about ending their life, even when they despair. The will to live is a powerful force that is hard to extinguish even among individuals faced with the most dire circumstances. (Gonzales: 2003) Survival is imprinted in our genes and reinforced by human culture and religion. Family and community support, support from ongoing medical and mental health care relationships, access to a variety of clinical interventions and support for help-seeking behavior can dissuade a would-be suicide.

Every suicidal act requires a means of self-harm. Limiting access to means of self-harm, therefore, can be an effective way to prevent self-destructive behavior. The name of this strategy is 'means restriction'. The goal is to separate, in time and space, the individual experiencing an acute suicidal crisis from easy access to lethal means of self-injury and personal harm. By making it harder for someone intent on self-harm to act on that impulse by denying them access to the means to accomplish it, buys time for the crisis to pass and for healing and recovery to occur. Alcohol, which lowers inhibitions, is frequently implicated in suicidal behavior, especially when it involves someone who is impulsive. Alcohol is also a depressive and can intensify the despair that emanates from a mood disorder, making recovery more difficult.

Human Factors

The difference between entertaining suicidal thoughts and acting on them can be as basic as having a casual encounter with a person - anyone - who exhibits concern and empathy.

Interviews with people who were talked out of jumping from the Golden Gate Bridge found that many people were deeply ambivalent about making the jump, even after they stepped over the railing and stood on the chord. Some realized they made a mistake in jumping during the four seconds it takes to reach the water. Only 2% of Golden Gate jumpers survive the 220 foot fall, but among those was one individual who recalled feeling that "everything in my life that I'd thought was unfixable was totally fixable - except for having just jumped." (Friend: 2003)

Ambivalence

The ambivalence of bridge jumpers and survivors points to a key strategy for saving lives. Maintaining a human connection with a suicidal individual is the best way to ensure that person's survival.

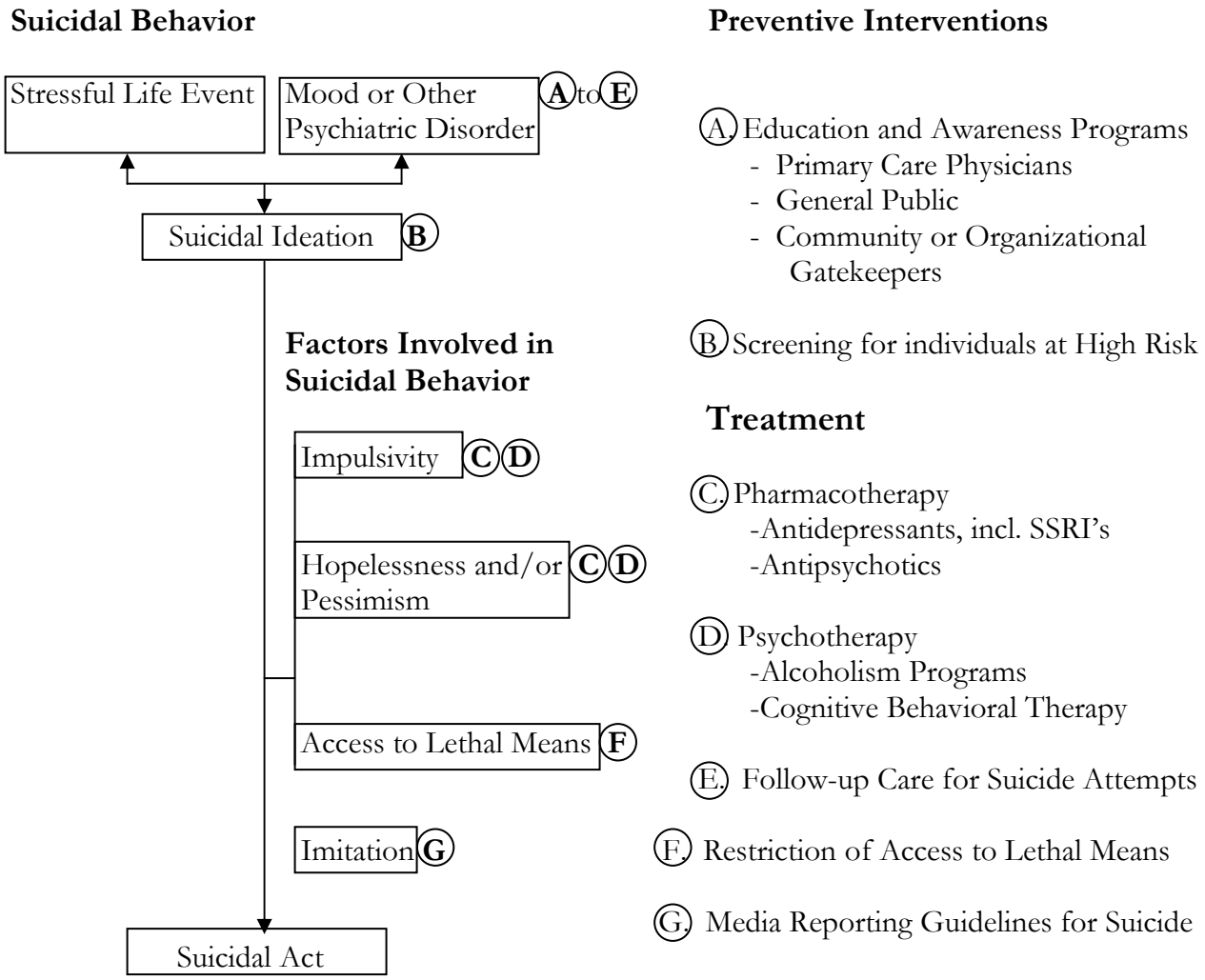
"The system in use on the Golden Gate Bridge is the "non-physical barrier". Its components include numerous security cameras and thirteen telephones, which potential suicides or alarmed passersby can use to reach the bridge's control tower. The most important element is randomly scheduled patrols by California Highway patrolmen and Golden Gate Bridge personnel in squad cars and on foot, bicycle and motorcycle." (Friend: 2003) These findings underscore the need for a universal hotline service able to reach individuals in remote locations, including the walkways on bridges, and provide emotional support and advice to those in danger of harming themselves.

Suicide Prevention Strategies

Designing and implementing a plan to curb suicides by bridge-jumping requires an overview of what is involved in the decision to end one's own life. A definitive study of all suicide prevention strategies devised worldwide was published in the Journal of the American Medical Association on October 26, 2005. Its lead author was Dr. J. John Mann, MD of Columbia University and the New York State Psychiatric Institute. Dr. Mann is also very familiar with the suicide problem in New York, as a member of the New York State Suicide Prevention Council. The purpose of the article was to determine which prevention strategies have been proven to work, and actually save lives, and those that have promise.

Figure 3 shows the elements of the decision process, and ways that have been devised to modify the outcome and save lives. Circled letters refer to relevant prevention interventions listed on right.

Figure 3. Targets of Suicide Prevention Interventions



Source: J.John Mann, MD et al., *Suicide Prevention Strategies: A Systematic Review*, ***JAMA***, October 26, 2005, vol. 294, no.16, 2064-2074.

The Mann task force found that two strategies stood out in preventing suicide:

(A). education and awareness programs for primary care physicians aimed at improving their skills at identifying and treating depression in their patients; and

(F). restriction of access to lethal means for the reasons cited above (pg. 6) Among the specific restrictions found effective are: firearm control legislation; restrictions on pesticides; detoxification of domestic gas; restrictions on barbiturates; blister packaging of analgesics, catalytic converter use on motor vehicles; and use of new lower toxicity anti-depressants (SSRI's).

Other strategies: (B). screening), (C). pharmacotherapy, (D). psychotherapy, (E). follow-up care for suicide attempts, and (G) media reporting guidelines for suicide, could be helpful components of a comprehensive strategy, but further evaluation is required to certify them as effective deterrents to suicide on a stand-alone basis. The New York State prevention plan endorses their use in combination with (A) and (F).

Lessons from the Mid-Hudson Bridge

While the Golden Gate Bridge has lessons for prevention, so does the Mid-Hudson Bridge. In 1984, two emergency call boxes were placed on the Bridge to offer people considering suicide a chance to seek help. The phones are accompanied by signs urging people considering suicide to call and assuring them that help is available 24 hours a day. It is believed to be the first such arrangement in the country in which crisis intervention phones were placed at the likely sites of suicides.

Jumper Ambivalence

The Mid-Hudson Project was a collaborative effort between the Authority, the Dutchess County Mental Health Department, and St. Francis Hospital in Poughkeepsie. Its premise was the same as that voiced by officials at the Golden Gate Bridge Authority: "It is generally accepted clinically and has been found to be true by the numerous telephone hot-line services that sprung up in the early 70's, that most people who attempt are ambivalent right up to the last...there is part of them that wants to live and some that wants to die...We are offering them a last-resort type of alternative to killing themselves." (Dr. David Sherwood, clinical psychologist at the Dutchess County Mental Health Department, 1984)

Personal Connection

Dr. Kenneth Glatt, then, as now, the Dutchess County Commissioner of Mental Hygiene, found it significant that the very first question posed by the first user of the system was: "am I talking to a real person, or is this just a recorded message?" (Personal interview, January 31, 2007). A live voice is a connection - a spark of human life - that cannot be replicated or substituted for by an inanimate physical barrier.

This is a major reason why the system on the Mid-Hudson Bridge has been successful: it provides instantaneous communication to a trained mental-health professional, who knows exactly how to engage that individual and keep them talking and listening until help arrives on the scene. The premise of the bridge phone system is shared by operators of suicide 'hot lines' and mental health 'warm lines' everywhere: keep the caller engaged and move the conversation to a different place: that despite their despair, there is meaning and value in life, and that their death would diminish us all, especially their friends and family.

Effectiveness

The number of lives saved by the MHB call box system is impressive: since 1984, 60 people were transported from the MH Bridge to St. Francis Hospital, of whom 38 required hospitalization, and 7 required out-patient care. Of the 7 who jumped to their death, only 1 had used the phone prior to jumping. Of the 526 Dutchess County residents who completed suicide from 1981-2005, only 30, or just 5.7% chose jumping, (from buildings, bridges, or cliffs) as the means to their end. In Dr. Glatt's words: jumping or falling from heights is a low-frequency method to achieve a low-frequency occurrence (suicide). (Personal interview, January 31, 2007).

The success of the MH Bridge phone system is reflected in the steady decline in suicides of Dutchess County residents through the years: 1981-85 (141), 1986-90 (126), 1991-95 (98), 1996-2000 (86), and 2001-2005 (75). These numbers track the slow, but steady decline in suicides statewide following the peak year of 1994. (***Saving Lives in New York***, vol.3)

Constructing a 'Human Barrier' against Suicide

Preventing suicides on NYSBA's bridges will most likely occur if we recognize the situation for what it is: a mental health problem that won't be solved by a technical 'quick fix' in the form of a 'curtain of steel' twenty miles long (the approximately length of all the spans of the five bridges). Rather, it will only be solved by addressing the needs of the people who are drawn to these bridges out of desperation by partnering with mental health professionals who know how to assess, refer and treat those in danger of self-harm.

New York State's suicide prevention plan calls for an integrated strategy of identifying people at risk, and intervening with 'evidence-based' programs that reduce suicidality across the life span. (***Saving Lives in New York*: 2005**)

Building on the work of Dr. Ken Glatt and his staff, the crisis counselors at St. Francis Hospital, and the 22 years experience of the hotline, the **Lifeline** program, and new communication technologies, NYSBA can instead construct a 'human barrier' that will outperform any physical barrier and save more lives. Moreover, it will do so without posing dangers to the motoring public as a physical barrier on the bridges could do, as will be explained below.

The central lesson of the Golden Gate Bridge experience since 1937 and of the Mid-Hudson Bridge since 1984 is that a safety system built around human activity, detection and two-way communication technologies can prevent suicides and save lives. The Golden Gate is a magnet for would-be suicides, with people traveling long distances to the GG Bridge where they end their lives. As explained by Dr. Lanny Berman, Executive Director of the American Association of Suicidology, "Suicidal people have transformation fantasies and are prone to magical thinking, like children and psychotics. Jumpers are drawn to the Golden Gate because they believe it's a gateway to another place." (2003) Despite all the countermeasures in place, the 'fatal allure' of the GG Bridge claims, on average, one death every other week. (Friend: 2003)

None of the 5 spans operated by NYSBA come close to achieving a 'magnet -status' in terms of attracting suicide attempters. Quite the opposite is true.

The most active span for suicidal behavior is the Mid-Hudson due to its twin walkways and proximity to the urban population in the City of Poughkeepsie. Even so, the incidence of suicide attempts, much less completions, by bridge-jumping is low (60 individuals referred to St. Francis Hospital over a 22 year period averages out to 2-3 serious incidents a year and a completed suicide once every 3 years).

As discussed earlier, the call box system has prevented an overwhelming percentage of suicide attempts, despite the fact that the railings on the MH Bridge are sufficiently low that most ambulatory people could climb over them unaided.

Like the persistent minority in the Bay area who have pushed for installation of a physical barrier on the Golden Gate Bridge, there have been calls locally for a structural barrier (fencing, netting, extended railing, etc.) on the Kingston-Rhinecliff Bridge which has been the scene of two suicides in December. The logic behind the request for a barrier is that a suicidal individual would have to go to extraordinary lengths to go up and over or around and over a fixed (fence) or flexible (net) barrier to complete the act. Faced with a barrier, it is said most people would give up trying to jump and leave. Other proponents point to the fact that once installed, a barrier is always "on duty" regardless of weather conditions, time of day, etc. Finally, a physical barrier doesn't require the presence of a human being to do its job. It's engineered to perform its function for many years if properly maintained.

Physical Barriers: Pros and Cons

Physical barriers are effective deterrents in certain situations, such as preventing access to balconies or rooftops on buildings over three stories (Abrams et al.: 2005). However, retrofitting them on the NYSBA bridges poses real concerns:

--- They are expensive to construct and maintain, especially given the size of the spans across the Hudson River (the Kingston-Rhinecliff Bridge alone would require approximately three miles of fencing). Given limited funds, money saved by not installing a barrier could instead be used to fund other safety features on the bridges, e.g. reduce icing conditions, painting, signage, maintenance, etc., benefiting many more bridge users every day of the year.

--- Barriers create major safety problems for the motoring public by obstructing equipment (e.g. cherry pickers) used in safety inspections of a bridge's physical condition. A six, eight, or ten foot 'safety fence' could render the equipment purchased by NYSBA for inspecting the bridge deck and supports useless and a total waste of taxpayers' dollars.

--- Barriers can create additional safety problems as a result of creating wind resistance. Retrofitting modifications to the bridge design to mitigate this risk can be expensive. This would apply especially to the Kingston-Rhinecliff Bridge which is the tallest of the five bridges, the most wind-whipped, and the crossing most often mentioned as a candidate for a barrier by its advocates.

--- Snow-plowing and removal could be affected by the presence of a high barrier, by reducing the area available for plowed snow to accumulate and melt. This could lead to icing conditions on the roadway and create a hazard to the driving public.

--- Issues of aesthetics and historic character are involved in any consideration of installing barriers, especially on the three oldest bridges spanning the Hudson (Rip Van Winkle, Mid-Hudson and Bear Mountain). Given the proximity of these structures to other landmarks, e.g. Olana (RVW) and West Point (Bear Mountain), and the invaluable viewsheds involved, these barriers are a visual blight. They are clearly incompatible with any notion of a 'scenic Hudson'.

--- A physical barrier does nothing to address the suicidal condition of the person who might be tempted to jump from the bridge. Unlike the live voice at the receiving end of a callbox on the Mid-Hudson Bridge, a physical barrier does not give a desperate person a reason to live or serve as a listening post for the real or imagined motives for being on the bridge at that point in time. Rather, it provides society with a false sense of security that we have somehow addressed the needs of would-be suicides, so we can continue to ignore the root problem - their likely mental illness, which is probably treatable.

--- Barriers can pose an irresistible challenge to certain vulnerable people bent on jumping. It would not take much effort for such an individual to carry an extension ladder in a pickup truck, drive to the middle of the Kingston-Rhinecliff Bridge, unload the ladder in a pull-off area and use it to climb over the highest possible fence that could be erected. It could be done in a matter of a few minutes and well before help could be summoned. Some people don't even need a ladder: one man scaled the 10 foot high curved metal barrier on the Empire State Building Observation Deck, (***New York Times***: 12/1/04) and another climbed over the high curved fencing along a "suicide bridge" in Schenectady. (***Albany Times Union,*** 11/8/04) Despite valiant rescue attempts, both men died from their falls. In the Schenectady incident, the metal barrier prevented the responders from reaching the jumper in time to save him.

--- Steve Miccio, the Executive Director of PEOPLe, Inc., an advocacy group for the psychiatrically labeled, has concluded after the latest suicides in December 2006: "We need to understand the bridge (KRB) is not the problem. The problem...is the stigma, shame, and fear behind mental illness and the thoughts that surround suicide. It is a subject many are afraid to discuss, and it is a subject often misunderstood and undertreated or untreated...The solution is to stop making headline news and becoming proactive in preventing suicide through talking about it, writing about it and infusing awareness and prevention into the schools and communities." (***Poughkeepsie Journal***, 1/17/07)

RECOMMENDATIONS

1. Install and Operate Call Boxes on all NYSBA Bridges

While NYSBA crossings (Bear Mountain, Newburgh Beacon, and Rip Van Winkle) have motorist aid call boxes that connect by short-distance radio to the bridge office or maintenance personnel, the Mid-Hudson Bridge is unique in its phone hookup via microwave transmission to the Dutchess County Office of Mental Health Hotline in Poughkeepsie. The success of suicide prevention on the Mid Hudson Bridge over more than two decades is clear evidence that the system works. Recent innovations now make it possible to provide the same service for all bridges. All other bridges should install and maintain the most appropriate communication link to enable a suicidal person to have virtually instantaneous contact with the live voice of a trained and certified mental health professional. This professional would be able to engage the individual, empathize with their situation, and maintain contact until an emergency responder arrives at the scene.

2. Formalize a Working Partnership with Lifeline to Serve as the Provider of Hotline Services using the Most Appropriate, Current Communication Technologies

Lifeline, a/k/a, The National Suicide Prevention **Lifeline**, came into service on January 1, 2005. It is a national system for providing immediate assistance to people in suicidal crisis. It works by helping a person in crisis build trust, share fears, and take positive action. Callers get immediate access to local resources, referral for services, and mental health expertise by dialing (1-800-273-TALK). Callers to **Lifeline** will receive free and confidential suicide prevention counseling from staff at the closest certified center in their national network. In the Hudson Valley, these centers are:

Dutchess County Department of Mental Hygiene (Poughkeepsie)
LifeNet (New York City)
211 **Lifeline** (Rochester)

The **Lifeline** is a central component in the Substance Abuse and Mental Health Services Administration's ongoing plan to reduce the incidence and impact of suicide. The Mental Health Association of New York City and its partners, National Association of State Mental Health Program Directors, Columbia University/Research Foundation for Mental Hygiene, and Rutgers University Graduate School of Applied and Professional Psychology, were selected to administer the **Lifeline's** network of crisis centers based on their experience in providing mental health services through telephone technology and for their vision to expand the services that would be available to the American public.

"The purpose and promise of this national suicide hotline is to be there for people in their time of need," said **Lifeline** Director, Dr. John Draper. "Working with our federal, state and local partners, we will be able to build on our strength and expand this national hotline to reach suffering individuals in ways that each of us could not do alone."

This recommendation would apply to services provided to suicidal individuals on all NYSBA Bridges except for the Mid-Hudson span. MHB would continue to maintain and operate the system it has established and which serves so well. Coordinating the operations and services of the two systems will be a key objective.

3. Training of NYSBA Personnel by NYSP

While State Police are the primary first responders for suicidal situations on the NYSBA bridges, it is prudent to provide Authority staff with training should the situation arise when they become a first respondent by accident. This is not a hypothetical situation. There have been instances in which Authority personnel have suspected a pedestrian on a bridge was acting or behaving in a manner consistent with emotional anguish, desperation or where self-harm could be reasonably inferred. In those situations, there are definite "do's" and "don't's" and it is important to know what they are. The New York State Police are trained to respond to such situations, and NYSBA will seek an agreement to provide such training to its personnel.

4. Counseling of NYSBA Personnel by the American Foundation for Suicide Prevention

Witnessing a suicide attempt is a profoundly unsettling event and NYSBA employees have been exposed to such events nearly every year. The near-certainty that someone will not survive a fall from any of the bridges, due to trauma or drowning, generates a sense of horror and in some cases, guilt, that the suicide could have been prevented. Grief counseling and working with survivors has long been the specialty of Mary Jean Coleman, MSW. Ms. Coleman is the former Executive Director of the Samaritans of the Capital District. Since 2005, she has been the Upstate Area Director for the American Foundation for Suicide Prevention. Besides being an expert counselor and suicide prevention trainer, she is a founding member of the New York State Suicide Prevention Council. NYSBA will seek the advice of Ms. Colman as well as counseling services to NYSBA staff as needed.

5. Including the Media in Awareness and Education Regarding Suicides and Mental Illness

Media play a major role in influencing peoples' images and ideas about mental illness and suicide. Certain ways of describing suicide in the news contribute to what is called "suicide contagion" or "copycat suicides". This is especially potent within the adolescent population. However, media can play a real role in preventing suicide - compassionate reporting and coverage, and accurate representation can both educate and reduce stigma leading to treatment and eventually healthy people. In response to the recent suicides on the Kingston-Rhinecliff Bridge, NYSBA has distributed the document, ***At-A-Glance: Safe Reporting on Suicide***, prepared by the Suicide Prevention Resource Center in Newton, Mass. to all in the Mid-Hudson region. The document provides guidance on "What to Avoid" and "What to Do". NYSBA, in conjunction with the St. Francis Hospital Mental Health Crisis Intervention Center, will sponsor an educational forum with invitations to all regional media to assist in the dissemination of suicide prevention information and the critical role media can plan in suicide prevention. Our featured presenter will be Dr. Madelyn Gould, Professor of Psychiatry and Public Health (Epidemiology) at Columbia

University. Dr. Gould is an expert on "suicide contagion" and the role of the media and has been honored many times for her contributions to the field of suicide prevention. She is also a founding member of the New York State Suicide Prevention Council and a Research Scientist at the New York State Psychiatric Institute, a research arm of the New York State Office of Mental Health.

6. Partnership with the Hudson River Suicide Prevention Coalition.

The New York State Office of Mental Health (OMH) and Suicide Prevention Council co-sponsored a statewide **Summit on Suicide Prevention** in November 2005. Many mental health specialists, advocates, and providers from the Hudson River region attended. At the **Summit**, a regional coalition was formed in the Valley to promote the development of local capacity to reduce the risk of suicide and promote healthy behaviors. It is administered through the OMH Field Office in Poughkeepsie. The Coalition is tasked with implementing the comprehensive suicide prevention initiative contained in the State's budget and funded at $1.5 million, the most budgeted by any state for this purpose. This program will train 'gatekeepers' to better identify people in the community who exhibit signs of suicidality; educate school personnel and students ages 13-18 about clinical depression and other causes of suicide; educate primary care practitioners about depression, especially among middle age and older men, and the best ways to treat it; improve the assessment of suicidal risk in individuals seen in hospital emergency room; enable regional coalitions to plan and identify high risk populations; and continue to expand the **SPEAK** program to include new language groups and new subjects. (See: Appendix)

NYSBA's commitment to support suicide prevention in the region is sincere and steadfast. We are in it for the long haul.

7. Evaluation and Continuous Improvement.

Sound management of these new initiatives requires a commitment to timely evaluation and continuous improvement. Planning, acquisition of materials and the expeditious installation of the communication technologies have already begun. Other components of the comprehensive plan will be launched within the month. As evidence-based results become available, both technical and educational, we will consider modifications and additions for adoption to ensure continuous improvement to our efforts.

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Appendix

Suicide Prevention Initiative

The $1.5 million in funding for the suicide prevention initiative can generally be divided in three main categories: 1) Regional Coalition Development ($375,000); 2) Training and Public Awareness Projects ($715,000); and 3) Administrative and Evaluation Initiatives ($410,000). The Regional Coalition Development entails providing Field Office access to funding to facilitate training, meetings, conferences, and information sharing specific to the local communities within their catchment areas. Each Field Office has developed a plan outlining how the allocated funding ($66,000 for NYC and $33,500 for each of the other regions) will be distributed. Additionally, each Field Office has received an additional $35,000 to develop suicide prevention strategies to target "high risk" populations within their regions.

The Training and Public Awareness projects include a wide variety of initiatives. We have entered into contract ($350,000) with the American Foundation of Suicide Prevention (AFSP) to develop three DVDs and companion facilitator guides that target primary care physicians, youth audiences (middle and high school), and adult middle and high school faculty audiences. A collaborative effort ($42,000) has been initiated with the New York Association of School Psychologists (NYASP) to enlist experts in many areas of suicide prevention to develop a series of podcasts that can be downloaded by adolescents from internet sites such as I-Tunes and MySpace. Three separate training endeavors are underway: 1) A contract with Livingworks, Inc. of Fayetteville, N.C. ($154,000) to facilitate the training of 48 trainers in 2007, to be able, in turn, to provide community gatekeeper training to 1600 – 1800 recipients annually. The 48 individuals will undergo intensive 5-day Train-the-Trainer trainer to develop skills to provide ASIST training to community groups; 2) staff of the New York State Psychiatric Institute are conducting a study/training ($67,000) which hopes to improve the care of Hispanic adolescents in four NYC

hospital emergency rooms following intentional self harm and the New York Coalition for Asian American Mental Health proposes to conduct a study of Chinese American Suicide ($22,000) and provide prevention services to other Asian American minorities ($26,000); and 3) The Suicide Prevention Resource Center (SPRC) has been contracted ($48,000) to provide a series of 5 one-day workshops for mental health clinicians focused upon screening, assessment, and managing high-risk clients.

The Administrative and Program Evaluation endeavors include the completion of an MOU with the Office of Temporary Disability Assistance (OTDA) to translate the office's Suicide Prevention Education and Awareness Kit (**SPEAK**) material into Russian and, as appropriate, other languages; a 2-year printing contract to print **SPEAK** and other public education material; the hiring of temporary staff to assist in the evaluation process; and the development of an internet portal to display the suicide prevention evaluation data.

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Hudson River Regional SPEAK Coalition For Suicide Prevention, Education, and Awareness

In recognition that suicide is a public health problem, the New York State Office of Mental Health has implemented a statewide initiative to develop 'suicide-safer' communities and save lives.

As part of this initiative, a Suicide Prevention Education and Awareness Kit (SPEAK) was unveiled and regional coalitions were developed.

The Hudson River Regional Coalition is comprised of county mental health commissioners/directors and representatives from each of the sixteen counties within the region, survivors, family members, advocacy groups, clinicians, school personnel, providers of mental health services, representatives from other statewide agencies as well as representatives from the OMH Field Office. Membership also includes key individuals from the NYS Council on Suicide Prevention (which was formed in 1998).

The interest and expert is e of many members are great assets to implementing this collaborative work.

The coalition embraces the task of dissemination of information, identification of populations at high risk for suicide, developing community based education, providing guidance to one another, and assisting the community in the implementation of evidenced based practices and awareness that suicide is preventable.

The Hudson River Regional SPEAK Coalition is coordinated through the Hudson River Field Office of the New York State Office of Mental Health:

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National Suicide Prevention Lifeline
666 Broadway, Suite 200
New York, NY 10012
T: (212) 614-6357
F: (212) 529-1959
www.suicidepreventionlifeline.org

Program Description

The federally-funded National Suicide Prevention Lifeline (1-800-273-TALK) is a network of crisis centers located in communities across the country that are committed to suicide prevention. Persons in emotional distress or in suicidal crisis can call anytime from anywhere in the Nation and speak to a trained worker who will listen to and assist the caller in getting the help they need. Calls are routed to the nearest available crisis center (of more than 120) in 46 states that are currently participating in the National Suicide Prevention Lifeline network.

The Federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) and Link2Health Solutions, Inc. launched the National Suicide Prevention Lifeline (1-800-273-TALK) on January 1, 2005. This national hotline network is part of the National Suicide Prevention Initiative (NSPI), an effort led by SAMHSA that incorporates best practices in suicide prevention with the goal of reducing the incidence of suicide nationwide. Link2Health Solutions, Inc., the administrator of the 3 year, $6.6 million federal grant, is joined by the National Association of State Mental Health Program Directors (NASMHPD) in a partnership to develop the network and integrate the hotline within state suicide prevention planning activities. Link2Health Solutions, Inc. as also partnered with Columbia University's Research Foundation for Mental Hygiene and Rutgers Graduate School of Professional and Applied Psychology to conduct the evaluation component of the project.

The National Suicide Prevention Lifeline has reached out to national and international experts and stakeholders in suicide prevention who provide consultation and advisement. This is accomplished through a Steering and Subcommittee structure that facilitates their input regarding the development and implementation of the following activities to support the continued delivery of quality service to callers across the nation:

- Recruitment of the most appropriate, high quality certified centers into the network
- Provision of access to information and trainings in evidence-based or evidence-informed practices for call center services
- Facilitation of efficient connectivity of callers in crisis to the nearest available center
- Development and dissemination of public education information to raise awareness of suicide prevention and promote the hotline number nationally
- Provision of technical assistance and support to networked crisis centers as needed

For more information on the National Suicide Prevention Lifeline, please visit our Web site: http://www.suicidepreventionlifeline.org or call:

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NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK

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JOHN DRAPER, Ph.D

Dr. Draper is the Director of the federally-funded National Suicide Prevention Lifeline Network, administered by Link2Health Solutions, and independent subsidiary of the Mental Health Association of New York City.

As the Lifeline's Director, Dr. Draper oversees all aspects of this service that connects 1-800-273-TALK callers to the nearest crisis center within a national network of more than 120 crisis centers across the country.

Prior to his work on the Lifeline, Dr. Draper had been the Director of Public Education and the LifeNet Multicultural Hotline Network for the Mental Health Association of New York City since July of 1996.

Dr. Draper previously served as Clinical Director of Interfaith Medical Center's Mobile Crisis Team in Brooklyn, where for 7 years he conducted and supervised hundreds of home visits to persons in psychiatric crisis of all ages and ethnic backgrounds.

In addition to his Directorship of the national network, he has a private practice in New York City, specializing in family systems and cognitive-behavioral approaches to treatment.

Dr. Draper received his doctoral degree in Counseling Psychology from the University of Missouri-Columbia in 1996.

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The **About the Lifeline Network**

The **National Suicide Prevention Lifeline** is a national, 24-hour, and toll-free suicide prevention service available to all those in suicidal crisis who are seeking help. Individuals seeking help can dial 1-800-273-TALK (8255). They will be routed to the closest possible provider of mental health and suicide prevention services.

The network is comprised of over 115 individual crisis centers across the country creating a nationwide coverage area. It is administered through Link2Health Solutions, Inc., an organization with experience in crisis, information, and referral hotline management.

The National Suicide Prevention Lifeline grant is one component of the National Suicide Prevention Initiative (NSPI), a multiproject effort to reduce suicide led by the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services.

The NYS Bridge Authority

The NYS Bridge Authority operates the Bear Mountain Bridge (BMB), Newburgh-Beacon Bridge (NBB), Mid-Hudson Bridge (MHB), Kingston-Rhinecliff Bridge (KRB) and Rip Van Winkle Bridge (RVWB) in the Hudson Valley Region of New York State.

Except for the NBB which has separate east bound and west bound spans to accommodate Interstate 84; all other bridges are single spans and are crossed by state highways of varying capacity.

The Mid-Hudson Bridge (MHB) is unique in that it currently has Suicide Prevention phones located in the middle of the span on each side. The phones are linked by direct radio (microwave) transmission to the Dutchess County Office of Mental Health Hotline, a 24/7 crisis counseling professional service, in Poughkeepsie, NY. This type of application would not work on any other span.

Since suicide by jumping or attempting to jump off a bridge is a police matter, the NYSBA does not keep a specific log or document of such incidents, however, according to published reports, between 1984 and June 2006, the Dutchess County center received 74 calls from the bridge, and only one person jumped. Of a reported 16 others who contemplated suicide and did not use the phone, six jumped. The system in place at the MHB has been considered a model for other entities and, where applicable, a similar system has been used elsewhere.

The BMB, NBB (east bound span) and RVWB all have walkways and all have motorist aid call boxes on them. These call boxes activate via open radio frequency to all bridge personnel monitoring the radio at that time.

The NBB (west bound span) and KRB do not have walkways and do not have motorist aid call boxes. Installation on the KRB is pending.

Incidents of suicide by jumping off the bridge on these spans are rare. No one span seems to be more prone to suicide deaths than others, however, it is believed that incidents are higher on the MHB due to close proximity to an urban area (City of Poughkeepsie) and sidewalks that allow pedestrian traffic to access the bridge.

NYS Bridge Authority as of 2/19/07

Law Enforcement Responders & Mental Health Areas

NYS Police	Area Covered	Commander	Phone Number
Troop F	Rockland, Orange	Major Raso	845-344-5300
	Ulster, Greene		
Troop K	Westchester, Putnam	Major Carey	845-677-7300
	Dutchess, Columbia		
Troop T - Zone 5	Thruway/Interstate 84	Capt. Hansen	845-564-6240

Bridge	Responder	Barracks	Phone #	Mental Health Intake
Bear Mountain	West - Troop F	Newburgh	845-567-1033	Arden Hill - Goshen
	East - Troop K	Cortlandt	914-737-7171	Westchester Med. Ctr.
	Palisades Park Police	Bear Mountain	845-786-2781	Arden Hill - Goshen
Newburgh-Beacon	West - Troop F	Newburgh	845-567-1033	Arden Hill - Goshen
	Troop T - Zone 5	Newburgh	845-567-0771	Arden Hill - Goshen
Mid-Hudson	West - Troop F	Highland	845-691-2922	St. Francis - Poughkeepsie
Kingston-Rhinecliff	West - Troop F	Kingston	845-338-1702	Benedictine - Kingston
	East - Troop K	Rhinebeck	845-677-7300	St. Francis - Poughkeepsie
Rip Van Winkle	West - Troop F	Catskill	518-622-8600	Columbia Mem.- Hudson
	East - Troop K	Livingston	518-851-2001	Columbia Mem.- Hudson

Selected Research

IBTTA
International Bridge, Tunnel and Turnpike Association

Neil Gray, Director of Governmental Affairs (202-659-4620, ext.14) has issued a member query at our request regarding wireless and other communication options, responses pending. Neil also provided addition sources for information regarding bridge suicide prevention.

Responses to the request received from:

1/5: Forth Estuary Transportation Authority, South Queensferry, UK – they have had some success with additional CCTV monitoring and regular patrols. Also noted that vegetation, particularly trees, under their bridge discouraged people from jumping in areas where it was practical. Alastair Andrew -General Manager

1/5: Chesapeake Bay Bridge and Tunnel Authority, Chief Pruitt (757-331-8940) Asked that we advise of our suggestions, they have a similar problem with no solution.

1/5: Port Authority of NY/NJ, Bridge Manager, George Washington Bridge (212-435-4804) said they have emergency phones, some fencing (although it causes problems with maintenance), regular patrols (full-time police) and limited access.

1/9: South Africa National Road Agency, Peter Suremann Pr Eng, said they have had some success with CCTV and suicide prevention phones.

Other Transportation Agency research

Aurora Bridge, Seattle Washington - attached
Coronado Bridge, San Diego - similar to Caltran response
Cold Spring Canyon Arch Bridge, Caltran - attached
Additional contact: Cary Web, Golden Gate Bridge, 415-923-2240

November 2006 – California Department of Transportation

Safety Barrier/Fencing for Cold Spring Bridge has been conceptually approved by the Department of Transportation (Caltrans) Highway Safety Improvement Program. A team will soon develop conceptual designs and evaluate environmental and cultural resources.

So far, the committee has identified the following suicide prevention strategies, and related findings, for the Cold Spring Bridge:

- Signage – Currently, a No Loitering sign is posted at the bridge. Other suggestions for signage include We Care About You or Distress Center — We Listen 24 Hours a Day. Both signs would include two suicide hotline numbers for assistance.
- Call boxes – Ideally, telephones would be located on both sides of the bridge and offer a direct 1-800 suicide hotline number as well as roadside assistance. Currently, the direct hotline service is not available in call boxes in California.
- Video cameras – Local law enforcement agencies do not have the resources to continually patrol the rural area or visually monitor the cameras. Either way, cameras do not prevent suicide, and may even serve as an attraction for it.
- Lighting – It's not certain whether installing lights would help reduce suicides.
- Safety Barrier/Fence - Partial barriers can actually increase suicide incidents. An effective barrier would be continuous and at least six-feet high. Various designs/material are available. Effectiveness, bridge strength, aesthetics, historic eligibility, cost and constructability would be factors in choosing a type/style of barrier. Temporary chain-link fencing might also be considered
- Safety net – A safety net installed on the bridge is an effective barrier for helping to reduce suicides.
- Pedestrian/bicyclist access – Restricting pedestrians and bicyclists from the bridge area would, most likely, impact local triathlon and hiking events.
- Public parking/pull out areas – It's not certain whether restricting parking or closing off pull out areas would reduce suicides. The roadside locations are necessary for disabled vehicles, commuters, keeping the traffic moving and maintenance staff's parking.
- Surveillance – Heightening surveillance efforts might be an effective suicide deterrent, but may require more law enforcement staffing and resources than is currently available.
- Public education – Educate the public on suicide prevention through the local media and community meetings and events. In addition, provide public awareness that dialing 9-1-1 is best for notifying law enforcement in emergencies.

At the May 22 town hall meeting, the Mental Health Association of Santa Barbara County and the county Search and Rescue publicly endorsed the committee's work and strategies for preventing suicide at the Cold Spring Canyon Arch Bridge.

Last updated: 11/27/2006

Washington State Department of Transportation

Aurora Bridge Suicide Prevention Project, Seattle Washington

We are concerned about people committing suicide by jumping from the Aurora Bridge. However it is important that we carefully consider any suicide prevention measure to be sure that it will be effective, to avoid unintended negative consequences and to comply with regulations and laws. Any attempts to deter people from attempting suicide from the Aurora Bridge must take into consideration many interests and values:

Effectiveness
We must carefully research and consider suicide prevention measures to assure that they will be effective and won't have unintended consequences. For example, suicide contagion is a concern. We are working with mental health and safety experts and are carefully considering options before taking action. We will also monitor the effectiveness of any action we take.

Traffic safety
Any suicide prevention measure must take into account traffic safety and must comply with safety regulations.

Neighbors
We must consider the effects of any suicide prevention measure on people who live, work and play in the Queen Anne and Fremont neighborhoods and on Lake Union and the Ship Canal.

Emergency response
Any suicide prevention measure must provide safe access for emergency responders. This includes emergency responders who are trying to dissuade someone who is on the bridge and threatening to jump and emergency responders who are trying to rescue people who have jumped into the water. Emergency dives into the murky, debris-strewn Ship Canal waters are a significant risk.

Structural integrity
If we install barriers on the bridge we must consider its structural integrity, particularly during an earthquake or windstorm.

Natural environment
We must research and consider the effects of any suicide prevention measure on the natural environment. Any solution that will significantly alter the bridge's physical structure will require environmental analysis and documentation.

Historic significance
The Aurora Bridge is a designated National Historic Landmark. Any suicide prevention measure that will affect bridge aesthetics will require regulatory review and approval.

Bridge maintenance
Any suicide prevention measure will require funding for maintenance. In addition, this maintenance may require lane closures, which can cause traffic delays.

Safety inspections
WSDOT inspectors must examine the Aurora Bridge every other year to watch for signs of structural damage or stress. Inspectors must closely scrutinize the underside of the bridge. Because the bridge is very high above ground and water, the crews use an under bridge inspection truck to get close enough to inspect the underside of the bridge. The truck sits on the highway atop the bridge. Bridge inspectors climb into a bucket attached to an arm on the truck. They are then lifted up and over the side of the bridge to inspect the bridge from below. Fencing or netting on the bridge may make it significantly more difficult, costly and disruptive to inspect the bridge.

Cost
We must consider the short-term cost to install suicide prevention measures and must also consider the long-term costs to maintain and operate the measures. We must identify short- and long-term funding sources.

http://goldengatebridge.org/projects/Barrier_Briefing1.php

BRIEFING #1
GOLDEN GATE BRIDGE SUICIDE DETERRENT STUDY
PHASE 1 MIDPOINT BRIEFING ON PRELIMINARY FINDINGS

The scope of work for the two-phased 24-month study includes preparing preliminary designs, conducting wind tunnel testing, preparing environmental documents, and soliciting public input.

Midpoint Briefing - Phase 1 Wind Screening of Generic Deterrent Concepts
Phase 1 began in late October 2006, with wind tunnel testing beginning in November 2006. The three generic concepts being wind tested include (1) horizontal nets, (2) adding to the existing railing, and (3) replacement of the existing railing with new taller railing. Design variations of three basic generic design concepts have been developed for use in analyzing wind response on Bridge movement, stability, and integrity, assuming both the presence of a median barrier and the absence of a median barrier.

The wind analysis is being undertaken to assist in identifying general design parameters that prove workable and those that won't work because they negatively impact the wind response of the Bridge. A report, due in May 2007, will identify general design parameters that prove to be acceptable from a wind perspective and which should be studied further in the full engineering and environmental analysis process to be undertaken in Phase 2.

Midpoint Phase 1 Preliminary Findings - Generic Design Wind Tests
- Railing heights ranging from 8 to 14 feet are being tested.
- Analysis is showing that the structure can not be very solid; early results indicate a 12% to 24% solid ratio (88% to 76% open).
- Some form of wind channeling appendage such as a "fairing" will be necessary - either on top of the railing or underneath the Bridge for any design option to prove workable; workable means that the design option doesn't cause wind problems for the Bridge.
- It appears based on tests thus far that workable options are possible for both building a new railing and adding to the current railing.
- A workable netting option has not been identified yet, but tests continue and many ideas are still being explored. It is evident that "fairings" will be needed with net options as well.
- To date, approx. 60 design variations have undergone wind analysis.

Suicide Deterrent Study Milestones
- May 2007: Phase 1 Wind Study Report released to the Board of Directors and the public.
- May/June 2007: Begin Phase 2 (18 months) which includes the full Preliminary Engineering/Environmental and Historical Preservation studies. Phase 2 includes detailed preliminary engineering and environmental analysis, including visual analysis, historical preservation evaluation, public outreach, and preparation of cost estimates.
- Late Summer 2007: Release Draft Environmental Document (Environmental Analysis/Initial Study) for public and agency review and input.
- Spring 2008: Release Final Environmental Analysis/Initial Study for public and agency comment.
- Spring 2008: Board Action.

Additional Background

- March 11, 2005, the Board approved proceeding with environmental studies and preliminary design work for development of a suicide deterrent system with the understanding that the funds required to conduct the studies would come from non-District sources. These initial actions were authorized to enable the Board to ultimately determine whether to proceed with construction of a physical suicide deterrent system.

- April 22, 2005, Suicide Deterrent System Criteria Adopted by Board

1. Must impede the ability of an individual to jump off the Golden Gate Bridge.
2. Must not cause safety or nuisance hazards to sidewalk users including pedestrians, bicyclists, District staff, and District contractors/security partners.
3. Must be able to be maintained as a routine part of the District's on-going Bridge maintenance program and without undue risk of injury to District employees.
4. Must not diminish ability to provide adequate security of the Golden Gate Bridge.
5. Must continue to allow access to the underside of the Bridge for emergency response and maintenance activities.
6. Must not have a negative impact on the wind stability of the Golden Gate Bridge.
7. Must satisfy requirements of state and federal historic preservation laws.
8. Must have minimal visual and aesthetic impacts on the Golden Gate Bridge.
9. Must be cost effective to construct and maintain.
10. Must not in and of itself create undue risk of injury to anyone who comes in contact with the suicide deterrent system.
11. Must not prevent construction of a moveable median barrier on the Golden Gate Bridge.

- June 28, 2006, a Request for Proposals for the Environmental Studies and Preliminary Design for a Suicide Deterrent System was released. On September 22, 2006, the District Board of Directors authorized executing an agreement for *Environmental Studies and Preliminary Design for a Suicide Deterrent System on the Golden Gate Bridge* with DMJM Harris in an amount not to exceed $1.8 million. An additional $200,000 was allocated for contingencies and staff support costs.

- Funding for the study came from: The Metropolitan Transportation Commission (MTC) provided $1,850,000. The City and County of San Francisco provided $100,000, the County of Marin provided $25,000, and the public and private citizen groups have provided $28,700.

For more information on media coverage of the topic of suicide, contact American Foundation for Suicide Prevention, New York, NY, (212) 363-3500 or visit http://www.afsp.org.

After the recent event at the Kingston-Rhinecliff Bridge, the NYSBA issues the following on 1/22/07.

Subject: Statement from the NYS Bridge Authority and Important Attachment

The NYS Bridge Authority will not have any comment on a specific incident of attempted suicide. This is a law enforcement matter and questions should be directed to the appropriate law enforcement agency.

The Authority recognizes that it has a public and moral responsibility to address the issue of suicide prevention. While safety issues are an ongoing concern of the Authority, several weeks ago we began an intensive study of what, as a public agency, we can do to aid in the prevention of suicides.

This project takes into account new technology, new education techniques and a better understanding of the prevention of suicides. Our focus is on a comprehensive, system-wide approach that includes the best recommendations of both state and national experts in the field of suicide prevention.

The Authority expects to conclude this study and announce a comprehensive program in the next three to four weeks. Premature discussion of the specifics of this study would be counter-productive to the goal of aiding in suicide prevention.

While we recognize that the media has a job to do, **the way a suicide attempt is reported can have unforeseen and tragic consequences** on others not involved in a specific incident.

Please reference the attached document. It provides clear and relevant information regarding the reporting of suicide attempts and comes with the highest recommendations of mental health professionals who are expert in the field.

Thank you.

(The document follows.)

SUICIDE PREVENTION RESOURCE CENTER

At-a-Glance: Safe Reporting on Suicide

Research indicates that the way suicide is reported in the media can contribute to additional suicides and suicide attempts. Conversely, stories about suicide can inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. The following recommendations have been developed to assist reporters and editors in safe reporting on suicide.

For Reporters

What to Avoid

- *Avoid detailed descriptions of the suicide, including specifics of the method and location.*
  Reason: Detailed descriptions increase the risk of a vulnerable individual imitating the act.
- *Avoid romanticizing someone who has died by suicide. Avoid featuring tributes by friends or relatives. Avoid first-person accounts from adolescents about their suicide attempts.*
  Reason: Positive attention given to someone who has died (or attempted to die) by suicide can lead vulnerable individuals who desire such attention to take their own lives.
- *Avoid glamorizing the suicide of a celebrity.*
  Reason: Research indicates that celebrity suicides can promote copycat suicides among vulnerable people. Do not let the glamour of the celebrity obscure any mental health or substance abuse problems that may have contributed to the celebrity's death.
- *Avoid oversimplifying the causes of suicides, murder-suicides, or suicide pacts, and avoid presenting them as inexplicable or unavoidable.*
  Reason: Research shows that more than 90 percent of suicide victims have a diagnosable mental illness and/or substance use disorder. People whose suicide act appears to be triggered by a particular event often have significant underlying mental health problems that may not be readily evident, even to family and friends. Studies also have found that perpetrators of murder-suicides are often depressed, and that most suicide pacts involve one individual who is coercive and another who is extremely dependent.
- *Avoid overstating the frequency of suicide.*
  Reason: Overstating the frequency of suicide (by, for example, referring to a "suicide epidemic") may cause vulnerable individuals to think of it as an accepted or normal response to problems. Even in populations that have the highest suicide rates, suicides are rare.
- *Avoid using the words "committed suicide" or "failed" or "successful" suicide attempt.*
  Reason: The verb "committed" is usually associated with sins or crimes. Suicide is better understood in a behavioral health context than a criminal context. Consider using the phrase "died by suicide." The phrases "successful suicide" or "failed suicide attempt" imply favorable or inadequate outcomes. Consider using "death by suicide" or "non-fatal suicide attempt."

What to Do

- *Always include a referral phone number and information about local crisis intervention services.*
  Refer to: The National Suicide Prevention Lifeline toll-free number, 1-800-273-TALK (273-8255), which is available 24/7, can be used anywhere in the United States, and connects the caller to a certified crisis center near where the call is placed. More information can be found on the National Suicide Prevention Lifeline website: *http://www.suicidepreventionlifeline.org*
- *Emphasize recent treatment advances for depression and other mental illness. Include stories of people whose treatment was life-saving or who overcame despair without attempting suicide.*
  Refer to: Suicide Prevention Resource Center's research and news briefs: *http://www.sprc.org/news/research.asp*
- *Interview a mental health professional who is knowledgeable about suicide and the role of treatment or screening for mental disorders as a preventive strategy.*
  Refer to: The American Foundation for Suicide

continued ➔

I. For Reporters *(continued)*

Prevention's "Talk to the Experts" page: *http://www.afsp.org/education/recommendations/6/index.html*

Reporters may also contact the Suicide Prevention Resource Center at 1-877-GET-SPRC (438-7772), the American Association of Suicidology at (202) 237-2280, or the Suicide Prevention Action Network USA at (202) 449-3600.

- *Emphasize decreasing trends in national suicide rates over the past decade.*
  Refer to: CDC's (Centers for Disease Control and Prevention) WISQARS (Web-based Injury Statistics Query and Reporting System): *http://www.cdc.gov/ncipc/wisqars/* or talk with an expert (see previous recommendation).
- *Emphasize actions that communities can take to prevent suicides.*
  Refer to: CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters: *http://wonder.cdc.gov/wonder/PrevGuid/p0000214/p0000214.asp*
  Suicide Prevention Resource Center's Evidence-Based Practices in Suicide Prevention: *http://www.sprc.org/whatweoffer/ebp_factsheets.asp*
- *Report on activities coordinated by your local or state suicide prevention coalition.*
  Refer to: Your state suicide prevention contact will be able to tell you if there are local groups or organizations providing suicide prevention training in your community. See the Suicide Prevention Resource Center's State Suicide Prevention webpages: *http://www.sprc.org/statepages/index.asp*

For Editors

What to Avoid

- *Avoid giving prominent placement to stories about suicide. Avoid using the word "suicide" in the headline.*
  Reason: Research shows that each of the following lead to an increase in suicide among media consumers: the placement of stories about suicide, the number of stories (about a particular suicide, or suicide in in general), and dramatic headlines for stories. Using the word "suicide" or referring to the cause of death as "self-inflicted" in headlines increases the likelihood of suicide contagion.
- *Avoid describing the site or showing pictures of the suicide.*
  Reason: Research indicates that such detailed coverage encourages vulnerable people to imitate the act.

What to Do

- *Suggest that all reporters and editors review* Reporting on Suicide: Recommendations for the Media. These guidelines for responsible reporting of suicide were developed by a number of Federal agencies and private organizations, including the Annenberg Public Policy Center.
  Refer to: *http://www.afsp.org/education/recommendations*
- *Encourage your reporters to review examples of good and problematic reporting of suicide.*
  Refer to: The American Foundation for Suicide Prevention's website: *http://www.afsp.org/education/recommendations/index.html*
- *Include a sidebar listing warning signs, or risk and protective factors for suicide.*
  Refer to: American Association of Suicidology's warning signs: *http://www.sprc.org/library/helping.pdf*

  National Strategy for Suicide Prevention's risk and protective factors: *http://www.sprc.org/library/risk.pdf*

  National Institute of Mental Health's Suicide FAQ: *http://www.nimh.nih.gov/SuicidePrevention/suicidefaq.cfm*

The recommendations in this publication were adapted from *Reporting on Suicide: Recommendations for the Media*, a 2001 report by the Centers for Disease Control and Prevention, National Institute of Mental Health, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, American Foundation for Suicide Prevention, American Association of Suicidology, and Annenberg Public Policy Center. The original report and supporting documents can be found at *http://www.afsp.org/education/recommendations*.

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Technical Summary Regarding Suicide Mitigation Efforts

The Information Technology Department has been tasked with researching solutions to reduce the number of suicides at the Kingston-Rhinecliff Bridge. These applications may also be implemented at Rip Van Winkle, Newburgh Beacon and Bear Mountain Bridges. Data was collected from entities who are responsible for operating bridges and have gone through similar studies and from suicide prevention specialists.

Options need to be measured against many factors (Note: the following are in no particular order):

I. Effectiveness – Will the option effectively reduce the number of successful suicide attempts or could it potentially lead to an increase in the number of incidents? Studies show that certain methods may actually make a despondent individual more aware of the option to use a facility to carry out their end.
II. Reliability – Is the option reliable? Will it stand up to the harsh elements associated with the bridge environment? If technology based, are we using a proven technology that is not prone to service interruptions. Does the option have lasting power or will it need to be replaced frequently?
III. Maintenance – Maintenance is a two fold consideration. What is the maintenance required to keep a solution up and running. Secondly, what impact will the solution have on our ability to properly maintain the facility? Also included in this category is the impact on the ability to perform proper bridge inspections.
IV. Impact on Mission: Does the option impede our ability to maintain and operate safe vehicle crossings over the Hudson River?
V. Aesthetics – Countless efforts have been make in the Hudson Valley to keep the river aesthetically pleasing. Are there any historic considerations or visual considerations that must be addressed?
VI. Incident Response – Does the installed measure help or hinder incident response personnel?
VII. Sensitivity – Does the solution offer an individual a path to 'help' or does it simply cause them to find another location to carry out their plans.
VIII. Cost – What are the short term costs associated with design and installation? What long term costs are there? Where will funding for a system come from?

The following is a list of prevention strategies that have been evaluated for the Kingston Rhinecliff Bridge. This summary has applications throughout the NYSBA System. Each strategy is followed by a brief list of benefits and/or negative factors that contribute to the final recommendation.

Fence:

1. Effectiveness – Effective at limiting access to potential jump areas. Can be scaled.
2. Reliability – Once installed, there is very little to go wrong.
3. Maintenance of Option – Easy to maintain by existing workforce (assuming chain link fence).
4. Maintenance of Facility – Sever hindrance to snow removal requiring possible closure of bridge. Hinders bridge maintenance and inspection operations.
5. Impact on Mission – May impede crossing of some over height vehicles. Snow removal may require closing of bridge.

6. Aesthetics – History shows fencing will cause opposition from scenic and wildlife groups.
7. Incident Response – May hinder emergency personnel. An individual who has scaled the fence would be unreachable by responders. May impede efforts involving fire or other emergencies on bridge.
8. Sensitivity – While a fence may stop an individual from jumping from the bridge, it does not offer help to the person. A fence says, 'we don't want you jumping here' as compared to 'we care about you and want to help you find a non-destructive solution.'
9. Cost – Extremely high cost for design and installation. Requires a long period of time for installation.

Cellular Callbox:

1. Effectiveness – Based on statistics from the Mid-Hudson Bridge, call boxes appear to be very effective. Out the last 60 individuals to use a callbox on MHB, only one proceeded to jump.
2. Reliability – Localized installation should increase reliability.
3. Maintenance of Option – Low maintenance. Batteries would have to be replaced periodically. Signage or labels need replacement as they fade.
4. Maintenance of Facility – No impact.
5. Impact on Mission – No impact.
6. Aesthetics – No impact. (Note: signage or labels on box will fade over time and need to be replaced).
7. Incident Response – Allows responders to know the location of the individual.
8. Sensitivity – Can be configured to call a crisis hotline with trained individuals answering calls.
9. Cost – $6500 per callbox (rough estimate) revise + $12/month service fee.

Satellite Callbox:

1. Effectiveness – See 'Cellular Callbox' (Note: calls from this type of callbox may take 30 to 60 seconds for a connection to be made. The number to be called cannot be pre-programmed).
2. Reliability – Somewhat reliable. Environmental factors such as solar flares may cause service interruptions.
3. Maintenance of Option – Unknown at this time. Batteries would have to be replaced periodically. Signage or labels need replacement as they fade.
4. Maintenance of Facility – No impact.
5. Impact on Mission – No impact.
6. Aesthetics – No impact. (Note: signage or labels on box will fade over time and need to be replaced).
7. Incident Response – Allows responders to know the location of the individual.
8. Sensitivity – User could call crisis center to talk to a trained professional.
9. Cost – $8,000 per callbox. $50/month + $1 per minute. Cannot restrict what number is dialed.

Landline Callbox:

1. Effectiveness – Very Effective – see paragraph on MHB call boxes at end of document.
2. Reliability – Very reliable.
3. Maintenance of Option – Low Maintenance. Signage or labels need replacement as they fade.
4. Maintenance of Facility – No impact.
5. Impact on Mission – No impact.
6. Aesthetics – No impact.
7. Incident Response – Allows responders to know the location of the individual.
8. Sensitivity – Can be configured to call a crisis hotline with trained individuals answering calls.
9. Cost – $46,000 +/- for conduit and copper installation. $500 +/- per callbox. Waiting on monthly fee from Telco. Conduit costs will vary significantly by bridge. Total solution across all facilities $365,000.

Radio Callbox:

1. Effectiveness – Allows individual to reach out for help. (Note: radio calls would come in over our existing radio system and be answered by Authority personnel.)
2. Reliability – Very reliable.
3. Maintenance of Option – Low maintenance. Batteries would have to be replaced periodically. Signage or labels need replacement as they fade.
4. Maintenance of Facility – No impact.
5. Impact on Mission – No impact.
6. Aesthetics – No impact
7. Incident Response – Allows responders to know the location of the individual.
8. Sensitivity – Allows individual to speak to a live person. Authority personnel are not trained in crisis management. Calls cannot be connected to a trained suicide prevention counselor.
9. Cost – $2,000 + $800 (if solar is needed for power).

Video Cameras:

1. Effectiveness – Will help with incident management, but in and of itself will have no effect on number or outcome of incidents. Some studies indicate that publicized surveillance may act as an attraction.
2. Reliability – Very reliable.
3. Maintenance of Option – Requires a higher level of maintenance. Malfunctioning cameras must be replaced. Preset view locations must be maintained.
4. Maintenance of Facility – Low.
5. Impact on Mission – Aids in the management of traffic flow.
6. Aesthetics – Low impact.
7. Incident Response – Allows responders to know the location of the individual.
8. Sensitivity – N/A
9. Cost – $20,000 to $500,000 – Fixed vs. Pan/tilt/zoom.

Safety Net:

1. Effectiveness – If the individual is aware of safety netting, they may choose not to use KRB but move on to another location. During the time it takes to move on, certain individuals may change their mind. Individuals that are caught by the net could still maneuver to the edge and jump.
2. Reliability – Depends on material of netting.
3. Maintenance of Option – High maintenance. Must be inspected on a regular basis.
4. Maintenance of Facility – May hinder certain maintenance operations such as painting. Could create a dangerous safety situation for maintenance personnel.
5. Impact on Mission – No impact.
6. Aesthetics – High impact for appearance of bridge.
7. Incident Response – May hinder response. Could create a dangerous safety situation for responders.
8. Sensitivity – Does not offer psychiatric help to the person.
9. Cost – High – Design/study will need to be completed for total cost estimate.

Lighting:

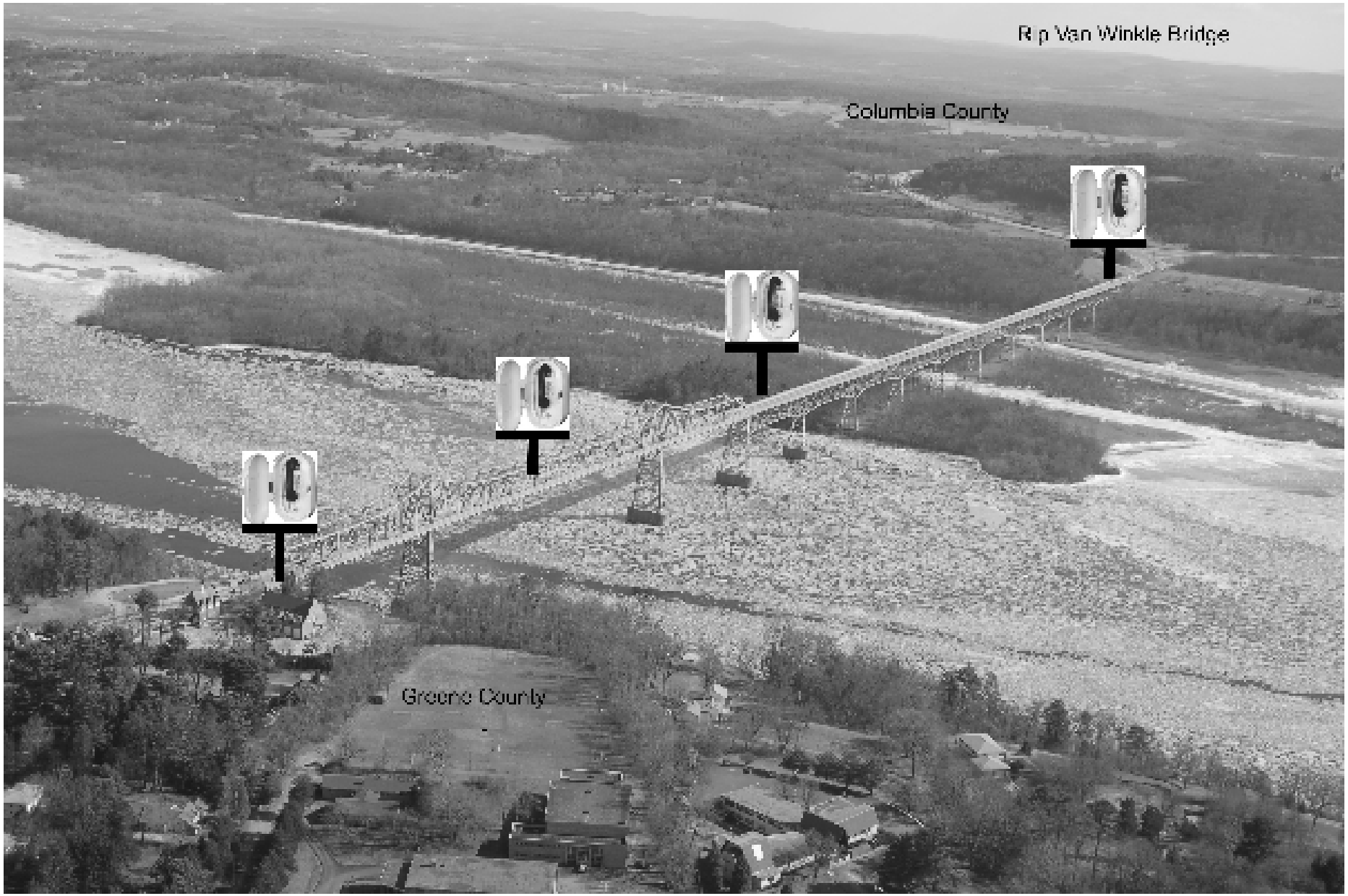
1. Effectiveness – It is not certain if installed lighting would help reduce suicides.
2. Reliability – Very reliable.
3. Maintenance of Option – Occasional replacement of bulbs required.
4. Maintenance of Facility – No impact.
5. Impact on Mission – No impact.
6. Aesthetics – Some environmental groups are against lighting.

7. Incident Response – May aide in search and recovery efforts.
8. Sensitivity – Does not offer psychiatric help to the person.
9. Cost – Design/study will need to be completed for actual cost estimate.

Patrols:

1. Effectiveness – Somewhat effective. The noticeable presence of patrols may discourage potential suicide victims.
2. Reliability – Past experience shows that outsourced, private services may not be reliable. Law enforcement patrols are not always present or available.
3. Maintenance of Option – No impact.
4. Maintenance of Facility – No impact.
5. Impact on Mission – No impact.
6. Aesthetics – No impact.
7. Incident Response – Properly trained patrols may allow for quicker response.
8. Sensitivity – Properly trained patrols allow for a sensitive response.
9. Cost – High.

Regardless of the solution, it is felt that there is no way to completely prevent suicide attempts at our facilities. Based on the evaluation above, call boxes have the greatest success in reducing deaths. They have a very low maintenance cost and a reasonable cost for installation. Call boxes offer individuals help from qualified suicide prevention specialists.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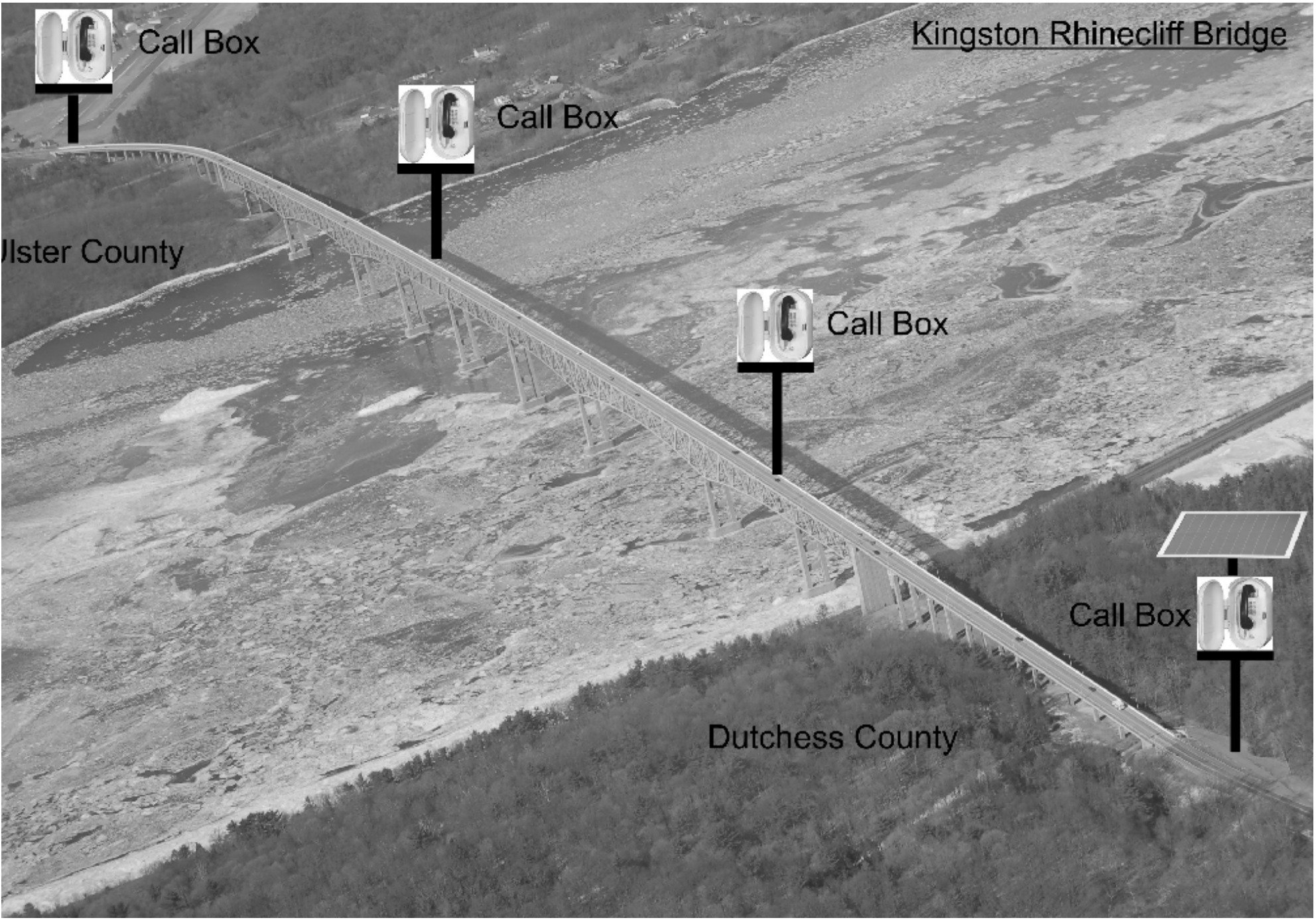
Columbia County
Greene County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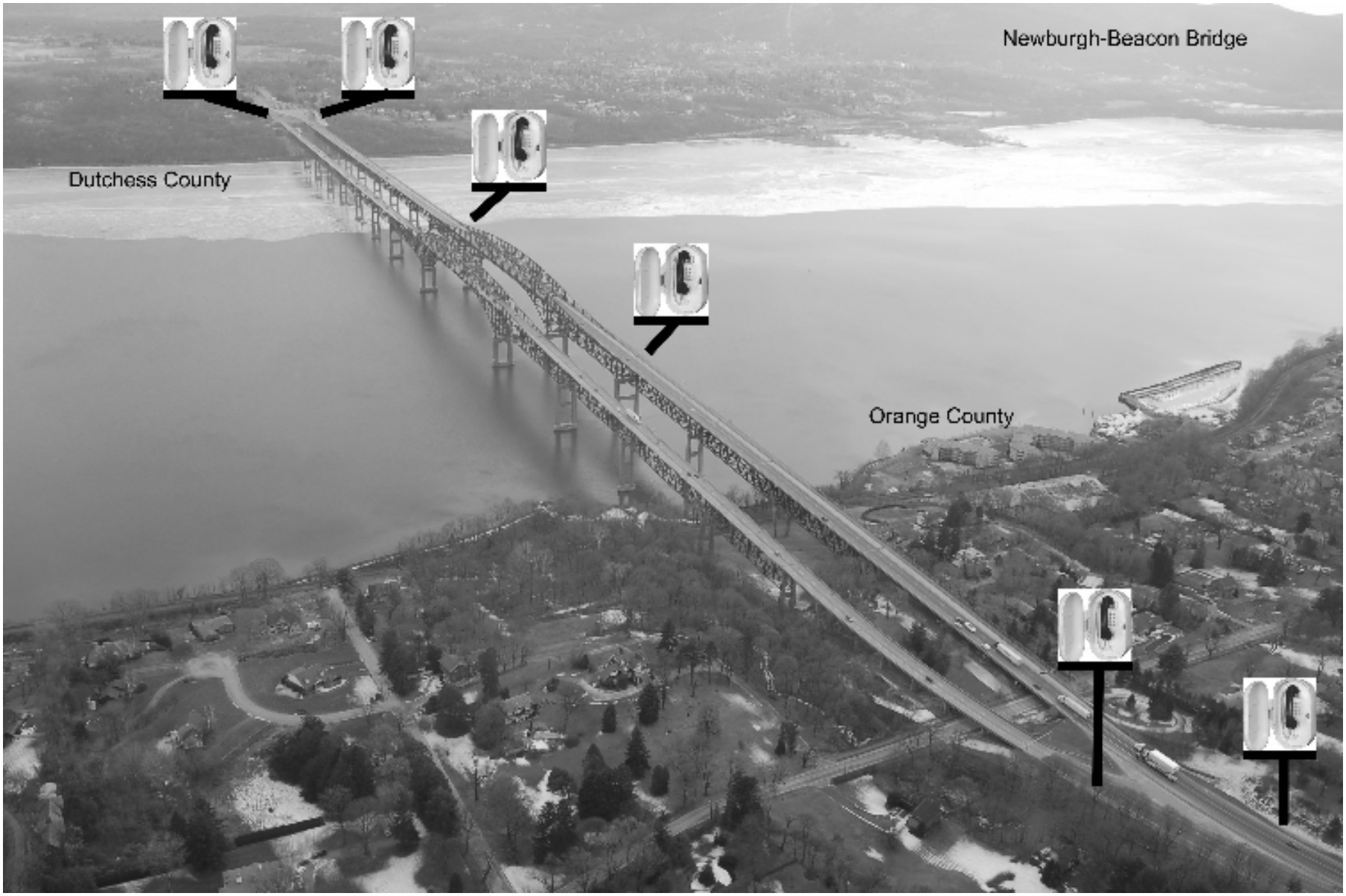
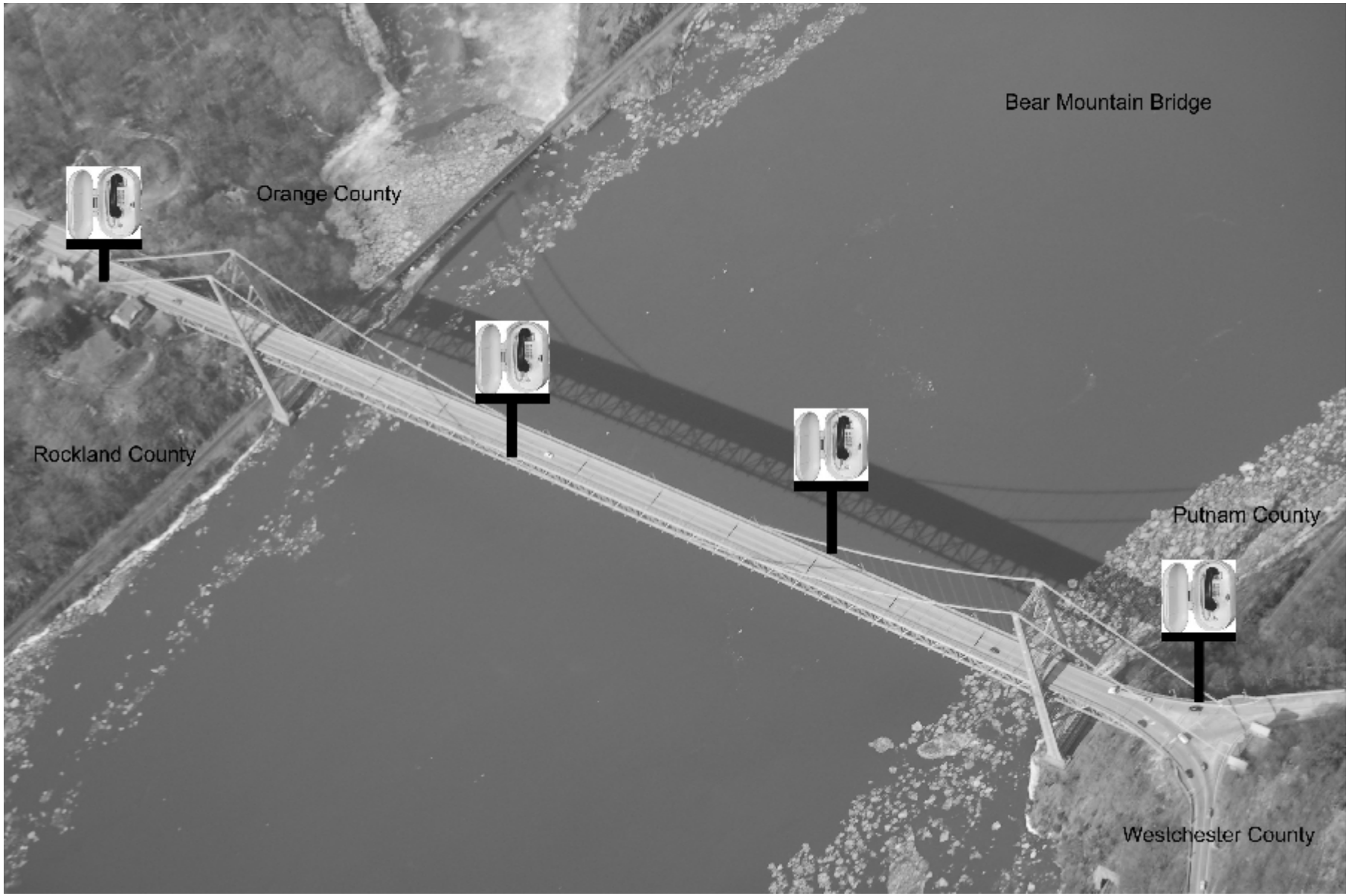
Call Box
Call Box
Call Box
Call Box
Ulster County
Dutchess County


Newburgh-Beacon Bridge
Dutchess County
Orange County


Bear Mountain Bridge
Orange County
Rockland County
Putnam County
Westchester County