

May 12, 2026

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RE: Bridge Barrier Bill H8148, IN FAVOR OF

Dear Chairman Abney and Members of the House Finance Committee,

I am writing to you to request that you please support Bill H8148, "AN ACT RELATING TO HIGHWAYS -- RHODE ISLAND TURNPIKE AND BRIDGE AUTHORITY," to direct the RI turnpike and bridge authority to "design a safety barrier and/or safety netting on the Mount Hope Bridge, the Claiborne Pell Bridge, the Staff Sergeant Christopher Potts Sakonnet River Bridge, and the Jamestown Verrazzano Bridge," further requiring RITBA to submit the design to the House and Senate Finance Committees on or before January 1, 2027, issue a RFP for the project on or before April 30, 2027, with construction and installation to commence no later than August 1, 2027.

I write in support of this bill as a clinical psychologist, Professor of Psychiatry and Human Behavior at Brown University, suicide prevention researcher and advocate, and RI resident. As you may be aware, our national rate of suicide has increased roughly 30% over the past 20 years, despite enormous efforts to develop, evaluate, and disseminate evidence-based interventions for suicide prevention. Although nearly 49,000 people die by suicide in the US annually, the rate of suicide attempt is nearly 30x this number, with approximately 1.5 million suicide attempts reported per year. The most updated statistics reveal that, in Rhode Island, we experience 1 suicide death every 3 days. This number translates to the 15th leading cause of death overall in our state, and for certain subgroups – particularly youth and young adults – suicide is currently the 2nd leading cause of death.

This pattern speaks to the need for not only individual-level, targeted preventive interventions but also **public health, population-level interventions** to support suicide prevention within our communities. Put simply, we cannot do it all with treatment alone; we need systems and programs in place to reduce risk for suicide on a wider scale.

Having spent over 20 years in the field of suicide prevention research locally, as well as nationally, I can speak to some of the unique challenges we face here in RI. Of particular concern is our location on the coast, and the many bridges that RI residents and visitors traverse daily to get to work, school, home, and other locations. These bridges support our movement across the state, but also provide enhanced access to one method of suicide that is especially lethal and hard to reverse, once attempted. **The installation of bridge barriers is critical**, because it creates space and time between an individual and something that can be used in a suicide attempt, effectively eliminating this one method at a moment in crisis, when someone may not be thinking clearly to ask for help – and cannot reverse course, once attempted.

Some have argued that investment in the elimination of one method of suicide – such as installation of bridge barriers – is insufficient. That "people will find another way to do it, if they really want to." Please understand that this argument overlooks the reality that different methods of suicide attempt carry different levels of lethality. As noted in the statistics above, we experience 30x more suicide attempts than suicide deaths annually; if we can reduce access to methods of suicide attempt that are especially lethal, even if we cannot reduce the total number of suicide attempts, this is still one way that we can effectively reduce the overall rate of suicide death and provide opportunities for people to seek treatment and support, so that they can live meaningful lives beyond a moment of crisis. The data support this notion. The large majority of people who survive a suicide attempt will not ultimately die by suicide.

To that point, there is evidence from other communities around the world that bridge barriers are, in fact, effective at reducing suicide death. As early as 2006, the National Institute of Mental Health in England

published a review of all suicide prevention approaches — barriers, signs and telephone hotlines, bridge patrols and staff trainings — they concluded that: “The most effective form of prevention at jumping sites is a physical barrier, which literally restricts access to the drop.” In 2013, Pirkis and colleagues in Australia analyzed nine studies done on the effectiveness of suicide barriers at bridges and cliffs in New Zealand, the United Kingdom, Washington, D.C., Maine, Switzerland, and Canada. They concluded that there was an 86 percent reduction in suicides at the various sites.

More recently, there are some important lessons learned from the Bloor Street Viaduct in Toronto, Canada. Prior to installation of the bridge barrier there, within North America, the number of suicides on Bloor Street was second only to those at the Golden Gate Bridge in San Francisco. Since the barrier was erected, however, there has been only 1 suicide death at the bridge. Of particular note, there was a period immediately following the installation of the bridge barrier when suicide “traffic” had seemingly relocated to other bridges; a pattern that some have attributed an inadvertent effect of the media reporting widely on the project. However, with over a decade of follow-up data, it was determined that this was a temporary phenomenon. In fact, what is most interesting about the data from Toronto is that suicide rates – by any means – across the city have decreased in the long-term, following the installation of the barrier at the Bloor Street Viaduct.

In Washington, DC, an anti-suicide bridge barrier was installed in 1986 on the Ellington Bridge, which was the site of one-half of all bridge suicides in the city. Since that time, suicide deaths from the Ellington Bridge were reduced by 90%, without changes in rates of jumps from either the nearby Taft Bridge or any other bridge in DC (Berman et al., 2021). Similar to what was observed in Toronto, suicide by all methods decreased significantly across the study period.

Most recently, the 2024 installation of the suicide safety nets on the Golden Gate Bridge have shown early promise – during installation of the nets, suicides declined by 26%. Once complete, early data from 2025 suggest that suicide deaths were reduced by 73%.

The lessons from the research to date are clear: 1) Bridge barriers are effective at reducing suicide deaths, 2) The preventive effects of bridge barriers may be more evident with longer term follow-up, and 3) Education to the public needs to take into account certain “media guidelines” around reporting, so as to avoid the temporary complication encountered in Toronto. One particular strength of the bill before you is the proposal to erect the bridge barriers across bridges in close proximity, which would further minimize this potential risk.

In conclusion, the timing of this Bill is critical, in that suicide rates continue to climb, and it is widely understood that the best approach for prevention must be multisectorial. Bill H8148 is an opportunity for RI to take a meaningful and effective population-level approach to suicide prevention to support the health and wellness of all our residents and visitors, and to be a leader in New England in the area of suicide prevention. This is the sixth year in a row that I have sent my written testimony in support of this bill; it is my sincere hope that it will be the last.

Thank you very much for your time and attention,



Lauren Weinstock, PhD