Reducing Suicide Risk by Limiting Access to Lethal Means

Impact of Firearms & Other Lethal Means on Suicidal Individuals

Current Status
Recommendations for Next Steps

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Prepared for the Vermont Department of Mental Health by:
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EXECUTIVE SUMMARY

A new report released by the Center for Health and Learning for the Vermont Department of Mental Health indicates the state's potential for a higher risk for suicide by firearm and the need for strategies that work with the gun-owning community, health and mental health providers to reduce this risk by limiting access to lethal means by individuals at risk for suicide. The report reviews current and historical data as well as promising approaches such as The New Hampshire Gunshop Project and CALM (Counseling on Access to Lethal Means) training program.

This research utilized primary sources, Vermont-specific research and analysis, and national resources to examine Vermont's current status regarding access to lethal means, and to make recommendations for steps Vermont can take to follow New Hampshire's lead in working to prevent firearm-related suicide deaths. The report also draws on the national work of the Harvard Injury Control Research Center's Means Matter initiative.

This research utilized primary sources, Vermont-specific research and analysis, and national resources to examine Vermont's current status regarding access to lethal means...

Overlapping demographics among Vermont's population and the demographics of firearm ownership indicate the state's potential for a higher risk for suicide by firearm, particularly among males. In a state with a high rate of firearm ownership and low rates of other lethal and non-lethal firearm incidents, a specific link between firearms and suicide in Vermont is clear.

Primary findings indicate that Vermont's gun-owning community is highly safety-conscious, and while gun ownership is high, the rate of homicide by firearm (7%) and accidental gun deaths (2%) in Vermont between 2007 and 2011 are both comparatively low. Indeed, this research into Vermont's gunshot deaths during this five year span finds the vast majority, 90%, related to suicide.

National suicide research identifies that a population already acknowledged to be at high-risk – white, non-Hispanic middle-aged men – is experiencing a significant increase in death by suicide. Males are statistically more likely to end their lives, and more likely to end their lives via gunshot. In Vermont this holds true, with males comprising approximately 90% of all gunshot wound deaths of any type (homicide, suicide, and accidental death), 80% of all suicide deaths by any means, and over 90% of suicide deaths by firearm. The breakdown of suicide by method and accidental death by firearm is not yet available for 2012, but the homicide by firearm rate for that year remained low at two deaths, while the total number of suicides by any means was 83.

An important distinction underlined by this research is that the demonstrated link between firearms and suicide in the collected data does not indicate that individuals who own firearms are more likely to be suicidal. Considerable data exist that people in households with firearms do not experience higher rates of suicide attempt by other method and do not exhibit higher rates of mental illness, substance abuse or suicidal thoughts, as compared with individuals living in households without firearms. Rather, the data indicate that when an individual who does own a gun is in crisis, if that crisis moves to a suicidal state, that individual is much more likely to use their firearm for a suicide attempt and is therefore much less likely to survive the attempt, than someone who does not have ready access to a firearm.

Suicide attempts with firearms are much more lethal than other forms of attempts, and very seldom allow time for intervention and help by family and friends. These data indicate that Vermont's suicide risk profile is similar to the nation as a whole, and identify the disproportionate death burden on men, in particular those aged

30 to 64, both in suicide as a whole and suicide by firearm. Middle-aged men are a population without a large body of existing research related to suicide risk factors, protective factors, and overall prevention, and there are no ready answers for risk reduction.

This research posits that traditional methods to reduce access to firearms are unlikely to be effective in Vermont's primary higher-risk population. There are means by which a suicidal individual could legally obtain a firearm in Vermont without being subject to a background check, and significant gaps in record reporting to the FBI national background check database present the potential for individuals to pass a check when they should be legally disqualified. However, the fact is that a large proportion of Vermont's population most at risk for suicide by gunshot already owns a firearm. Plans for Vermont interventions to prevent suicide among middle-aged men must account not only for this fact, but also for the reality that "help-seeking" – a traditional and effective theme of suicide prevention – is not a culturally-promoted quality for men, and is in fact often culturally discouraged.

The report concludes that creative approaches building on the existing connectedness, responsibility, and safety-conscious mindset of the gun-owning community, coupled with efforts to de-stigmatize help-seeking and promote open communication about depression and other mood disorders, may be more effective at preventing suicide by gunshot in Vermont.

For a full copy of the report see: www.vtspc.org/

For more information, contact: info@healthandlearning.org

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INTRODUCTION: Addressing Access to Lethal Means

In examining Vermont's current status on reducing access to lethal means as a method of suicide prevention, this research focuses primarily on the lethal means category of firearms. Other forms of lethal means are discussed, but this research was tasked with specifically exploring New Hampshire's experience with reducing access to lethal means, encouraging discussion here in Vermont, and making recommendations for moving forward to action. New Hampshire's impressive progress has been primarily in the area of firearms safety, with the Gun Shop Project and the CALM: Counseling Access to Lethal Means intervention.

The Harvard Injury Control Research Center's Means Matter initiative supports research and implementation of initiatives on reducing access to lethal means by suicidal individuals. In 2009, Cathy Barber, MPA, of Means Matter, began work with representatives from the state of New Hampshire on the Gun Shop Project. These representatives included Elaine Frank, MHS, Program Director of the Center on Access to Lethal Means (CALM) at the Injury Prevention Center at Dartmouth College, and the co-developer, with Mark Ciocca, of the CALM: Counseling Access to Lethal Means training program, a recognized Best Practice program in the Suicide Prevention Resource Center's (SPRC) Best Practices Registry. Additional representatives included Elizabeth Fenner-Lukaitis, MSW, of the New Hampshire Bureau of Behavioral Health, and Ralph Demico, a federally licensed firearms dealer, retailer, and owner of Riley's Sport Shop in New Hampshire.

The goal of the Gun Shop Project is to reduce suicide by firearm by working collaboratively with the gun-owning community to expand suicide prevention awareness using messages created with and for gun retailers and gun owners.[1] The primary vehicles for the project included hard copy materials in the form of a Tip Sheet for retailers on warning signs to watch for in customers, and posters, brochures and hotline cards promoting suicide awareness and prevention to be distributed in gun shops. These were distributed to New Hampshire gun shops and at last evaluation approximately half of all shops reached were displaying some form of the materials long after initial distribution.[2] Other states and areas, notably the state of Tennessee and Shasta County, California, are now implementing similar programs utilizing adapted collateral materials.[3]

The CALM: Counseling on Access to Lethal Means intervention is a 90-minute to two-hour training program on why and how to address lethal means reduction during mental health crises, and is designed for mental health workers who counsel families. However, the material is appropriate for anyone to review, including general public, and offers skills-building opportunities. CALM has been presented in more than a dozen states, and is available as an online program through the Suicide Prevention Resource Center and for emergency department personnel through the Colorado Department of Health and Human Services.

The goal of the CALM intervention is to increase knowledge about the association between access to lethal means and suicide, and the role of means restriction in preventing suicide; and to increase the skills and confidence of professionals in working with clients and their families to assess and reduce access to lethal means.[4]

This research utilized primary sources, Vermont-specific research and analysis, and national resources to examine Vermont's current status regarding access to lethal means, and to make recommendations for steps Vermont can take to follow New Hampshire's lead in working to prevent firearm-related suicide deaths.

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[1] Personal Interview re: New Hampshire's *Gun Shop Project*. Cathy Barber, MPA; Elaine Frank, MHS; Eliot Nelson, MD; Elizabeth Fenner-Lukaitis. 20 February 2014.
[2] Ibid.
[3] *The Gun Shop Project*. Webinar. 26 March 2014.
[4] CALM: *Counseling on Access to Lethal Means*. Best Practice Registry, Section III. Suicide Prevention Resource Center.

II. REDUCING ACCESS TO LETHAL MEANS: FIREARMS

A. Current Status:

1. Vermont, Suicide, and Firearms

Vermont, a primarily rural state with strong hunting traditions and an independent culture, is home to many people who own firearms, including handguns and long guns. Specific data on exact numbers are difficult to ascertain. The number of gun owners in the United States as a whole and by state is a debated statistic with numerous sources reporting disparate numbers.[5]

The national Behavioral Risk Factor Surveillance System (BRFSS) reported 38% of U.S. households owning firearms in the 2004 survey, the last date the firearm ownership question was asked. [6] Two more recent polls that are widely cited arrived at significantly different results. One, a Gallup phone poll in 2011, quotes 47% of households reporting a gun in the home. Another, the General Social Survey in-person poll from the National Opinion Research Center at the University of Chicago in 2013, quotes 34% of households reporting at least one gun in the home. [7]

This range of results holds true across many studies, with national polls regularly reporting rates of gun ownership that vary from 35% and 52% of poll respondents. [8, 9] The reasons for such wide variation have been theorized, but no definitive answers have been reached. Poll experts studying the problem do not believe the discrepancies are wholly accounted for by alternate wording of questions, as is often the case with wide differences in poll results on the same subject, conducted by different organizations. [10]

Theories for the inconsistencies range from individual resistance to acknowledging gun ownership, fear of repercussions, desire to give what is perceived to be a socially-acceptable answer, difference in comfort-level when responding over the telephone as opposed to in-person on such a heated issue, and the difference in response that has been historically found when women answer the phone in a heterosexual coupled household. [11,12] Numerous polls have confirmed that when a woman answers for a household, there is a statistical difference in results: women will more often state there are no guns, while men are consistently more likely to state that there is at least one gun in the home or garage. Poll experts theorize this could be due to male partners not always telling female partners about the firearm. [13, 14, 15]

Vermont ownership statistics present these same challenges. The BRFSS data from 2004 estimated Vermont's percentage at 44% of adults owning firearms.[16] A recent poll by statewide news website VTDigger and the Castleton Polling Institute found that approximately half of all voting Vermonters own guns: 47% reported yes, they

[5] Bialik Carl. "Guns Present Polling Conundrum." *Wall Street Journal*. 22 March 2013. www.blogs.wsj.com/numbersguy/guns-present-polling-conundrum-1223/

[6] Behavioral Risk Factor Surveillance System. http://apps.nccd.cdc.gov/brfss/ [7] Ibid.

[8] Hepburn, L, M Miller, D Azrael, and D Hemenway. "The US gun stock: results from the 2004 national firearms survey." *Injury Prevention*. February 2007; 13(1): 15–19. doi: 10.1136/ip.2006.013607.

[9] Tavernise, Sabrina and Robert Gebeloff. "Share of Homes with Guns Shows 4-Decade Decline." *New York Times*. 9 March 2013.

[10] Bialik, "Guns Present Polling Conundrum."

[11] Ibid.

[12] Tavernise, "Share of Homes with Guns Shows 4-Decade Decline."

[13] Ibid.

[14] Azrael, Deborah, MS, et al. "Are Household Firearms Stored Safely? It Depends on Whom You Ask." *Pediatrics*. Vol. 106 No. 3, 1 September 2000.

[15] Hepburn, L. M Miller, D Azrael, and D Hemenway. "The US gun stock: results from the 2004 national firearms survey." *Injury Prevention*. February 2007; 13(1): 15–19. doi: 10.1136/ip.2006.013607.

[16] Behavioral Risk Factor Surveillance System. http://apps.nccd.cdc.gov/brfss/

owned at least one gun, and 50% reported no gun ownership.[17] Other estimates of Vermont gun ownership put the number at between 44 – 55%.[18]

Other means of assessing Vermont's rate of firearm ownership include examining hunting and sport shooting statistics. Vermont is among the top 12 states with the highest percentages of hunters per capita.[19]

Analysis in 2006 and 2007 indicates that while the national average of annual hunting participation declined to only 5% of the population, it was 14% in Vermont. Over one third of adult Vermonters (41%) have hunted at some time, and approximately one quarter (23%) have hunted within the past five years.[20, 21] Of an estimated 90,000 individuals hunting in Vermont in 2011, 74% were resident hunters.[22] In 2011, Vermont was estimated to have 76,931 sport shooters.[23] These figures do not count hunters under age 16 years, or individuals owning handguns or long guns who are not hunters or sport shooters, e.g. those who are collectors, or who own firearms for self-defense and protection. Notably, rifles and shotguns are the most common equipment used by hunters, with 97% using one or both in their hunting, along with muzzleloaders and archery equipment.[24]

Though the numbers range and this is acknowledged by all of the studies, taken together the foregoing statistics support the assertion that approximately half of Vermont households own guns.

As ownership of firearms is difficult to calculate, so is "safe storage"– the practice of storing all firearms unloaded, locked, and storing ammunition in a separate location. The BRFSS data from 2002 affirmed the safety-consciousness of Vermont's gun-owning population – at a calculated 45.5% of the Vermont population owning a gun (BRFSS 2002 figure), 3.7% stored a firearm loaded, and 2.4% stored a firearm loaded and unlocked, below the national median of 7% storing loaded, and 4.2% storing loaded and unlocked.[25] These numbers drop to 3.2% and 1.5%, respectively, for Vermont households with children under 18.[26]

While gun ownership is high, the rate of homicide by firearm (7%) and accidental gun deaths (2%) in Vermont between 2007 and 2011 are both comparatively low. Indeed, research into Vermont's gunshot deaths finds the vast majority are related to suicide.[27, 28, 29] Between 2007 and 2011, ninety percent of all gunshot deaths in Vermont were due to suicide. (See Figure 1.[30])

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[17] Krantz, Laura. "VTdigger/Castleton poll: Vermonters support concealed carry permit for guns." *VTdigger*. 28 April 2014.

[18] Robinson, Kate. "Gun safety law is in limbo, despite recent teen suicides." *VTdigger*. 4 March 2011.

[19] Samuel, Dave. "Which State has the Highest Percentage of Hunters?" *The Sportsman's Guide*. Accessed 15 May 2014.

[20] Big Game Management Plan 2010 – 2020: Creating a Road Map for the Future. Vermont Fish & Wildlife Department.

[21] Public Opinion on Wildlife Species Management In Vermont. 2007. Conducted for the Vermont Fish and Wildlife Department by Responsive Management.

[22] *2011 National Survey of Fishing, Hunting, and Wildlife-Associated Recreation—Vermont*. U.S. Fish and Wildlife Service and U.S. Census Bureau.

[23] *Target Shooting in America*. Southwick Associates for the National Shooting Sports Foundation. www.nssf.org/PDF/research/TargetShootingInAmericaReport.pdf

[24] Public Opinion on Wildlife Species Management In Vermont. 2007. Conducted for the Vermont Fish and Wildlife Department by Responsive Management.

[25] Okoro, Catherine A., David E. Nelson, James A. Mercy, Lina S. Balluz, Alex E. Crosby and Ali H. Mokdad. "Prevalence of Household Firearms and Firearm-Storage Practices in the 50 States and the District of Columbia: Findings From the Behavioral Risk Factor Surveillance System, 2002." *Pediatrics*. 2005;116;e370. http://pediatrics.aappublications.org/content/116/3/e370/T1.expansion.html%20for%202002

[26] Ibid.

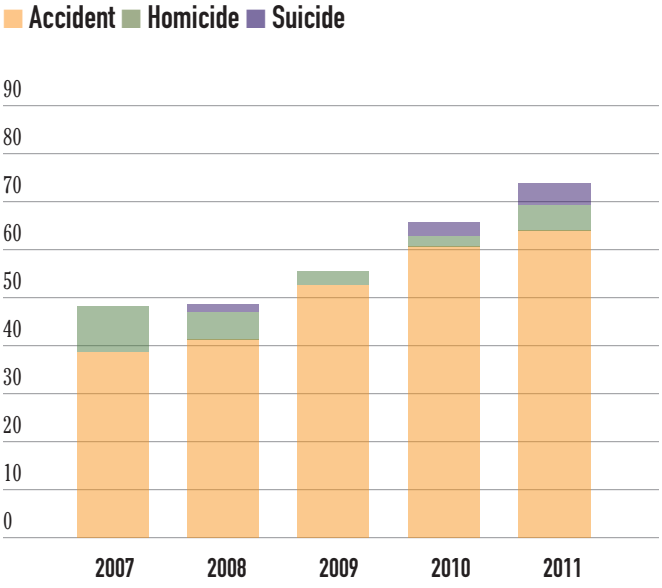
[27] *Vermont Suicide Prevention Data Brief December 2013*. Vermont Suicide Prevention Center; Vermont Child Health Improvement Program.

[28] Web-based Injury Statistics Query and Reporting System. (WISQARS) Centers for Disease Control. http://www.cdc.gov/injury/wisqars

[29] Crime in the United States. Federal Bureau of Investigation. http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s.

[30] Vermont Vital Statistics System.

Figure 1: *Vermont deaths by firearm, 2007 - 2011*



In that same time period of 2007 – 2011, more than half of all Vermont suicides were by gunshot.[31, 32] From the Vermont Department of Health's December 2013 Vermont Suicide Prevention Data Brief (see: Vermont Suicide Prevention Center , www.vtspc.org/vsp/statistics-data/):

> *Males are statistically more likely to end their lives, and more likely to end their lives via gunshot. Approximately 90% of all gunshot wound deaths are male; about 80% of all suicide deaths are male; and males make up 90% or more of gunshot wound suicide deaths*.[33]

In 2012, individual suicide by firearm and accidental death by firearm counts are not yet available, but the homicide by firearm rate for 2012 remained low at two deaths, whereas the total number of suicides, using any means, was 83.[34, 35]

An important distinction is that the demonstrated link between firearms and suicide in the collected data does not indicate that individuals who own firearms are more likely to be suicidal.[36] Considerable data exist that individuals in households with firearms do not experience higher rates of suicide attempt by other method.[37] Consistently, individuals in households with firearms have been demonstrated to have no higher rates of mental illness, substance abuse or suicidal thoughts, than individuals living in households without firearms.[38]

Rather, the data indicates that when an individual who owns firearms is in crisis, if that crisis moves to a suicidal state, the individual is much more likely to use that firearm for a suicide attempt and is much less likely to survive the attempt, than someone in a home with no firearm. Suicide attempts with firearms are much more lethal than other forms of attempts, and very seldom allow time for potential intervention.[39]

According to the CDC's Web-based Injury Statistics Query and Reporting System (WISQARS), in the analysis of nonfatal injuries treated in hospital emergency rooms nationwide, unintentional injury by firearm is not among the top 10 causes of hospital emergency room visits for injuries, for the period of 2006 through 2012.[40] Nor are nonfatal firearm injuries high among causes of emergency room visits in Vermont.[41] An unintentional firearm injury

[31] Web-based Injury Statistics Query and Reporting System. (WISQARS) Centers for Disease Control. http://www.cdc.gov/injury/wisqars

[32] *Vermont Suicide Prevention Data Brief December 2013*. Vermont Suicide Prevention Center; Vermont Child Health Improvement Program.

[33] Ibid.

[34] Crime in the United States. Federal Bureau of Investigation. http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s.

[35] Vermont Vital Statistics. Preliminary data.

[36] Miller, Matthew; Catherine Barber, Richard White, Deborah Azrael. "Firearms and Suicide in the United States: Is Risk Independent of Underlying Suicidal Behavior?" *American Journal of Epidemiology.* 2013. doi: 10.1093/aje/kwt197. First published online: 23 August 2013.

[37] Ibid.

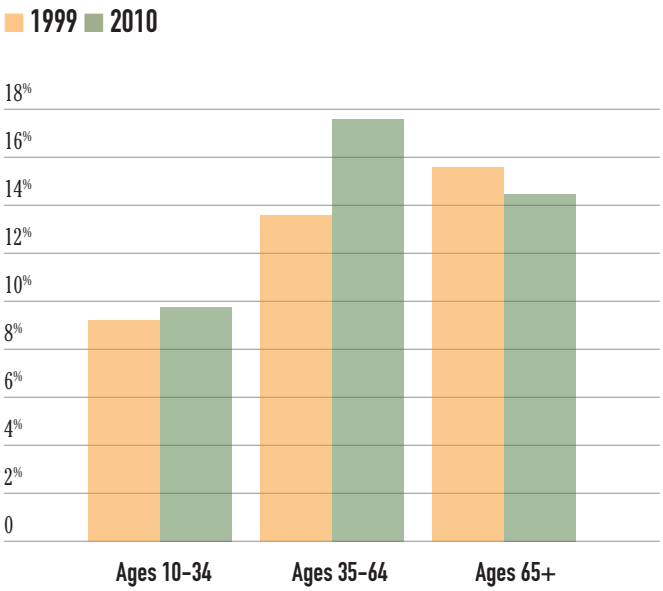
[38] Ibid.

[39] Means Matter. http://www.hsph.harvard.edu/means-matter/basic-suicide-facts/how/

[40] Web-based Injury Statistics Query and Reporting System. (WISQARS) Centers for Disease Control. http://www.cdc.gov/injury/wisqars

[41] "Injury in Vermont." Vermont Department of Health. Injury Prevention Program. June 2008.

Figure 2: *Rate of Suicide by age range, United States, 199 and 2010*



would have a high likelihood of resulting in an emergency room visit, and while it may have a higher expectation of resulting in death due to the lethality of gunshots, in Vermont the rate of unintentional firearm deaths also remains low.

The analysis of a low rate of unintentional firearm related injuries is echoed in a 2010 report from the National Shooting Sports Foundation, related specifically to the sport of hunting, which calculated a rate of injury of .05% per year per 100 individuals hunting with firearms.[42] This is further underlined by the fact that injuries in general disproportionally affect males at twice the rate of females, and the majority of gun owners are male.[43, 44] Despite men suffering 50% more injuries than women, and more males using firearms, the rate of unintentional firearm injury is comparatively low, particularly in Vermont.

As the forgoing data indicates, in a state with high firearm ownership coupled with low rates of other lethal and non-lethal firearm incidents, a link between firearms and suicide in Vermont is clear.

Overlapping demographics among the Vermont population as a whole and the demographics of firearm ownership indicate the state's potential for a higher risk for suicide. National suicide research identifies that a population already acknowledged to be at high-risk – white, non-Hispanic middle-aged men – is experiencing a significant increase in death by suicide.[45] In studies examining the ten-year period of 1999 through 2010, the rate of suicide death increased by 28% for the age range 35 – 64. Suicide is now the 4th leading cause of death for this age range, versus the 8th leading cause of death in 1999.[46] During this same time period the rate of death by suicide rose 7% for ages 10 through 34, and dropped by 5.9% for ages 65 and over. (See Figure 2.[47])

Research confirms this was not a regional anomaly due to crises in specific areas of the country, as the rate rose in every one of the 35 states in the study.[48] The rate of increase consistently reflected the 80/20 gender split, with the number of middle-aged men's suicide deaths increasing over three times that of middle-aged women.[49] Middle-aged men are a population without a large body of existing research related to suicide risk factors, protective factors, and overall prevention.[50]

The following four charts (Figures 3 through 6) provide data on Vermont suicide trends in the decade of 2000

[42] *Hunting: Participation and Injury Data 2010*. National Shooting Sports Foundation. 2010. NOTE: This report calculates only survived injuries, not deaths.

[43] Hepburn, L, M Miller, D Azrael, and D Hemenway. "The US gun stock: results from the 2004 national firearms survey." *Injury Prevention*. February 2007; 13(1): 15–19. doi: 10.1136/ip.2006.013607.

[44] *The Facts Hurt: A State-by-State Injury Policy Prevention Report*. Trust for America's Health & Robert Woods Johnson Foundation. January 2013 (update).

[45] *Surprising Health Disparity: Men in their Middle Years*. Webinar. Injury Control Research Center for Suicide Prevention. 11 March 2014.

[46] Ibid.

[47] Web-based Injury Statistics Query and Reporting System. (WISQARS) Centers for Disease Control. http://www.cdc.gov/injury/wisqars

[48] Ibid.

[49] Ibid.

[50] Caine, E., in *Surprising Health Disparity: Men in their Middle Years*. Webinar.

Figure 3: *Vermont suicide trends, 2000-2011*

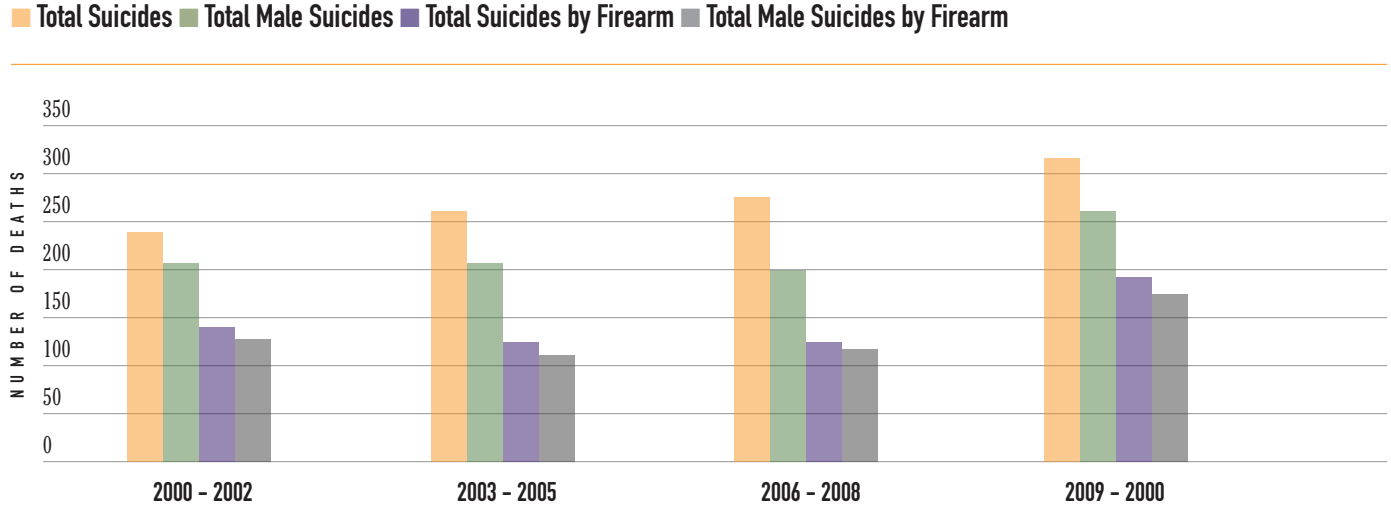


Figure 4: *Vermont suicide trends, 2000-2011. Men and firearms: Aged 30 - 64*

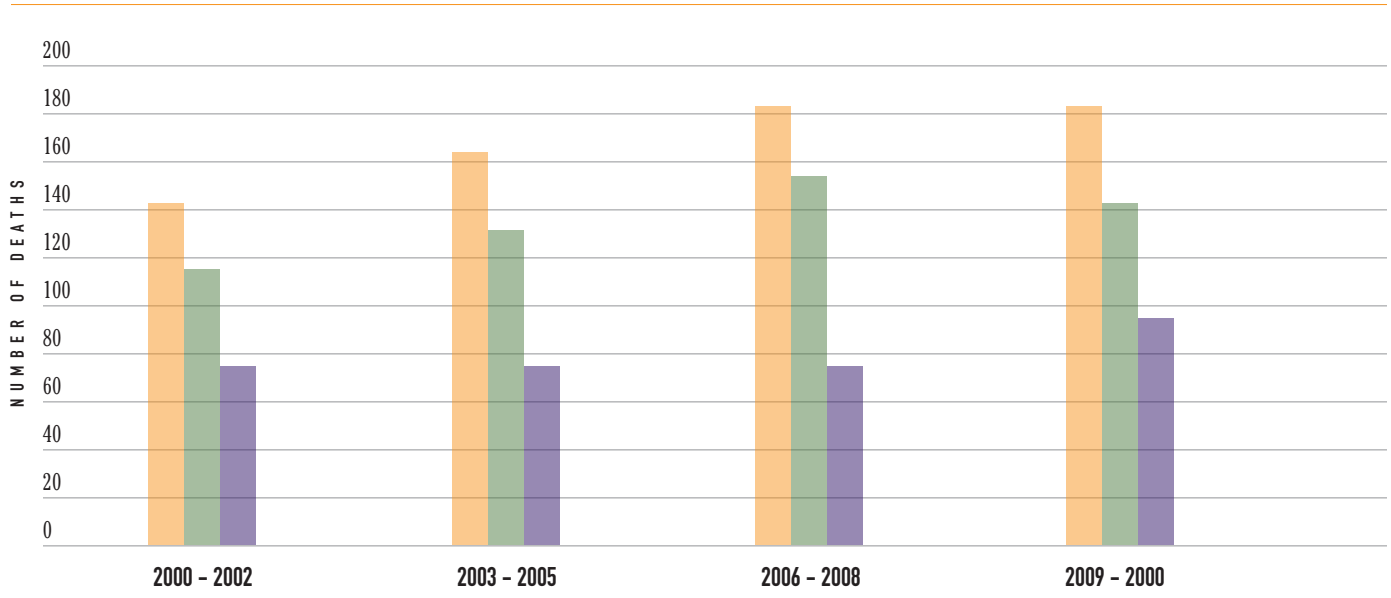
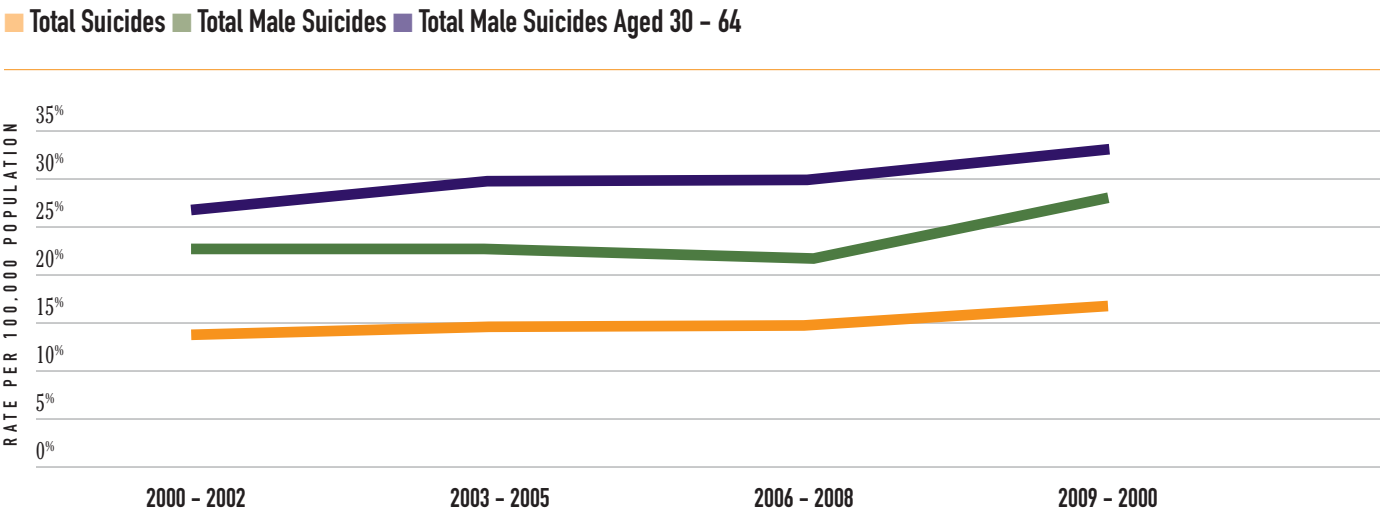


Figure 5: *Vermont suicide trends, 2000-2011*



to 2011. These data indicate that Vermont's suicide risk profile is similar to the nation as a whole, and identify the disproportionate death burden on men, and in particular men aged 30 through 64, both in suicide as a whole and suicide by firearm.[51]

In examining the national and state risk statistics in relation to Vermont's population overall and the state's gun-owning community, there is a good deal of overlap, indicating Vermont has a sizeable population that falls within the higher risk category for suicidal ideation and behavior during a significant crisis.

- Vermont skews heavily white; 95% in the 2010 Census.[52]
- Approximately 42% of Vermont's population falls between 34 and 64 years of age.[53] In addition, one segment of the gun-owning population – hunters – skews older in the Northeast, with an average age of 45.[54]
- Hunters skew heavily male, calculated at 92% male in the northeast.[55]
- Nationally, the gender breakdown on gun ownership overall has been approximately 75% male, according to a six-year aggregate of polls from Gallup, specifically examining the time slice of 2007 – 2012.[56]
- By definition, the shooting community represents individuals with extensive knowledge, experience, and access to firearms – many Vermonters who fall within the national and state suicide risk profile already have at least one firearm in their home.

An additional risk factor for men in general is an established reticence to seek assistance in times of emotional crisis. Men are less likely to access therapy, which is a leading tool in preventing suicidal crisis.[57] Over decades, research consistently indicates that men of all

[51] All chart data from WISQARS.

[52] www.census.gov

[53] www.census.gov

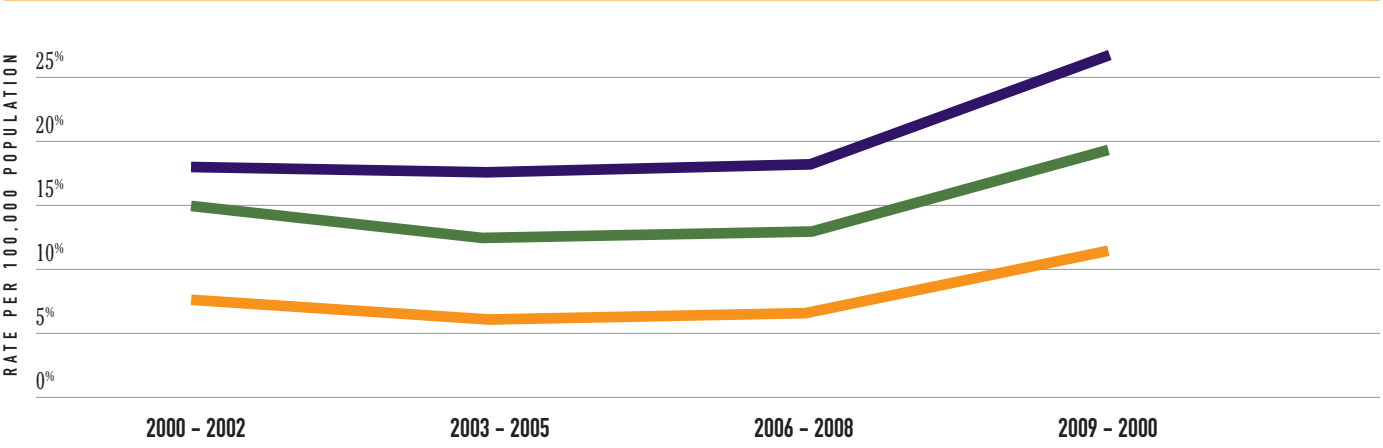
[54] *A Portrait of Hunters and Hunting License Trends: National Report*. Southwick Associates for the National Shooting Sports Foundation. www.nssf.org/PDF/HuntingLicTrends-NatlRpt.pdf

[55] Ibid.

[56] Jones, Jeffrey. "Men, Married, Southerners Most Likely to Be Gun Owners." *Gallup Politics*. 13 February 2013. www.gallup.com/poll/160223/men-married-southerners-likely-gun owners.aspx

[57] American Association for Suicide Prevention. Treatment. https://www.afsp.org/preventing-suicide/treatment

Figure 6: *Vermont suicide trends, 2000-2011*



ages and ethnicities are less likely than women to seek help of any kind for a variety of health concerns, including mental health (depression, stressful life events, substance abuse) even though men experience these health issues at the same or greater rates as women.[58, 59, 60] Data demonstrates women are approximately twice as likely to seek therapy as men.[61] Of men who are willing to seek help for depression, the proportion of men accessing therapy as treatment appears to be decreasing over time. While the rate of men interested in therapy as treatment for depression was 56.2% in 1998, ten years later that number was down to 42.5%.[62] In that same time, men choosing medication alone as treatment for depression rose, from 68.8% in 1998 to 73.3% in 2007.[63]

With the number of male gun owners considerably higher than females, this indicates that a significant portion of Vermont's at-risk population, were they to experience a crisis, may be less likely to define themselves as depressed, less likely to seek help, and more likely to access medication alone rather than therapy if they do seek treatment.

In light of these data, plans for interventions to prevent suicide among middle-aged men must consider that "help-seeking" is not a culturally promoted quality for this population, and is in fact a culturally discouraged activity. Interventions that de-stigmatize help-seeking are strongly indicated, as well as interventions that integrate screening for depression and suicidal ideation into primary care practice, given general practitioners have a greater chance of seeing men at risk than mental health professionals.[64, 65, 66]

It is important to note that gun owners in particular

[58] Winerman, Lea. "Helping Men Help Themselves." Monitor on Psychology. American Psychological Association. Vol 36, No 6. June 2005.
[59] Freed, Besty Bates and David. "Aversion to Therapy: Why Won't Men Get Help?" *Pacific Standard: The Science of Society*. 25 June 2012.
[60] Men and Depression. National Institute of Mental Health, US Department of Health and Human Services. Screening for Mental Health. www.mentalhealthscreening.org, www.mentalhealthscreening.org/screening/resources/men-and-depression.aspx
[61] Freed, B and D. "Aversion to Therapy."
[62] Ibid.
[63] Ibid.
[64] Ahmedani, et al. "Health Care Contacts in the Year Before Suicide Death." *Journal of General Internal Medicine*. DOI:10.1007/s11606-014-2767-3.
[65] Zero Suicide. http://zerosuicide.actionallianceforsuicideprevention.org/identifying-and-assessing-suicide-risk-level
[66] Luoma JB, Martin CE, Pearson JL. "Contact with mental health and primary care providers before suicide: a review of the evidence." *American Jounral of Psychiatry*. 2002; 159(6):909-16.

may have a perceived added disincentive to seek help for depression or other mental health concerns, due to a high concern over the federal statute and additional state laws that prohibit purchase and ownership by individuals deemed mentally ill. The formal wording of the mental health exclusion in the Gun Control Act of 1968, as written into 18 U.S. Code § 922(d)(4), is as follows:

> "[such person]… has been adjudicated as a mental defective or has been committed to any mental institution." [67]

The language used in this statute reflects that this law has not been revisited and updated to apply current perspectives and understanding about mental health and mental illness. However, for the purposes of this research, the critical issue is that this statute requires a court or other "lawful authority" be involved, to specifically adjudicate or to involuntarily commit an individual, in order to invoke a prohibition on that person to purchase or own guns. Vermont statutes add no further categories of prohibition, concerning mental health or any other circumstance. Therefore, an individual in Vermont seeking treatment for depression or mental health support during a crisis would not fall into the prohibited category. Despite this fact, there is still a great deal of misunderstanding about mental health and mental illness in general, and knowing that "mental illness" is part of the federal prohibition at all could lead gun owners to resist any setting or circumstance that might be perceived as them being mentally ill or needing mental health services.

Some other state laws have expanded the prohibited categories and have broader reporting requirements, including broader definitions of mental illness. Among others:

- Hawaii has state language identifying prohibited individuals as those who have been "diagnosed as having a significant behavioral, emotional, or mental disorders as defined by the most current diagnostic manual of the American Psychiatric Association or for treatment for organic brain syndromes;" [68]
- Idaho applies the terminology of "currently suffering" and "mentally ill" in applications for concealed carry; [69]
- Georgia will not issue a license to individuals who have been "hospitalized as an inpatient in any mental hospital… within five years of the date of his or her application;" [70]
- Louisiana prohibits those "suffering from 'mental or physical infirmity due to disease, illness, or retardation' which prevents the safe handling of a handgun." [71]

Given the range of state laws and the various definitions and interpretations of mental illness, including the archaic language in the federal statute, it is not an unrealistic concern that firearm owners would be even less likely to seek professional help of any sort for a mental health crisis, even though doing so in the state of Vermont would not affect their ability to own and purchase firearms.

One approach to de-stigmatization of help-seeking is to promote supportive messages to normalize the language and resources around depression awareness and suicide prevention. These messages are ideally placed in avenues that the target male population is most likely to encounter, as with the Gun Shop Project, or integrated into primary care settings where men at risk may be most likely to interact with any healthcare professional. Online resources that can be viewed alone, on one's own time, and can be easily passed on to a friend, are highly advised. The recent encouraging research produced by Colorado's Man Therapy™ online outreach initiative, discussed in more detail later in this research, speaks to the potential of this type of resource. The national movement toward

[67] 18 U.S. Code § 922(d)(4)

[68] National Conference of State Legislatures. http://www.ncsl.org/research/civil-and-criminal-justice/possession-of-a-firearm-by-the-mentally-ill.aspx. Accessed 1 October 2014.

[69] Ibid.

[70] Ibid.

[71] Ibid.

the Action Alliance for Suicide Prevention's Zero Suicide integration initiative, also discussed in more detail below, speaks to the increasing recognition that primary care plays a vital role in reaching those at high risk.

Lastly, in addressing the paucity of research on suicide in the mid-life population, Dr. Eric Caine, one of the United States' foremost researchers in the field of suicide prevention and risk factors for suicide, who is Co-Director of the Center for the Study and Prevention of Suicide at University of Rochester Medical Center and Director of the Injury Control Research Center for Suicide Prevention (ICRC-S), noted that societally, middle-aged white men are often viewed as in their "prime of life," and as a privileged race, gender and class. Therefore, they are less likely to be perceived as "society's responsibility" in terms of services and initiatives.[72] Further complicating the efforts to reach these most at-risk men is the fact that they are viewed as "unlikely victims."

An overall review and synthesis of the above research indicates that Vermont has a considerable population of men who fall into a demographic category defined as at high-risk for suicide. Further, the men among this population who do experience crisis have a higher than average chance of owning a firearm and keeping it in the home.

Traditional methods to reduce access to a firearm by a suicidal individual – screening for purchase of firearms, therapy and other treatment for depression – may have limited success affecting access during crisis for a population that has a 50% chance of already owning at least one gun.[73, 74] Creative approaches such as those used in the Gun Shop Project, building on the connectedness of the tightknit gun-owning community, may be more plausible and effective. If coupled with an online initiative such as Man Therapy™ aimed at de-stigmatizing help-seeking and encouraging communication about depression, and a primary care screening initiative such as Zero Suicide, these methods together may impact suicide rates in the highest risk group.

2. Existing Vermont Laws & Regulations

Vermont has minimal existing regulations regarding firearms, and some of the least restrictive firearm laws in the country. Vermont residents are not required to obtain a permit to purchase rifles, shotguns or handguns, nor a license to own a firearm. Vermont residents are not required to register as an owner of a firearm, nor are they required to obtain a permit to carry rifles, shotguns and handguns, including concealed carry.[75] These same firearms may be carried on public property, excepting school buildings and busses, and courts of law.[76] Vermont recognizes all other states' firearm permits.

Like all states, Vermont must comply with federal laws regarding firearms. These federal regulations include:

- conducting the required background check on all individuals purchasing a firearm from a federally licensed firearm dealer, and
- honoring the prohibitions of certain classes of individuals from purchasing and possessing firearms.[77]

The federal classes of prohibited individuals include:

- Convicted felons,
- Certain domestic violence offenders,
- Those unlawfully using or addicted to controlled substances, and
- An individual who has been "adjudicated as a mental defective or who has been committed to a mental institution." [78]

[72] Caine, E., in *Surprising Health Disparities: Men in their Middle Years*. Webinar.

[73] *Portrait of Hunters and Hunting License Trends*.

[74] Freeman, Ali. "Vermont Fish and Wildlife deals with declining licenses." WCAX. 22 February 2013. www.wcax.com/story/21311652/declining

[75] Vermont State Statutes.

[76] Ibid.

[77] 18 USC § 922

[78] 18 USC § 922

Many states have incorporated these federally prohibited categories into their state laws, and expanded the prohibited categories.[79, 80] Unlike other states, Vermont has not expanded on the federally prohibited classes and adds no additional requirements.[81, 82, 83]

Existing Vermont state restrictions include:

- No one may carry a dangerous or deadly weapon, openly or concealed, with the "intent or avowed purpose of injuring a fellow man;"
- No one may carry a dangerous or deadly weapon "within any state institution or upon the grounds or lands owned or leased for the use of such institution, without the approval of the warden or superintendent of the institution;"
- No one may possess a firearm "within a school building or on a school bus;"
- No one may possess a firearm "on any school property with the intent to injure another person;"
- Pawnbrokers and retail merchants must keep records of sales and purchases of all revolvers and pistols;
- No one other than a parent or guardian may sell or give a firearm or ammunition to a child under the age of 16;
- A child under 16 must have parental permission to possess a handgun;
- Manufacture, sale, use and possession of silencers is prohibited;
- Possession or sale of a "zip gun" (a homemade gun) is prohibited.[84]

Vermont game statutes further specify that individuals hunting may not use or carry a "machine gun of any kind or description," or an "auto-loading rifle, except a .22 caliber rifle using rim fire cartridges," and that no one may carry a "loaded rifle or shotgun in a vehicle."[85]

Over many years, repeated legislative attempts to alter Vermont state gun laws have been unsuccessful, including efforts to broaden state laws. The executive and legislative branches of Vermont state government have been resistant to the expansion of gun laws, and numerous representatives of such are on public record as not supporting legislative action to change Vermont firearm laws.[86] The legislature has elected not to consider previously submitted bills, including background checks and safe storage laws.[87, 88, 89]

When examining the legal and regulatory restriction of access to firearms by suicidal individuals, the following issues arise:

- **Background Checks**: Background checks, and how and under what circumstances they apply, are the subject of a great deal of debate nationally. By federal law, all individuals purchasing from a federally licensed firearm dealer must pass a background check, but individuals buying or trading guns with someone who is not a federally licensed firearm dealer are not subject to the background check requirement.[90] At the same time, only individuals who "regularly engage" in the business of buying and selling fire-

[79] Developments in Mental Health Law.
[80] National Conference of State Legislatures.
[81] The Vermont Statutes Online, Title 13: Crimes and Criminal Procedure; Chapter 85: WEAPONS; 13 V.S.A. § 4013.
[82] Developments in Mental Health Law. www.dmhl.typepad.com
[83] Law Center to Prevent Gun Violence. www.smartgunlaws.org
[84] The Vermont Statutes Online, Title 13: Crimes and Criminal Procedure; Chapter 85: WEAPONS; 13 V.S.A. § 4013.
[85] The Vermont Statutes Online, Title 10: Conservation and Development, Chapter 113: GAME; § 4704, 4705.
[86] H.R. 2454: Aaron's Law Act, related to safe storage; H.124 regarding background checks and police authority to enforce federal law prohibiting felons and domestic violence offenders from possessing guns; Senate resistance to passage of H.375 currently under deliberation.
[87] Hallenbeck, Terri. "Can you say gun control in Vermont? Not very easily." *Burlington Free Press.* 17 December 2012.
[88] Rudarakanchana, Nat. "Leahy Chairs First Congressional Hearing on Gun Control." *VTDigger*. 30 January 2013. www.vtdigger.org
[89] Carlson, Kristin. "Shumlin tweaks gun control message for national audience." WCAX.com. 22 February 2013.
[90] 18 USC § 922

arms for profit may apply to be federally licensed dealers, therefore many private sellers do not qualify to apply.[91]

It is difficult to accurately assess how many firearms are purchased outside of licensed dealers. These are commonly known as "private sales." Opportunities do exist for undocumented private sales to take place, through in state person-to-person sales and websites such as www.armslist.com, listing significant numbers of private party sellers.[92]

Unlicensed individuals may legally sell firearms to other unlicensed individuals, as long as they live in the same state, with no record keeping or background check required. An unlicensed individual may sell to another unlicensed individual who lives in another state, but cannot ship the firearm directly to the buyer. Rather, the seller must make arrangements to have the firearm shipped to a federally licensed dealer in the buyer's state, who then must conduct a background check on the buyer prior to releasing the weapon.[93]

One of the largest concerns surrounding online sales is that online transactions can be harder to track and may provide more anonymity for both buyers and sellers. In its 1999 decision to eliminate gun sales, online auction giant eBay noted, "After careful consideration of the issue, we believe the process of buying and selling firearms online is sufficiently different from the offline world, and it is appropriate for us to end the user listing of firearms on eBay… Online sellers cannot readily guarantee that buyers meet all the qualifications and comply with the laws governing firearm sales."[94]

In summary, there do exist means by which a suicidal individual could legally obtain a firearm in Vermont without being subject to a background check.

• **Background Check Limitations**: The federally mandated background check is performed through the National Instant Criminal Background Check System (NICS), an FBI database established in 1993. This database is compiled based on the submission of state records. Two categories of individuals point up the limitations in this method of reducing access, both of which have an established higher risk of suicidal behaviors – those with contact with the criminal justice system, and those with mental health conditions that make them a danger to themselves or others.

Suicide research indicates that men and women who have had contact with the criminal justice system appear to have a significantly higher rate of suicide than the general population.[95] Even people who have not been convicted of a crime are still shown to be at higher suicide risk. However, even with repeated contact with the justice system, without a conviction on record these individuals would not flag as a prohibited category on a federal background check.

As previously quoted, the federal statute contains severely outdated language regarding mental health – "adjudicated a mental defective" – and states across the nation have a wide variety of laws related to prohibitions concerning mental health conditions.[96] The overall intent of the mental health restrictions is to prevent those with mental health issues that present a danger to self or others from purchasing firearms, particularly in a moment of crisis or extreme despair. However, as with contact with the criminal justice system, the NICS database is reliant on records

[91] www.nra.org

[92] www.armslist.com

[93] 18 U.S.C. 922(a)(3) and (5), 922(d), 27 CFR 478.29 and 478.30

[94] "eBay to Stop User Listings of Firearms and Ammunition on the Site." Press Release, eBay. 19 February 1999.

[95] "Contact with criminal justice system may be associated with suicide risk." *Journal of the American Medical Association*. 8 February 2011.

[96] Simpson, Joseph R., MD, PhD. "Bad Risk? An Overview of Laws Prohibiting Possession of Firearms by Individuals With a History of Treatment for Mental Illness." *Journal of the American Academy of Psychiatry and the Law Online*. September 2007. 35:3:330-338.

submitted from each state, and not all states submit mental health records that would place an individual into a prohibited purchaser category, that would then raise a flag on the background check if the individual attempted a purchase.[97, 98]

Forty-three states have laws that require or authorize the reporting of some people suffering with mental illness to the federal NICS database, or a state database, for use in firearm purchase background checks.[99] Vermont does not mandate either the collection of mental health records at a single state location, nor any reporting to the NICS.[100] Vermont is noted as one of fifteen states that has submitted fewer than 100 total mental health records (24 records as of November 2013) over the twenty years of the existence of the NICS.[101]

This raises an additional cause for concern, on the part of physicians and other professionals who have concerns about a specific patient or client regarding safety for firearm purchase. No mechanism exists in the state for an individual to be reported as a danger to self or others, even by healthcare professionals who may be in a better position than most to assess the comprehensive health of an individual.

There have been efforts at the national level to address the problems with the NICS reporting, including grants to assist states in creating appropriate and updated technology systems, and currently there is a potential HIPPAA expansion underway at the federal level, under a Notice of Proposed Rulemaking from the Department of Health and Human Services on this subject.[102]

In summary, the potential exists for individuals in Vermont to pass a federal background check to purchase a firearm despite qualifying for a federally prohibited class, due to lack of record reporting to the FBI's NICS database.

• **Federal Enforcement**: The lack of Vermont statutes confirming or expanding the federal prohibited categories can create difficulties in enforcement of firearm laws, particularly in a small rural state. In Vermont, because there is no state law specifying prohibited categories, if an individual falling within a federally prohibited category (e.g. a convicted felon) is found to be in possession of a firearm, the matter is under federal jurisdiction, and the Bureau of Alcohol, Tobacco, Firearms and Explosives "has primary investigative responsibility."[103]

However, the Criminal Division to the United States Attorneys' Offices itself raised a pertinent issue in its statement on the passage of Title 18, USC, Section 922(g)(9) (the Lautenberg Amendment) in the fall of 1996, noting that in some locales ATF agents "may not be immediately available." Such is the case with Vermont, with one ATF field office based in Burlington, and a limited number of agents

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[97] *GUN CONTROL: Sharing Promising Practices and Assessing Incentives Could Better Position Justice to Assist States in Providing Records for Background Checks*. Government Accountability Office Report to Congressional Requesters. July 2012. GAO-12-684.

[98] Fix NICS Campaign. http://www.fixnics.org/factinfo.cfm

[99] Smart Gun Laws. http://smartgunlaws.org/mental-health-reporting-policy-summary/#footnote_83_5725

[100] Ibid.

[101] Fix NICS Campaign. http://www.fixnics.org/staterankings.cfm

[102] Office of the Federal Register. "Health Insurance Portability and Accountability Act Privacy Rule and the National Instant Criminal Background Check System."

[103] Criminal Division to the United States Attorneys' Offices upon the passage of Title 18, United States Code, Section 922(g)(9) (the Lautenberg Amendment) in the fall of 1996.

to respond to statewide demands.[104, 105]

As noted above, regarding the inability to confiscate weapons from felons, suicide research indicates that men and women who have had contact with the criminal justice system appear to have a significantly higher rate of suicide than the general population.[106]

In summary, barriers exist to local Vermont law enforcement confiscating firearms from individuals in prohibited categories, including those at potentially higher risk of suicide.

• **Domestic Violence**: The issue of seizure of firearms in cases of domestic abuse is highly complicated, under circumstances when the risk of suicide, and combined homicide/suicide, is higher than average. In Vermont, between 1994 and 2012, a total of 29 individuals died by suicide in circumstances related to domestic violence – 27 male and 2 female.[107] Of these instances, 23 involved firearms.

Federal law states that individuals subject to a full relief from abuse order cannot possess firearms, nor can anyone convicted in any court on a misdemeanor domestic violence charge. Federal law does not prohibit firearm possession by an individual under a temporary relief from abuse order. If an individual does not accumulate criminal charges as a result of the relief from abuse order, the guns are likely to be returned.[108]

Historically, Vermont has had no state statutes or provisions around firearm seizure and storage in circumstances related to domestic violence, relying on the federal prohibitions and judicial orders.[109] Since 2009, Vermont's Domestic Violence Fatality Review Commission has recommended annually to the legislature that Vermont follow the lead of New Hampshire, Massachusetts and New York in setting up an official system to ensure confiscation and proper storage of firearms, according to Washington County Sheriff Sam Hill, member of the Commission.[110] New Hampshire passed a state law several years ago that prevents prohibited persons from surrendering their guns to family members or friends, a recommendation the Commission has made to the state legislature.[111] In New Hampshire, a prohibited person can pay to have a federally licensed gun dealer store his or her weapons.

Without state guidance, it has not always been clear to Vermont's law enforcement officials if and when an abuser's gun should be taken away when a relief from abuse order is issued in a case of domestic violence.[112, 113] State judges have discretion to prohibit domestic abusers from possessing firearms as a condition of their relief from abuse order, but Vermont judges have been "reluctant to order local

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[104] "*However, in many locales ATF agents may not be immediately available. The Department will be working with the other federal agencies to determine what if any other investigative alternatives are available. In the meantime, United States Attorneys' Offices should be working with state and local law enforcement to establish guidelines for handling these cases which will often arise in emergency situations, such as when a local officer responds to a domestic complaint and learns that a firearm is present and that one of the parties is prohibited under this statute."* – Ibid - US State's Attorney's Office Statement

[105] Picard, Ken, "Many "Prohibited Persons" Still Have Guns Because Cops Have Nowhere to Put Them." *Seven Days*. 8 May 2013. www.sevendaysvt.com

[106] "Contact with criminal justice system may be associated with suicide risk." *Journal of the American Medical Association*. 8 February 2011.

[107] *Vermont Domestic Violence Fatality Review Commission 2013 Report*. Vermont Domestic Violence Commission.

[108] Ibid.

[109] Ibid.

[110] Ibid.

[111] Picard, Ken. "Many Prohibited Persons…"

[112] Women's Law – www.womenslaw.org

[113] Vermont Network Against Domestic & Sexual Violence – www.vtnetwork.org

police to seize firearms in part because they know many police departments have no place to store them or lack the staff and resources to maintain them properly."[114]

In summary, numerous complications exist concerning removal of firearms from individuals in circumstances involving domestic violence, a population that for multiple reasons is at increased risk for suicidal ideation and potentially violent behavior to self and others.

3. 2014 State Legislative Activity

Recent legislative activity occurred in Vermont following the early March 2014 Town Meeting elections, at which Burlington residents voted to change that town's charter on three separate counts to tighten gun laws: allowing police to seize weapons from suspects of domestic violence, banning firearms from any city establishment with a liquor license, and requiring gun owners to safely store all guns. Town charter changes require state legislature approval, and legislative leaders responded to the vote with statements that the charter changes conflict with existing state gun laws. Approval of the charter changes would require amendment of state laws. Legislators stated that the Burlington charter changes would not be taken up for examination by the legislature, which effectively nullifies their affect.

As part of the spring 2014 legislative season, the Vermont legislature passed H.735, a larger bill related to a variety of state fees, which makes provisions regarding the storage of firearms for people who are subject to a relief from abuse order. The intent was to provide financing for a location at which firearms could be safely held. The bill created a fee structure to provide funding for a holding facility, should firearms need to be turned over to a police department or federally licensed firearms dealer. Considerable debate and changes ensued.[115] The final bill was passed with a different fee structure than originally proposed, but maintaining the ability to collect a fee from the suspect for storage, to provide better ability for police and dealers to store weapons.[116]

A concern that prompted the bill was that in the absence of appropriate storage facilities, individuals subject to a relief from abuse order were often not required to turn weapons over to authorities, but instead could turn them over to friends/family members. This has been controversial in that it does not offer enough protection to the victim of abuse, when the abuser can likely obtain their firearms back easily from a relative or friend as opposed to police or a firearms dealer. Other states, including New Hampshire, limit the potential recipients of surrendered firearms to police.[117]

The original measure created a storage facility requiring firearms be surrendered to the police or a federally licensed firearm dealer, and did not include friends or family in the category of people allowed as holders of weapons. The final bill included language allowing the surrendering of firearms to friends or family, with specific guidelines on the duties and commitment of the person taking possession of the firearms, and specifying that the person taking possession must demonstrate that he/she "understands the obligations and requirements of the Court order," including the potential that they could be "subject to civil contempt proceedings… if the person permits the firearms, ammunition, or other weapons to be possessed, accessed, or used by the person who relinquished the item or by any other person not authorized by law...."[118] Language was also maintained that in the event the person required to relinquish the weapons somehow gains access to them, they will be turned over to police or

[114] Picard. "Many 'Prohibited Persons'…"

[115] Krantz, Laura. "Lawmakers: Deal with Shumlin preempted other gun control measures this session." *Brattleboro Reformer* as reposted by *VTDigger*. 8 March 2014. www.vtdigger.org

[116] Vermont State Statutes.

[117] www.smartgunlaws.org; http://smartgunlaws.org/domestic-violence-and-firearms-in-new-hampshire/

[118] Vermont State Statutes.

a federally licensed firearms dealer.[119, 120]

B. Addressing Access by Suicidal Individuals

1. Existing Vermont Research Base

This research acknowledges the pre-existing efforts of Dr. Eliot Nelson, M.D., to identify research and resources regarding current status of reducing access to lethal means and the potential for a Vermont Gun Shop Project. Dr. Nelson is a Vermont pediatrician, Professor of Pediatrics at the University of Vermont's College of Medicine and Vermont Child Health Improvement Program (VCHIP), and member of the American Academy of Pediatrics Council on Injury, member of Vermont's Child Fatality Review Team, member of the Vermont Suicide Prevention Coalition which advises the Vermont Suicide Prevention Center, a program of the Center for Health and Learning.

Dr. Nelson has done extensive literature review and conducted research on youth suicide and youth firearm suicide, and has therefore been able to provide thoughts and guidance on firearm suicide in general. This research utilizes his work as a guiding model for data collection and analysis. In partnership with the Vermont Child Health Improvement Program, Dr. Nelson has researched and reported data regarding suicide correlates in youth and suicide prevention efforts, tracked decades of firearm-related injury data, and provided testimony at the national level on the need for a strong public health approach to address the crisis.

Dr. Nelson and the Vermont Child Health Improvement Program (VCHIP) have contributed expertise to the assessment of reduction-of-access efforts currently underway in Vermont, and the advisability, potential success, and implementation of a project similar to New Hampshire's Gun Shop Project. While Dr. Nelson's primary research and focus has been with children and youth, as has VCHIP's, both he and VCHIP have consistently watched for the most appropriate avenues and programs to support the extension of the work on lethal means to the adult population, such as a Gun Shop Project.

Findings of research from VCHIP and Dr. Nelson align with the current national findings of organizations such as the Children's Safety Network (CSN), that the significant rate of firearm-related suicide deaths indicates that safe storage and more accurate background checks could help to reduce youth death by firearm – both suicide and unintentional accidental deaths.[121,122] The VCHIP data was readily available for this research, and the careful accounting of Vermont suicide deaths over time and categorical breakdowns readily underlined the strong connection between firearms and suicide death in Vermont. This has been further supported by review of CDC data.[123]

Dr. Nelson facilitated contact between the researcher and the parties best-positioned to advise on the success of New Hampshire's Gun Shop Project – those highlighted in the introduction, including Elaine Frank, at the Injury Prevention Center at Dartmouth; Elizabeth Fenner-Lukaitis, at the New Hampshire Bureau of Behavioral Health; and Catherine Barber of the Harvard Injury Control Research Center of the Harvard School of Public Health. Both Dr. Nelson and Dr. Thomas Delaney of VCHIP have participated in ongoing discussions and review of this document, and offered support and participation going forward on next steps.

The additional data compiled for this report from the Behavioral Risk Factor Surveillance System, the CDC's Web-based Injury Statistics Query and Reporting System database, the FBI's Crime in the US reports, and additional resources, contribute to the base of research to provide a solid statement regarding Vermont's suicide

[119] Krantz, Laura. "Deal on gun storage reached in conference committee." *VTDigger*. 7 May 2014. www.vtdigger.org

[120] Vermont State Statutes.

[121] *Vermont Suicide Prevention Brief December 2013.*

[122] *Firearm Related Injuries among Youth Ages 15 through 24*. Children's Safety Network.

[123] *Vermont Suicide Prevention Brief December 2013*, et al.

crisis. The data underscores the need to approach the challenging issue of firearms access by suicidal individuals in a creative and thoughtful manner.

2. Existing Vermont Infrastructure: Vermont Suicide Prevention Center & Vermont Suicide Prevention Coalition

Vermont has strong existing resources in the area of reducing access to lethal means advocacy and action. The Vermont Suicide Prevention Center (VT-SPCe) represents an inter-agency, public and private effort to address the issue, and is advised by the active body of the Vermont Suicide Prevention Coalition (VT-SPCo).

The VT-SPCo brings together a thriving body of Vermont professionals and volunteers deeply committed to the cause of suicide prevention. The Coalition counts among its members strong advocates for reducing access to lethal means regarding firearms, including Eliot Nelson, MD, a leading voice in keeping firearm means restriction in the discussion of state suicide prevention work, and Thomas Delaney, PhD., of VCHIP, and Chief Evaluator of the Vermont Youth Suicide Prevention project.

The Vermont Suicide Prevention Center, under the management of the Center for Health and Learning, provides an existing infrastructure to facilitate forward movement with chosen initiatives. The Coalition provides an existing source of committed individuals to conduct legwork.[124]

Reducing access to lethal means has been one of the major goals of the national and Vermont Platforms for suicide prevention since 2004. The Coalition demonstrated its interest and action-minded approach to the topic in spring of 2014, when the body voted to endorse legislation concerning bridge barrier modification as a form of reducing access to lethal means – and utilized the opportunity to underline the public health crisis of suicide death by the means of firearms.[125] In sending the letter of support for the bill to the legislature, the Coalition elaborated on the importance of examining reducing access to lethal means regarding all means, and the clear need to prioritize means restriction efforts as pertains to firearms – the most common form of means used in suicide in Vermont.[126]

The VT-SPCo has advocated consistently for a strong presence of information on reducing access to lethal means at the annual Vermont Suicide Prevention Symposium. In 2013, Cathy Barber, MPA, of the Harvard School of Public Health's Injury Control Research Center presented on Why Means Matter. Her presentation focused on the efficacy of reducing access to lethal means as a suicide prevention mechanism, including a discussion of New Hampshire's Gun Shop Project. Ms. Barber participated in the Gun Shop Project creation in New Hampshire.

In the 2014 Vermont Suicide Prevention Symposium Elaine Frank, MHS, developer of the New Hampshire Firearm Safety Coalition and a primary force in the creation of the Gun Shop Project, presented on CALM: Counseling on Access to Lethal Means. Ms. Frank is the co-developer of CALM, a training program on why and how to address lethal means reduction that works directly with mental health workers who counsel families. The work of CALM, while initially piloted for family counselors with youth in crisis, provides an applicable model that transfers well to an adult audience.

3. Firearm Community & Safety Norms

As noted in the prior section "Current Status," Vermont has many residents who own firearms – for hunting, sport shooting, collecting, and self-defense. Vermont has a strong hunting and shooting community, and has a number of active groups strongly supportive of firearm ownership, including the Vermont Federation of Sportsmen's Clubs, Gun Owners of Vermont, Vermont Citizen's Defense League, and Vermont 2A. These organizations are generally opposed to legislative changes to Vermont's current gun laws. There is recognition in the firearms community that the gaps in the NICS database

[124] Eliot Nelson, MD; Thomas Delaney, PhD; Linda Heimerdinger, LICSW.

[125] Correspondence from the Vermont Suicide Prevention Coalition to the Vermont Legislature.

[126] *Vermont Suicide Prevention Brief December 2013*.

concerning state records is an issue affecting safety, and while numerous points are debated within the firearm community itself on FBI reporting and what qualifies as an infraction that should invoke prohibition of purchasing or owning firearms, many in the shooting community support ensuring the NICS database receives full records from states on individuals who may be a danger to self or others.[127]

Firearm owners as a community – and Vermont firearms owners in particular – are safety conscious, as is demonstrated by the low rate of accidental gunshot wounds referenced in "Current Status" above. Reliable numbers on gun storage practices are difficult to obtain, as statistics vary widely from study to study, but in addition to the statistics quoted above on Vermont gun owners' safety practices, additional studies repeatedly find that the majority of gun owners do not store guns loaded. Statistics show that locked storage of guns is more variable, and ranges from "approximately half" to 75% of gun owners utilizing locking gun storage.[128, 129, 130] The number of accidental deaths due to firearms has decreased over the last thirty years in the US as a whole, which indicates increased safety among gun owners and gun-owning households over time.[131]

The large majority of organizations dedicated to the promotion of hunting, sport shooting, collecting and firearm ownership emphasize safety. In Vermont, all first time hunters must successfully complete the free Hunter's Safety Course before getting a hunting license.[132] In conducting this research, the presence of the Four Rules of Gun Safety and the Ten Gun Safety Rules (by various names) were prominently located throughout materials. The National Rifle Association conducts numerous nationwide trainings, education programs, and safety courses – and maintains certified instructors in all states, including Vermont. Certified instructors are trained to "uphold the quality and integrity of national firearm safety and training standards established by NRA," and "promote firearm safety and the shooting sports."[133] The NRA created the Eddie Eagle GunSafe® Program to "teach children in pre-K through third grade four important steps to take if they find a gun."[134] It also offers youth-specific safety and training programs, and produces numerous safety materials, including its Ten Gun Safety Rules.[135]

The National Shooting Sports Foundation (NSSF), the trade association for the firearms industry with more than 8,000 members – including manufacturers, distributors, firearms retailers, shooting ranges, sportsmen's organizations and publishers – states that since 1961, the organization has "strived to promote firearm safety education across the United States through a variety of outreach programs."[136] The NSSF maintains prominent safety information on its website, that displays the well-known and widespread *Rules of Safe Gun Handling*.[137] The NSSF runs the First Shots® Program, and First Shots: Second Round, for new gun owners both youth and adult. With a stated goal of promoting safe and responsible firearm ownership and use, free seminars are held at

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[127] Fix NICS. www.fixnics.org

[128] Azrael, Deborah, MS, et al. "Are Household Firearms Stored Safely? It Depends on Whom You Ask." *Pediatrics*. Vol. 106 No. 3, 1 September 2000.

[129] Dahlbert, Linda L. et al. "Guns in the Home and Risk of a Violent Death in the Home: Findings from a National Study." *American Journal of Epidemiology.* 2004; 160 (10): 929-936. doi: 10.1093/aje/kwh309.

[130] Johnson, Renee M., PhD, et al. "Are Household Firearms Stored Less Safely in Homes With Adolescents? Analysis of a National Random Sample of Parents." *Archives of Pediatric Adolescent Medicine*. August 2006; 160(8): 788–792. doi: 10.1001/archpedi.160.8.788.

[131] Barrett, Paul M. "Guns, Children and Accidents: Four Blunt Points." *BloombergBusinessWeek*. 30 September 2013.

[132] Vermont Fish and Wildlife; http://www.vtfishandwildlife.com/edu_hunter.cfm

[133] NRA Programs & Services. www.training.nra.org/instructors.aspx

[134] NRA Programs & Services. www.eddieeagle.nra.org/

[135] NRA Programs & Services. www.youth.nra.org/resources-information.aspx

[136] http://www.nssf.org/

[137] Ibid.

partner ranges throughout the country, of which Vermont has two.[138] The NSSF is directly involved in three national firearm safety efforts including Project ChildSafe, Don't Lie for the Other Guy, and FixNICS.

Project Childsafe: www.projectchildsafe.org

Project ChildSafe was developed and is sponsored by the National Shooting Sports Foundation® (NSSF), and is a 501(c)(3) nonprofit organization. It is a nationwide program that promotes safe firearms handling and storage practices among all firearm owners through the distribution of safety education messages and free firearm Safety Kits. The kits include a cable-style gun-locking device and a brochure that discusses safe handling and storage. Since 2003, the Project has partnered with local law enforcement agencies to distribute more than 36 million safety kits to gun owners in all 50 states and five U.S. territories. As of April 2014, more than 500 retailers, sporting clubs and conservation organizations have signed on to support the Project ChildSafe program and promote the message "Own It? Respect It. Secure It."

Don't Lie for the Other Guy: www.dontlie.org

The NSSF partners with the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) in the latter's "Don't Lie for the Other Guy" campaign. The aim is to better educate America's firearms retailers on how to detect would-be straw purchasers and to raise public awareness that it is a serious crime to buy a firearm for a prohibited person or for someone who does not otherwise want his or her name associated with the transaction. The campaign was developed by NSSF and ATF in 2000 and has been active in cities around the country. The ATF identifies key cities in which to launch the Don't Lie campaign. Firearms retailers in and around the city receive enhanced training materials on identifying straw purchasers. NSSF leads a public awareness campaign to educate members of the community on what a straw purchase is and the severe penalties associated with attempting such an illegal buy.

FixNICS: www.fixnics.org

FixNICS is a national campaign of the NSSF to encourage states to report to NICS all records that establish someone is prohibited from owning a firearm under current law. FixNICS states, "FBI NICS databases are incomplete because many states have not provided all records that establish someone is prohibited from owning a firearm under current law, especially including mental health adjudications and involuntary commitments orders. However, a background check is only as good as the records in the database. That is why the firearms industry supports improving the current NICS system by increasing the number of prohibiting records states submit to the FBI databases, helping to prevent illegal transfers of firearms to those who are prohibited from owning firearms under current law. Including these missing records will help ensure more accurate and complete background checks."

The culture of safety that exists in the firearms community could be a tool in reducing the rate of firearm-related suicide deaths, through emphasizing group norms of watching out for and protecting friends and family.

4. Legislative Advocacy

Vermont has a number of grassroots organizations advocating on gun laws, both to maintain the status quo and to change Vermont's laws. These organizations represent strong voices in the state on the issues of firearm ownership, purchase, background checks, safety, storage, and others as they arise.

Among a number of organizations advocating maintaining Vermont's current legislative stance on firearms, are the following:

Vermont Federation of Sportsmen's Clubs, Inc. http://www.vtfsc.org/

[138] Ibid.

The VFSC is Vermont's NRA State Association. The stated mission of the organization includes:

- Protect, restore, educate, improve & help manage our land, water, air, our game, fish, birds, other wildlife & natural resources.
- Preserve our right to hunt, fish, trap, and own firearms.
- Promote and encourage good sportsmanship. Foster & encourage all the shooting sports.
- Encourage the public to respect fish & game laws & regulations.
- Strengthen good landowner/sportsmen relations.
- Educate the public on issues affecting fish & wildlife.
- Support other organizations with goals similar to the Federations.
- Encourage communications among sportsmen, landowners, non-hunters, anglers, and trappers, government, and the general public.
- Monitor & lobby legislature on issues important to the sportsmen.
- Sponsor the Keenan Memorial Fund which promotes conservation training and good sports skill and attitudes amongst young people.

The VFSC has been in existence since 1875, and has representation from multiple hunting, sport shooting groups and clubs throughout the state. They maintain a registered lobbyist and are highly active in legislative advocacy to maintain Vermont's gun laws in their current state.

Gun Owners of Vermont, Inc. http://www.gunownersofvermont.org/
A non-partisan pro-gun organization, "committed to a no-compromise position on firearms ownership rights." Gun Owners of Vermont's organizational mission is to "supply facts to members about pro-gun and anti-gun legislation, legislators' voting records, statements, and to lobby on the state level." Like VFSC, they provide advocacy and network among gun owners. They focus specifically on the right to bear arms, as opposed to the wider, hunting and sporting goals of VFSC.

Vermont Citizen's Defense League http://vtcdl.org/
Vermont Citizen's Defense League is dedicated to supporting the Vermont Constitution, Chapter I, Article 16th, "that the people have a right to bear arms for the defense of themselves and the state."
Their website identifies their goals as –

- Organize: Bringing Vermont gun rights activists together.
- Educate: Dispelling anti gun myths and propaganda.
- Lobby: Defending our rights against corruption and outside influence.

As stated in their goals, VCDF is specifically an activist and advocacy organization, focused on the issue of the right to bear arms.

Vermont2A https://www.facebook.com/pages/Vermont2A/409882772432036
Vermont 2A is identified as "a second amendment resource for Vermonters to provide up to date information about legislative matters that erode our second amendment rights." The organization's focus is on legislative advocacy.

Local Action
Along with these four organizations with their specific legislative work, Vermont fields a large number of localized hunting and sporting groups and clubs throughout the state, along with shooting ranges and affinity groups. These organizations have independent missions, but are networked through the statewide organizations and come together around issues of import to the hunting and shooting community. Dedicated members of the community throughout the state participate in letter-writing campaigns, host and attend forums, and communicate with their legislators.

Current action advocating changes to Vermont gun laws is primarily driven by Gun Sense Vermont.

Gun Sense Vermont www.gunsensevt.org
GSV is an independent, grassroots organization begun in 2013, advocating changes to Vermont law to codify firearm

safety measures. GSV has both gun-owning and non-gun-owning members from over 160 Vermont towns, a mailing list of 1,400 people as of April 2014, and at last report had acquired over 7,000 signatories on a broadly-worded petition asking Vermont's governor to strengthen Vermont's gun laws.[139] In its one year of existence, GSV has cultivated a strong, visible public presence.

GSV is committed to not taking an anti-gun stance. The organization strives to not be a polarizing force, but rather promote its position as "pro-gun responsibility." Their emphasis regarding suicide prevention and education is to encourage the community approach – as a community, we take care of our friends, and if they have guns and are experiencing troubled times, we can offer to support them by holding onto their firearms for them.

Like the advocacy organizations above, GSV works primarily on a legislative level, "seeking to close the gaps" in Vermont's gun laws and to "affirm that respecting the second amendment can go hand in hand with keeping guns out of the wrong hands and saving lives."[140] The organization's current priority goal is universal background checks.[141] GSV's analysis is that the universal background check initiative is an accessible goal that does not create new gun control measures, but rather works to improve pre-existing federal mandates that have gaps in application and enforcement. Specifically, GSV advocates making the background check policy apply to private sales, private online transactions, and transfers of firearms between unrelated individuals.

GSV hopes to establish an ongoing relationship with legislators about gun safety, to help legislators understand that there is citizen support for such measures.[142] GSV has begun working with a lobbyist, and is forming a Political Action Committee. GSV advocates the incorporation of public records into the federal background database, an effort for which federal grant funds have been made available, to assist states in accomplishing in the 2007 NICS Improvement Act.

Despite consistent effort to be clear and vocal concerning GSV's respect for the Second Amendment right to bear arms, founder Ann Braden recognizes that in advocating for legislative changes of any nature to Vermont gun laws, GSV has been perceived as anti-gun ownership by individuals greatly vested in the topic of firearm legislation, and she works to correct this misperception.[143]

5. Existing Program Interventions

The *Gun Shop Project* is a creative, grassroots approach that is well-founded in public health theory and historical findings on the success of peer outreach in changing community norms. Formed through the local initiative of Elaine Frank, at the Injury Prevention Center at Dartmouth College, and Ralph Demico, owner of Riley's Sport Shop in New Hampshire, the project employed direct peer messaging to the target audience – the owners of sporting goods stores, and the gun-owning community.

A two-fold approach included a tip sheet for firearm dealers on recognizing the warning signs of a potentially suicidal customer, and collateral material to be displayed in the gun shops to be seen by customers. The tip sheet gave employees basic education about what to watch for and how to be aware of suicide risk. The collateral material included posters that were designed with the assistance of the gun-owning community, depicting two men sitting at a kitchen table, with a handgun on the table between them. One is obviously distraught while the other is listening. The message of the poster is clearly stated – if you are concerned about a family member or friend, ask them how they are doing. It displays a short list of warning signs, and highlights the important facts

[139] Personal interviews with Ann Braden, 3 March 2014 and 13 May 2014.

[140] Ibid, and www.vtgunsense.org

[141] Ibid.

[142] Ibid.

[143] Personal interviews with Ann Braden, 3 March 2014 and 13 May 2014.

that guns are the leading cause of suicide deaths, and that attempts with guns are more deadly than suicide attempts with other means.

An additional piece of collateral produced is the 11th Commandment of Gun Safety brochure, which capitalizes on the well-known tradition of the 10 Commandments of Gun Safety in the gun-owning community, and adds an 11th with the message that if a loved one is at risk for suicide, hold their firearms for them. Suicide hotline cards were also distributed to the gun shops for display, in an effort to increase the general knowledge level and awareness about suicide.

The founders report success with their process outcomes, of approximately 50% of firearms dealers utilizing the distributed materials, and 50% of the materials still being up and visible one year later. They do point out that no official study has yet been conducted linking a Gun Shop Project with a causal decrease in suicide deaths by firearm in the communities reached with messaging. As an education and awareness campaign, these connections remain to be studied.

Given the risk factors found in this research and applying the public health knowledge concerning the benefits of peer outreach, taking action on a Gun Shop Project, a low-cost effort with positive participation from the target audience and excellent existing models, is promising. Enhancing such a project with additional creative programming that support a similar outcome, some of which has demonstrated results under study, may increase efficacy.

To this end, the following existing interventions are summarized, as potential enhancing efforts.

CALM: Counseling on Access to Lethal Means

Another strong prevention effort that originated in New Hampshire is CALM: Counseling on Access to Lethal Means, created by Elaine Frank from the Injury Prevention Center at Dartmouth College and Mark Ciocca from Capital Valley Counseling. CALM is a program designed to train mental health care providers to conduct firearm safety counseling with parents of their young clients, and to reduce at-risk youth's access to firearms and medications as a preventive strategy for suicide. The program is listed in the Best Practices Section III – Adherence to Standards of the Suicide Prevention Resources Center (SPRC).

During the two-hour training workshop, mental health care providers are introduced to the public health approach to suicide prevention and the importance of reducing access to firearms and medications as a prevention strategy. Upon completing the training, participants have better understanding of the association between access to lethal means and youth suicide, and the importance of counseling parents about reducing access to lethal mean.[144] The course emphasizes that restricting access to medications, firearms, and other lethal means should be part of a comprehensive suicide prevention strategy. The CALM training dispels the myth that "taking away one method for suicide will simply cause someone to find another one," teaching that 90 percent of people who survive a suicide attempt do not go on to die by suicide.[145] While the basic outline of CALM is geared toward family counselors working with youth in crisis, the success of the program as a best practice suggests an analogous approach to preventing suicide in adults.

This research-based program now also includes a free online course, also called Counseling on Access to Lethal Means (CALM). Based on the in-person workshop, the online course was produced by the developers of the original workshop (including Elaine Frank, referenced throughout this report), the SPRC, the Harvard Injury Control Research Center at the Harvard School of Public Health, and the Injury Prevention Center at Dartmouth College. Students who finish the course, take a pre- and post-test, and provide feedback will receive a certificate of completion. Those completing the course are also eligible for two hours of continuing education credit

[144] C.A.L.M. – Counseling on Access to Lethal Means. Best Practice Registry, Section III. Suicide Prevention Resource Center.

[145] *SAMHSA News.* Spring 2014, Volume 22, Number 2.

from the National Board for Certified Counselors or the National Association of Social Workers.[146]

In promoting the new free online course this spring, the Substance Abuse and Mental Health Administration (SAMHSA) notes that while the program was designed for those who already have training and experience in mental health counseling. It is also appropriate for substance abuse counselors and primary care providers. The Harvard School of Public Health has evaluated the training in NH, and found it to be well received by the majority of trainees. The CALM workshop was presented to a state firearm safety coalition; "representatives from gun manufacturers and gun owner groups on the coalition found the workshop content acceptable and largely non-controversial."[147]

While CALM has existed for some time, Vermont would be well-served by bringing more attention to the availability of the free online training, or by organizing additional in-person trainings in the state. Plans by the developers are currently underway to expand CALM trainings to emergency department and primary care health providers. This research finds that thus far, CALM has been underutilized in Vermont as a resource.

The Vermont Suicide Prevention Coalition is aware of this program, and Elaine Frank presented a workshop on CALM at the 2014 Vermont Suicide Prevention Symposium. This increased activity and exposure at the Symposium provides a knowledge base for increased use of CALM overall by Vermont professionals.

With the Vermont Department of Mental Health's stated intent to deliver to primary care and other clinicians a 2014 report on the highest efficacy prevention means, CALM is strongly recommended for further consideration and inclusion in that collection.

Man Therapy™

Man Therapy™ is an inventive online suicide prevention campaign produced by Cactus, a Denver-based ad agency, in conjunction with the Carson J. Spencer Foundation and the Office of Suicide Prevention at the Colorado Department of Public Health and Environment (CDPHE). Man Therapy™ uses a fictional character – Dr. Rich Mahogany – to create a humorous, inviting website setting for men to click through. Development of the campaign utilized focus groups and direct feedback from the target audience to determine a successful approach to talking about mental health with a middle-aged, white male audience.[148] With features such as the "18 Point Head Inspection," Man Therapy™ uses an interactive approach that has produced promising results during it's initial evaluation phase of July 2012 through January 2014. The approach has been so promising from the beginning of implementation, that in June 2013 Australia arranged to license the concept for nationwide deployment with an Australian-tailored approach, creating a new "therapist" – Dr. Brian Ironwood.[149]

Current tabulation of the first 18 months indicates that the website is achieving a high number of visits, at 359,537 hits, of which 288,917 are unique visitors.[150] The utilization of the website features is encouraging:

- 38,249 visitors took the 18 Point Head Inspection.
- 22,390 visitors took the mobile quiz version of the 18 Point Head Inspection.
- 19,476 called the crisis line.[151]

Also of note is that at the end of the initial evaluation period, the website was still averaging a "length of stay" by visitors of 6 minutes, which is extremely successful in web analytics.[152] Among the most notable qualitative data:

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[146] *SAMHSA News.* Spring 2014, Volume 22, Number 2.

[147] Means Matter. Harvard School of Public Health.

[148] *Using Online Communications Approaches for Suicide Prevention: An Overview of Communication Planning for Prevention and an Applied Example from Colorado's Mantherapy.org*. Webinar. South by Southwest Injury Prevention Network. 14 January 2014.

[149] Ibid.

[150] Ibid.

[151] Ibid.

[152] Ibid.

- 80% would recommend the site to a friend.
- 50% "agreed" or "strongly agreed" that they were more likely to seek help after visiting the website.[153]

In a culture that actively discourages men from discussing emotional/mental health issues and displaying vulnerability, a resource that increases interest in help-seeking and that men feel comfortable recommending to a friend is a valuable asset. In an effort such as the one under study in this report – the Gun Shop Project – that is working to actively engage the value of male friendship, companionship, loyalty and caring, this type of resource could greatly augment impact.

Zero Suicide

Zero Suicide is a national movement to integrate depression and suicide risk screening into healthcare settings. It is an intervention focused on eliminating suicides in healthcare and behavioral healthcare systems, and includes a specific set of tools and strategies. The core message is that suicide deaths for people under care are preventable, but to prevent these deaths people must be asked about depression and suicide directly by their healthcare professionals.[154] This is an approach that has not been advocated in the past for primary care settings.[155]

The tenets of Zero Suicide include:[156]

1. Creating a leadership-driven, safety-oriented culture that commits to the goal
2. Systematically identifying and assessing suicide risk levels
3. Ensuring every person has a "pathway to care" that is timely and adequate
4. Developing a competent, confident, and caring workforce
5. Using effective, evidence-based care, including collaborative safety planning, restriction of lethal means, and effective treatment of suicidality, specifically
6. Continuing contact and support
7. Applying a data-driven quality improvement approach to inform system changes

While all aspects are equally important for a full consideration of Zero Suicide, for the purposes of this research and reaching a potentially at-risk population of Vermont gun owners, numbers 2, 3, and 5 are of particular import. These three tenets address the following facts:

1. More people are seen in primary care than in mental health care and individuals identified as at risk require a "pathway to care" – both especially true of men, particularly those resistant to the idea of mental health treatment.[157, 158, 159]
2. Reducing access to lethal means by suicidal individuals is an evidence-based approach to suicide prevention.[160] Zero Suicide lays out a structure of asking directly about suicide with a short screening tool, enacting a safety plan including discussion of access to lethal means if screening is positive, and talking to family if the individual is willing.

To understand the import of this approach, it is necessary to understand that primary care providers see patients who never enter the mental health system. The

[153] Ibid.

[154] Zero Suicide. www.zerosuicide.actionallianceforsuicideprevention.org

[155] United States Preventive Task Force. Recommendations. www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/suicide-risk-in-adolescents-adults-and-older-adults-screening. 2 October 2014.

[156] Zero Suicide. www.zerosuicide.actionallianceforsuicideprevention.org

[157] Freed, Betsy Bates and David. "Aversion to Therapy: Why Won't Men Get Help?" *Pacific Standard: The Science of Society*. 25 June 2012.

[158] Men and Depression. National Institute of Mental Health. www.nimh.nih.gov/health/topics/depression/men-and-depression/men-and-depression-screening-and-treatment-in-primary-care-settings.shtml

[159] Winerman, Lea. "Helping Men Help Themselves." *Monitor on Psychology*. American Psychological Association. Vol 36, No 6. June 2005.

[160] Zero Suicide. www.zerosuicide.actionallianceforsuicideprevention.org

primary care doctor's office is a setting of privacy and confidentiality that offers a level of sanctioned vulnerability – a place were high-risk individuals may be able to allow the level of vulnerability necessary to display emotional distress.

Primary care already plays a role in suicide – providers regularly see patients who go on to die by suicide, sometimes within just a few weeks or months of their death. Current analysis indicates:

- 83% of persons who died by suicide received health services in the year prior to death. Half of those received health services within four weeks of death.[161]
- 45% of people dying by suicide had contact with their primary care physician within one month before dying by suicide. This number leaps to 75% of older adults, especially older men.[162, 163]
- Half of those who died by suicide did not have a mental health diagnosis; only 24% had a mental health diagnosis within the four-week period prior to death.[164]
- Over 60% of those who died visited a medical specialist or primary care provider without a mental health diagnosis.[165]
- Those who died following a primary care visit were more than twice as likely to have seen their PCP rather than a mental health counselor.[166]
- Most antidepressants are prescribed by primary care physicians, including family doctors and pediatricians, with almost four out of every five prescriptions for psychotropic drugs in the U.S. written by physicians who aren't psychiatrists.[167]

Given the evidence, primary care professionals are seeing people in a great deal of emotional distress and primary care is the treatment-of-choice for many depressed patients. As efforts to de-stigmatize help-seeking among men are implemented through multiple messaging approaches, Zero Suicide offers a strong complement to the models described herein by identifying healthcare interactions as a prime venue.

C. Summation

Suicide research strongly supports the findings that choice of means makes the most significant difference in whether or not a suicide attempt will result in death, or provide enough delay that help can be implemented. The choice of method can be seen as the final "fork in the road" that is the strongest predictor of the outcome for the suicidal individual. The simple model below based on the work of Keith Hawton, PhD, provide a visual depiction of this fork, and how critical that moment can be.[168]

Logically, there is a high rate of firearm suicide death in Vermont – particularly among men – because firearms are the most fatal method of suicide, and for Vermont men the most common method used. The high rate of completed suicides by males in Vermont is directly linked to the choice of firearm as mans. Decreased access to firearms by an individual in a suicidal crisis allows more time and opportunity for other lifesaving interventions.

Vermont's status in the area of reducing access of

[161] Ahmedani, et al. "Health Care Contacts in the Year Before Suicide Death." *Journal of General Internal Medicine*. DOI:10.1007/s11606-014-2767-3.

[162] Zero Suicide. www.zerosuicide.actionallianceforsuicideprevention.org

[163] Luoma JB, Martin CE, Pearson JL. "Contact with mental health and primary care providers before suicide: a review of the evidence." *American Jounral of Psychiatry*. 2002; 159(6):909-16.

[164] Ahmedani, et al. "Health Care Contacts in the Year Before Suicide Death." *Journal of General Internal Medicine*. DOI:10.1007/s11606-014-2767-3.

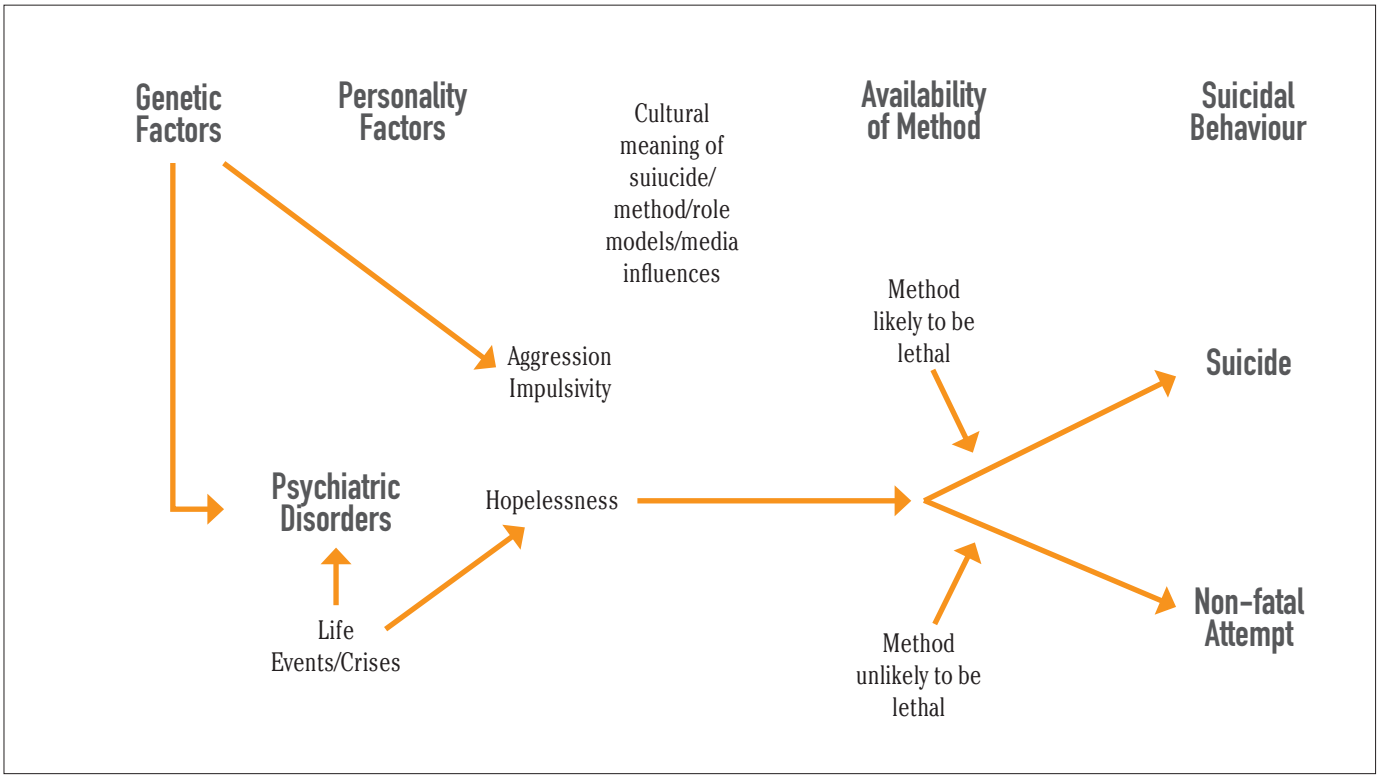
[165] Ibid.

[166] Zero Suicide. www.zerosuicide.actionallianceforsuicideprevention.org

[167] Smith, Brendan L. "Inappropriate prescribing." *APA Monitor.* June 2012, Vol 43, No. 6. http://www.apa.org/monitor/2012/06/prescribing.aspx.

[168] Keith Hawton, PhD.

Simplistic model of some causes of fatal and non-fatal suicidal behaviour



Modified from Keith Hawtion, PhD

suicidal individuals to lethal means as regards firearms can be summarized in the following factors:

1. The existing body of evidence demonstrates a strong link between firearms and suicide in Vermont. The overlap between Vermont's demographic profile and the current national findings on suicide and age, race, and gender, further suggests that Vermont would do well to reach out to a population that not only fits the increased-risk demographic, but also has a high chance of already owning a firearm.

2. Current Vermont firearm laws codified into the statutes and culture of the state have few restrictions on firearm purchase and ownership. Both the legislative and executive branches of the state government are resistant to legal measures perceived to affect access to and ownership of firearms in any way. As elsewhere across the nation, the citizens of Vermont demonstrate strong feelings on both sides of the issue, and there are organized citizen groups advocating both for and against changes to Vermont law.

3. Strong infrastructure exists for moving forward on actions outside of the legislative process to address prevention of suicide deaths by firearms, including the organizational capacity of the Vermont Suicide Prevention Center; solid leadership and proactive groundwork already in place by members of the Vermont Suicide Prevention Coalition; strong connections with supportive professionals with extensive experience conducting a Gun Shop Project; and enthusiasm for such a project among the membership of the Vermont Suicide Prevention Coalition.

4. Numerous highly active organizations of passionate firearm-owners exist in Vermont, with large memberships who care a great deal about their community and communicate frequently. The community exhibits a high degree of similarity to the hunting, sporting

and firearm culture of New Hampshire, a state that has successfully implemented a community outreach campaign in the Gun Shop Project.

5. Citizen legislative advocacy is ongoing for changes to state firearm laws, to increase universal background checks and improve the NICS records reporting, with strong grassroots presence and visibility.

Lowering the risk of suicide by firearm in the gun-owning community is a complicated issue that may best be addressed from the inside of that community, through emphasis on its pre-existing culture of "watching out for each other," and pride in their own commitment to gun safety.

It is important to distinguish that this issue, at its central essence, is not about refusing ownership of firearms or taking firearms away from citizens who care deeply about owning them. Rather, this issue is about finding and helping individuals who are struggling with so much pain and despair, that they are more likely to attempt suicide – and if they own a gun, they are more likely to utilize that gun in the attempt. When a gun is used in the attempt, it most often ends in death.

This research finds that to decrease firearm deaths by suicide the immediate focus must be on recognizing that saving the lives of gun owners is a conversation and a cause that must be shifted from firearm legislation to mental health promotion, and to communities, families, and networks of friends and peers. How can a community support efforts to help gun owners in crisis reach out for help, rather than reach for their gun at the moment of greatest despair? How can a community support the family and friends of gun owners in reaching out to their loved ones in need?

In conclusion, efforts to increase awareness and reduce risk in the gun-owning community need to be completely decoupled from legislative efforts related to firearms. Efforts toward visibility and awareness campaigns, and reduction in the stigma attached to mental health concerns and help-seeking, are strongly advised.[169]

A Gun Shop Project based on the New Hampshire model offers a feasible, accessible first step approach, if implemented with the expert advice and guidance of gun owners themselves. Vermont is well-positioned to take action immediately and launch the first step – a Vermont Gun Shop Project. Further efforts to enhance the aims of the Gun Shop Project through interventions such as Zero Suicide, CALM and Man Therapy™ are strongly advised as ongoing follow up.

III. REDUCING ACCESS TO LETHAL MEANS: OTHER

A. Overview

As noted in Section II, the vast majority of Vermont suicide deaths (60%) are the result of firearms, higher than the national average of 50%.[170, 171] The speed of movement from preparation to attempt, coupled with the high lethality of firearms, makes them the primary focus in reducing access to lethal means efforts. As such, this research focused primarily on firearms. However, a brief review was conducted of restriction of other lethal means. A more detailed review is beyond the scope of this research.

Other lethal means accounting for suicide deaths in Vermont include: poisoning-including overdose (22%); suffocation, including hanging (14%); drowning (2%); cutting or piercing (1%); and falls (1%). The specific means used in these deaths varies, and restriction can be considerably more complicated, such as high structures to leap from, plastic bags for suffocation, or access to

[169] One possible exception, based on data from other states, may be child-access prevention laws. See Webster, ScD, MPH, Daniel W., et al, "Association Between Youth-Focused Firearm Laws and Youth Suicides." *Journal of the American Medical Association*, Vol 292, No. 5, 594-601. 4 August 2004.

[170] VCHIP, Vermont Vital Statistics System.

[171] American Foundation for Suicide Prevention.

over the counter medications for overdose.

A notable sex discrepancy exists when considering lethal means. The most recent Vermont research tells us that men are four times more likely to die by suicide than women overall, and 64% of male suicide deaths were firearm related. Here we see reflected the effects of high lethality of means choice. While 43% of female suicide deaths were also firearm related, a higher number were due to poisoning, at 48%.[172] Nationally, poisoning is third on of the list of common means of suicide. Poisoning represents 17% of all suicides nationally, compared to firearms comprising 51% and suffocation comprising 25%. In Vermont, poisoning is the second most common form of suicide death, accounting for 22% of Vermont's death by suicide, and is the leading cause of suicide death for Vermont women.[173]

B. Other Means

1. Poisoning

At 22% of all suicide deaths in Vermont, poisoning is the second leading lethal means in the state. In addressing reducing access to lethal means, it is important to consider that poisoning, and the restriction of medications and other life threatening substances, is of equal or greater concern for females as firearms.

This is especially true as Vermont examines suicide prevention over the lifespan, with a considerable uptick in Vermont suicide rates among women after age 65[174], an age range with a higher likelihood of being prescribed pain killers, along with other medications. The Mayo Clinic, a leader in pain research and management, indicates that women and older adults receive more prescriptions overall.[175]

The Department of Health and Human Services National Health Interview Survey reports that women are more likely to have chronic pain, to be prescribed higher doses and to use pain medication longer than men. They are twice as likely as men to have migraines and severe headaches.[176] Women are much more likely to experience fibromyalgia than men, with middle-aged women at highest risk.[177] Women make up 80 to 90% of the diagnosed cases of fibromyalgia.[178]

Midlife is now the peak age for suicide death for both men and women, with suicide rising from the 8th leading cause of death for 35 – 65 year olds in 1999, to the 4th in 2010.[179] Notably, in the same time period that saw such an increase in suicide deaths in midlife, the rate of overdose deaths in women rose 40%, mostly middle-aged women taking prescription painkillers. This is a significant change from previous decades in which the majority of overdose deaths nationally were men using heroin or cocaine.[180]

Overdose deaths include both suicidal and accidental overdose, and nationally men still die by overdose at significantly higher rates than women.[181, 182] This is an important consideration when reviewing these data.

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[172] VCHIP, Vermont Vital Statistics System.

[173] Ibid.

[174] Ibid.

[175] Age and Sex Patterns of Drug Prescribing in a Defined American Population; Wenjun Zhong, PhD, Hilal Maradit-Kremers, MD, MSc, Jennifer L. St. Sauver, PhD, MPH, Barbara P. Yawn, MD, MSc, Jon O. Ebbert, MD, Véronique L. Roger, MD, MPH, Debra J. Jacobson, MS, Michaela E. McGree, BS, Scott M. Brue, BS, Walter A. Rocca, MD, MPH; Mayo Clinic Proceedings; June 21, 2013; www.mayoclinicproceedings.org

[176] *Department of Health and Human Services National Health Interview Survey*; Department of Health and Human Services Report (23).

[177] Mayo Clinic Fibromyalgia; MedLinePlus of the National Institutes of Health.

[178] National Institute of Health, National Institute of Arthritis and Musculoskeletal and Skin Diseases. www.niams.nih.gov/Health_Info/Fibromyalgia/

[179] *Surprising Health Disparity: Suicide among Men in their Middle Years*. Webinar. Injury Control Research Center for Suicide Prevention. 11 March 2014.

[180] Stobbe, Mike. "Drug overdose deaths spike among middle-aged women." *The Big Story*. AP. 2 July 2013.

[181] "CDC - Vital Signs: Overdoses of Prescription Opioid Pain Relievers – United States, 1999 – 2008." *Morbidity and Mortality Weekly Report*; 60(43); 1487 – 1492. 4 November 2011.

[182] *AAPM Facts and Figures on Pain*. American Academy of Pain Medicine. www.painmed.org

However, Vermont data from 2010 indicates that poisoning – including intentional overdose – is a more common a choice of lethal means for suicidal women in Vermont as is firearms. The most recent data analyzing the period of 2001 through 2013, indicate that [intoxication] remains the leading cause of death for women at 44%, with the rate of firearm suicides 23%.[183]

Also notable is the rate of attempted suicides by poisoning. At the last calculation for the time period for which solid data is available, poisoning was the cause of 76% of female suicide attempts.[184] Coupled with the higher rates of chronic pain in women and this significant rise in female overdose death, is the fact that people in rural counties are approximately two times more likely to overdose on prescription painkillers as urban dwellers.[185]

All of this indicates that while men are at higher risk of death by suicide, and firearm means restriction is most definitely a high priority, an examination of reducing access to lethal means in Vermont that serves the female population is needed. The means restriction strategies may include safe messaging focused on poisoning, overdose, and prescription pain medication.

1a. State Restriction Efforts: Poisoning

Vermont has an existing Prescription Monitoring System (VPMS) through the Vermont Department of Health, to assist in management of controlled substances. When a Schedule II, III, or IV controlled substance is dispensed to an outpatient, a standard set of information about the patient, the prescriber, and the drug is collected and entered into the VPMS, then maintained for six years on a secure, central database. Information from the VPMS is then available to providers and pharmacists to help in effectively managing patient treatment. Providers have access to a full history of their patient's prescriptions for controlled substances and the system can alert a provider to possible abuse of - or addiction to - controlled substances.[186]

The Vermont Board of Medical Practices issues policies as relates to prescribing controlled substances and potentially addictive medications. These policies outline a standard practice guideline for physicians that points up the greatest difficulty – distinguishing the need for pain management from drug seeking behaviors and/or addictions.

At its April 2, 2014 meeting, the Vermont Board of Medical Practice adopted a new policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain – revising the existing 2004 policy.[187] This movement came about after the Federation of State Medical Boards (FSMB) published a revised model policy in 2013 that incorporates "the latest best practices and new developments in the healthcare profession regarding the safe and effective use of controlled substances to treat chronic pain." Specifically, the FSMB Model Policy reflected the considerable research conducted since the 2004 revisions to policy, particularly in recognizing "that there is a lack of evidence as to the effectiveness and safety of long-term opioid therapy."[188] To wit:

> *Despite that lack of evidence, opioids are widely used to treat chronic pain, and FSMB's intent in creating a Model Policy was to promote the public health by encouraging state medical boards to adopt consistent policy regarding the treatment of pain, particularly chronic pain, and to promote patient access to appropriate pain management and, if indicated, substance abuse and addiction treatment. The Model Policy emphasizes the professional and ethical responsibil-*

[183] Vermont Vital Statistics. 2012 and 2013 PRELIMINARY DATA.

[184] Vermont Vital Statistics, 2010.

[185] "CDC - Vital Signs: Overdoses of Prescription Opioid Pain Relievers."

[186] Vermont Department of Health – Vermont Prescription Monitoring System.

[187] *Use of Opioid Analgesics in the Treatment of Chronic Pain*. Vermont Board of Medical Practice.

[188] Ibid.

ity of physicians to appropriately assess and manage patients' pain, assess the relative level of risk for misuse and addiction, monitor for aberrant behaviors and intervene as appropriate.[189]

The Vermont Board of Medical Practice incorporated much of the FSMB's Model Policy into Vermont's Policy.

Also in April 2014, Vermont took steps to restrict access to newly FDA-approved narcotic painkiller Zohydro, a member of the opioid family of medication which includes morphine, heroin and oxycodone (branded as OxyContin).[190] Governor Peter Shumlin issued emergency rules making it harder for physicians to prescribe the most powerful painkillers. In his announcement, Shumlin noted that the rules are intended to ensure that in prescribing this opiate in Vermont, "we won't repeat the mistakes that we made with OxyContin with an even more powerful form."[191] Vermont's emergency rules require that prescribers of Zohydro conduct a thorough medical evaluation and risk assessment, rules supported by the Vermont Medical Society.[192]

These measures, coupled with the governor's call for action during his 2014 State of the State address – in which he noted that Vermont had nearly double the deaths from heroin and opioids in 2013 than in 2012 – it is clear that Vermont is attending to restricting access to certain prescription medications that have been rising in use and abuse in the last decade, at least partially accessed through official prescriptions.

This research finds that attention on restriction of prescription medication is the current primary approach to reducing lethal means access in the area of poisoning.

2. Falls

Placing barriers on high structures is considered a primary method for restricting access to high structures that are, have been, or are at risk for being used for jumping/falling suicides. A brief review found limited information related to jumping/falling suicides and restriction of access to such structures.

2a. State Restriction Efforts: Falls

In the 2014 legislative session, bill H.865 was introduced, calling for the update of bridge structure design standards to address the prevention of suicide and safety of first responders, in the design of bridges in Vermont, specifically Quechee Bridge. The disposition of this bill included an official communication dated May 7, 2014, from Patrick Brennan, Representative from Chittenden County and Chair of the Transportation Committee, to Brian Searles, Secretary of the Agency of Transportation, requesting that "the Agency study the issue of suicide prevention and first responder safety in connection with bridge design standards, and report back to the Committee at the beginning of the 2015 legislative session with its findings, and that the Agency raise this issue for discussion during the Stakeholder Group review process." The communication further requested that the Agency study "whether the Quechee Bridge is safe for pedestrians and how the design of that bridge could be improved to enhance pedestrian safety, so that if the Agency determines that a pedestrian safety project is warranted and is a priority, it may be included in a future proposed transportation program.".[193]

3. Suffocation, Drowning, Cutting/Piercing

This research found no current activity in these areas, as concerns restriction of lethal means.

C. Summation

This research finds that in relation to lethal means other than firearms, the issue of prescription medication abuse is a primary focus of attention in

[189] Ibid.

[190] Garbitelli, Beth. "Vermont restricting access to powerful painkillers." *Washington Times*. 3 April 2014.

[191] Ibid.

[192] Ibid.

[193] Communication from Representative Patrick Brennan to Agency of Transportation Secretary Brian Searles. 7 May 2014.

Vermont. This meets expectations, as poisoning is the second highest means of suicide in Vermont. In addition, restricting means to certain modes of suicide such as hanging, cutting, drowning and jumping can be much more difficult to accomplish.

Of particular interest in discussing other means of suicide, is the following statement from Ken Norton, LICSW, Director of the NAMI NH's Connect Suicide Prevention program:

> *"It is not unusual for people to have very specific ideas/plans for what they will use, where and when they will attempt and how they will complete the suicide... Research shows that if you eliminate access to a specific plan/method most people will not substitute a different method particularly in the short run."*

Mr. Norton maintains that "restricting means" to those forms of suicide for which the means are widely present and difficult to control, can be approached from the perspective of restricting immediate access to the means described by the suicidal individual as the preferred method.

Realistically, this requires not only foreknowledge that an individual is suicidal, but also that the individual is willing to disclose their plans/preferred means. Mr. Norton points to the role the social worker can take in working with individuals on this, but many individuals who kill themselves do not have an existing relationship with a social worker or therapist.

However, Norton notes that this form of restriction "can also be done by anyone with a little basic knowledge of how to do it." He recommends the standard suicide prevention practice of asking the individual directly if they are contemplating killing themselves, and if so, how. Then focus specifically on removing access to the means that would allow that form of suicide.

This draws a direct connection to the previously discussed CALM program, Counseling on Access to Lethal Means, available as both an in-person training and a free webinar. While reducing access to firearms is a focus of the CALM training, it also attends to other lethal means such as medications, their connection to suicide, and the importance of reducing access. Promoting the further expansion and reach of CALM in Vermont assists in the efforts to address the broader topic of lethal means, across the categories of method.

IV. RECOMMENDATIONS

A. Firearms

Vermont's many cultural and geographic parallels with New Hampshire, the state that has so successfully implemented the Gun Shop Project, bodes well for similar efforts here. While there are notable differences, the sport hunter/firearm community is likely to be one of the more homogenous groups between the two states given the strong cultural bonds in the gun-owning community. Therefore, the primary recommendation of this research is to capitalize and build upon the existence of New Hampshire's Gun Shop Project, and to model Vermont's forward movement on the New Hampshire format.

Attached is a work plan that lays out the sequential steps taken by the principals driving New Hampshire's Gun Shop Project, with references where applicable to existing opportunities in Vermont - Appendix I: Sample Work Plan for a Vermont Gun Shop Project. New Hampshire's is a clear, straightforward model, being utilized in other rural states with high rates of firearm ownership. The NH principals identified numerous "lessons learned" along the way, and shared these to enhance Vermont's efforts.

Below are specific recommendations for progressing from discussion to action here in Vermont.

1. **RECOMMENDATION**: Replicate New Hampshire's Gun Shop Project in Vermont, with minimal adaptation, beginning with the human resources available through the Vermont Suicide Prevention Coalition.

   A. **EXPEDITE IMPLEMENTATION**. The similarities of New Hampshire and Vermont and the succinct model NH has provided offer a clear roadmap to model Vermont's

implementation.

i. **Create a Gun Shop Project workgroup**. Interest and infrastructure exists in the VT-SPCe and VT-SPCo. Leadership and coordination is available through the Center for Health and Learning, facilitators of the VT-SPCe.

ii. **Facilitate workgroup for highest efficacy**. Prime needs are recruitment of gun-owning community participation, then creation of campaign materials, followed by distribution – all highly specific goals with excellent models in place. Strong leadership to facilitate and keep the workgroup on task are imperative.

B. TAILOR IMPLEMENTATION. The success of a self-propelled community public health campaign can depend greatly on first impressions with the target community. Two essential components of success are collaboration with the gun-owning community from the very start, and respectful interaction with the gun-owning community utilizing the language and comfort zone of community individuals.

i. Honor and build upon existing cultural cohesion. The gun-owning community has strong cultural cohesion, with close-knit networks and established group norms, including safety concerns and practices.

• *Build upon pre-existing safety-consciousness*. Hunter's Safety Courses are a strong part of the hunting tradition, and groups from the National Rifle Association to commercial gun manufacturers promote and emphasize gun safety rules and firearm training. Elaborating on the existing safety culture demonstrates respect for the work the gun-owning community has done and continues to do to address safety. It also acknowledges that gun safety rests in the hands of the gun-owner as opposed to an outside force.

• *Utilize the Eleventh Commandment model*. The Ten Commandments of Gun Ownership – variously known as Ten Commandments of Firearm Safety, Ten Commandments of Safe Shooting, Ten Safety Rules for Firearm Safety, etc. – is a list of safety measures that came directly out of the gun-owning community. The Eleventh Commandment model provides a brochure that adds a "commandment" that directly addresses suicide risk among your gun-owning friends as an added safety consideration for gun owners.

• *Build on hunting traditions*. Hunters influence hunters. Hunting traditions have deep cultural roots in Vermont, often strongly linked to male family and friendship networks. Building on these ties provides a strong opportunity to not only reach a high-risk population for suicide – middle-aged men – but also to influence group norms on a broader scale.

ii. **Locate community partners in firearm-owning community**. Vermont has existing infrastructure in the Vermont Suicide Prevention Coalition, and that body provides a ready resource of people to begin recruiting for a workgroup.

• *Prioritize gun-owning individuals*. Using a consumer approach, all efforts should include the input of gun owners who are also active gun users, e.g. hunters and sport shooters as well as collectors and history enthusiasts. If the VT-SPCo does not have current members who own and use firearms, prioritize additional recruitment on gun owners with Coalition members before the first meeting of the workgroup is held. Look to Vermont's many active gun owners' organizations.

• *Create specific guidelines for workgroup*. Examples can be found in *Appendix II: Sample Guidelines for Work Group*. It is imperative that individuals participating in the workgroup be willing and able to work in a setting that discusses firearms in a positive and encouraging manner and does not prioritize or involve background checks or other legislative measures. In order to be respectful

of traumatic personal experiences with firearms, and/or deeply-held ethical positions on firearms, it will be imperative that some people who are enthusiastic about reducing access to lethal means efforts self-select out of this initiative, or be encouraged to consider that this workgroup may not be the best fit for their interests.

iii. **Use open and positive language**. Reframe the phraseology in any communication about a potential Gun Shop Project, including during discussions in meetings. This is of utmost importance in working collaboratively with any highly language-sensitive population. Use of the term "restriction" in a gun shop or with a gun club can have a significant and immediate detrimental effect on the project's overall success.

- *Clarify project's narrow focus*. Ensure the Gun Shop Project is truly not associated with legislative measures to advance gun control. Suicide prevention work within the firearm community needs to be its own initiative, focusing on the safety of firearm owners, without a secondary agenda.

- *Discontinue use of "lethal means restriction" as a label with this project*. While the phrase is used commonly in the field to refer to all means restriction such as pills, pesticides, and bridge barriers, it is a barrier and an obstructive phrase to use in conversation and planning of a gun shop project, even in meetings.

- *Replace "restrictive" words with language supportive of gun-owning*. The project needs to be welcoming to and supportive of gun owners. Use terminology that is accurate to this specific project, such as "keeping our hunting community safe," "gun owners against suicide" or "gun owner tips… by gun owners, for gun owners." Examples can be found in Appendix III: Terminology.

C. REPLICATE IMPLEMENTATION SUCCESSES. Much excellent work has been done by the New Hampshire, Tennessee, California and other states. Using existing resources will improve efficiency and reduce both expenses and campaign missteps.

i. **Utilize New Hampshire "road map."** Base implementation work plan on New Hampshire's example. Example in *Appendix I: Sample Work Plan*.

ii. **Publically utilize other states' successes.** Base a central tenet of the campaign on "replicating the great work done in New Hampshire and Tennessee" to encourage reception of efforts in Vermont gun shops and firearm-owning communities. Both NH and TN would be valuable visible cultural partners in reaching the firearm-owning communities.

iii. **Utilize pre-existing successful materials**. Use materials created by the other states as direct models – including signs, brochures, posters, and cards – to be adapted to Vermont.

iv. **Move beyond "gun shops."** The *Gun Shop Project's* primary focus, as outlined in the work plan, is providing materials to gun shop owners. However, project successes have included expansion of reach in many states.

- Gun Shows: Distributing suicide awareness materials at gun show settings has proven highly successful when combined with give-aways and raffles.

- Locks given away to attendees were very successful in bringing people to the table and engaging in conversation. The most popular lock is a combination lock – Combination Trigger Lock or Combination Shank Lock.

- Gun safes as raffle prizes were extremely popular. A gun safe is a higher-priced item ($150 - $160), and gun owners were enthusiastic about this prize.

- Providing the raffle ticket, and/or information on the free lock, to the participant as they enter the show and giving them directions on where to

bring the ticket to enter or how to pick up their free lock helps encourage people to approach the table.

• Partners: Enlist the collaboration of organizations, and campaign for other issues, that reaches the gun-owning population.

• VA hospitals were identified as a strong potential partner with access to many gun owners.

• Collaboratively distribute materials.

2. **RECOMMENDATION**: In adapting the Gun Shop Project for use in Vermont, consider studying the success of Man Therapy™, an online suicide prevention intervention specifically for middle-aged men that meshes well with the target population of the Gun Shop Project, and addresses the concept of reducing the stigma associated with depression, mental health struggles, and help seeking.

3. **RECOMMENDATION**: Expand awareness of and education on CALM: Counseling on Access to Lethal Means. Bring C.A.L.M. training to Vermont; expand awareness of the C.A.L.M. free resource.

4. **RECOMMENDATION**: Investigate barriers to reporting mental health records to the FBI background check database.

a. **CURRENT VERMONT PARTICIPATION**. In researching Vermont's current status on reducing access to lethal means, the issue of more effective FBI background checks was raised. A brief survey of the literature available indicates that, according to FBI data from November 2013, Vermont is one of 15 states that have submitted less than 100 mental health records (24 total) to the National Instant Criminal Background Check System since its inception in 1993.[194]

b. **CONDUCT ADDITIONAL RESEARCH AS NEEDED**. Full research into current participation, potential barriers, and potential resolutions to the reporting of mental health records to NCIS is beyond the instructed scope of this document.

B. Other Means

Within the scope of this project and its charge to investigate New Hampshire's success with the Gun Shop Project, this research finds that specific recommendations are difficult to produce regarding lethal means for other modes of suicide including poisoning, suffocation/hanging, cutting/piercing, drowning and jumping. The primary recommendation regarding other means at this time is a reinforcement of the recommendation under FIREARMS, to explore expanding the CALM training intervention.

This research also recognizes the positive work that is being done on poisoning, in the form of the Governor's Forum on Opiate Addiction, held in June 2014.

1. **RECOMMENDATION**: Additional research focused on other means. Within the scope of this project and its charge to investigate New Hampshire's successes to guide Vermont action, specific and meaningful recommendations are difficult to produce regarding other lethal means, without additional research.

2. **RECOMMENDATION**: Implement CALM training. The primary recommendation regarding other means is a reinforcement of the recommendation under FIREARMS, to expand the reach of the CALM training intervention in Vermont, and provide increased education in both training and public messaging about research on the low rate of "substitution of method."

[194] Fix NICS. www.fixnics.org

APPENDICES

A. Sample Work Plan for a Vermont Gun Shop Porject
B. Sample Work Group Guidelines
C. Sample Terminology
D. Compendium of Gun Shop Porject Collateral Material
(attached under separate cover)

APPENDIX A. Sample Work Plan for a Vermont Gun Shop Project

GOAL:

Reduce the number of suicide deaths by gunshot in the state of Vermont.

OBJECTIVES:

Assist gun shop owners to avoid selling firearms to suicidal people.
Offer suicide prevention outreach information to gun owners and friends of gun owners at gun shops, gun ranges, and gun shows.

ACTION STEPS	NOTES
ESTABLISH WORKGROUP GUIDELINES	
• Establish specific goal	Prepare guidelines in advance of introducing recruitment to the VT-SPCo.
• Establish specific tone	
RECRUIT WORKGROUP & PARTNERS	
• Membership	
o Vermont Suicide Prevention Coalition	Poll VT-SPCo membership to determine if any current members are gun owners.
Introduce workgroup guidelines.	
o Gun Owners	Essential that the gun-owning population be included from the very first meeting.
o Firearm Retailer(s)	Essential when working with retailers that a fellow retailer is involved.
• NH Partners	Consider asking for additional involvement of NH Gun Sho Project principals, including Ralph Demico, owner of Riley's Sport Shop; Elaine Frank; and Cathy Barber.
• Remain in contact with "Means Matters"	Means Matter offers support & assistance and is interested in new initiatives.

ACTION STEPS	NOTES
DETERMINE EVALUATION MEASURES NH struggles to evaluate long term efficacy.	
• Percent of participation? • Length of time displayed? • Number of materials taken? • Partnerships developed?	
DEVELOP MATERIALS	
• Determine marketing/outreach materials desired	Tip Sheet – "How to recognize a potentially suicidal customer;" Brochure, Hotline Card, Information Card, Poster. NH did not work specifically with online options. Online options could capitalize on referring to other online resources specific to the target population, e.g. ManTherapy website, a highly appropriate resource for the gun-owning population.
• Examine existing materials from NH Gun Shop Project	Brochure, Poster, Hotline Card
• Examine any existing materials from additional states (Tennessee, California)	Compendium of collateral material examples attached to this document.
• Adapt materials to Vermont audience	In creating Vermont materials establish a link in writing to the existing NH Gun Shop Project; potentially other states.
• Workshop with additional gun owners	Bring visual materials to hunters and sport shooters, retailers, and ask for feedback. Incorporate feedback.
• Finalize and print	
DISTRIBUTION	
• Plan distribution approach o Mailings o In Person o Phone Calls o Internet Contact	NH's use of mailings and in person follow-up was successful.

ACTION STEPS	NOTES
DISTRIBUTION *(continued)*	
• Compile mailing lists o Retailers o Gun shows o Shooting ranges	Vet distribution list (telephone or additional research) as many retailers with their FFL are not actually physical stores, but individuals.
• Prepare Mailer Packet	Select materials to be mailed based on follow-up plans.
• Write cover letter	Select signers carefully. Must be signed by a gun shop retailer, along with any other signers.
FOLLOW UP	
• Conduct follow up as planned	
EVALUATION	
• Implement long-term evaluation	

APPENDIX B – Sample Workgroup Guidelines

Sample Guidelines for Gun Shop Project Workgroup

Vermont is pursuing a Gun Shop Project, similar to New Hampshire's. This project works to involve the gun community in suicide prevention, including gun owners, gun retailers, gun ranges and gun shows. In order to succeed, Vermont will need a committed core group of people to help.

1. **Founding Goal**: This workgroup aims to reduce the number of firearm-related suicide deaths in Vermont.

2. **Founding Objectives**:
   a. Increase the number of promotional pieces designed with gun owners for gun owners that contain safety messages concerning suicide – including but not limited to hotline cards, brochures, posters and tip sheets.
   b. Increase the number of gun retailers who receive material on helpful tips on how to recognize a potentially suicidal customer.
   c. Enhance the existing culture of safety among gun owners with helpful messages on how to notice and respond to a potentially suicidal friend, relative or acquaintance.

3. **Membership**: This workgroup will have membership representing gun owners, gun retailers, and members of the suicide prevention community.
   a. Recruitment of representative membership may be needed and is essential before proceeding. All groups must be represented before beginning work.
   b. Initial volunteers will be asked to recruit other members based on these membership requirements.

4. **Group Norms**: This workgroup is founded on the principles of care and support for the gun-owning community. The established norms will be a tone of mutual respect for differing opinions, but with a baseline expectation of a positive and supportive atmosphere regarding the purchase and ownership of firearms. This is not a legislative advocacy committee.

5. **Self-Selection**: Firearms can be a hard topic and emotions can run high. Please recognize that depending on your personal experiences, this project may not be your ideal workgroup.
   a. Only you can assess your willingness and ability to participate in this workgroup, but we ask that you consider your personal needs carefully before signing up.
   b. If you have had traumatizing experiences with firearms, this may be a difficult working environment for you.
   c. This is not a legislative advocacy group, and is not advocating existing or future legislation on firearms, including but not limited to background checks, purchase restrictions, or concealed carry.
   d. This workgroup is not a "gun control" workgroup.

6. **Timeline**: This workgroup is dedicated to making this project happen in a timely and efficient manner. The *Gun Shop Project* is a straightforward project with excellent models from New Hampshire's work.

APPENDIX C – Terminology

Research tells us that individuals with quick access to firearms are at increased risk of death by suicide, as are their children and family members, because of the high lethality of firearms in a suicidal crisis.

It is also common knowledge that ideology, beliefs, political stances and emotions run high on the issue of firearm ownership in United States society.

To truly work to save lives, community efforts from within the gun-owning community and their family and friends can be a strong place to begin. Because this issue is so politicized, the language and phrasing used can have a huge impact. This topic has created a lot of demonization on both sides. When political issues are reduced to sound bites, language and phrasing are even more important.

"Lethal means restriction" is a term of the suicide prevention community, representing a catch-all phrase for helping a suicidal person avoid easy access to means used for killing oneself, including firearms, medications, knives, bridges, motor vehicles, ligatures and more. The suicide prevention community recognizes this shorthand, but many people who do not work in the field of suicide prevention do not.

"Lethal means" are assumed by most people to mean "guns" and frequently when prevention workers mean guns, they use "lethal means." It is important to say "guns" or "firearms" when that is what is meant. When "lethal means" are defined as guns then the term becomes "gun restriction" and these words are equivalent to "gun control." Taken out of the context of suicide prevention, to say "gun restriction" means that listeners hear "gun control." "Gun control" has also become a catch-all phrase that causes immediate and deep emotional reactions all across the political and ideological spectrum.

Because the *Gun Shop Project* is not part of the political battleground of "gun control vs. freedom to bear arms," and is specifically a positive and supportive program to firearm ownership, it is imperative to keep well-meaning but misused language from branding it as a political effort to ban guns, and thereby affecting its success.

Even more importantly, when all people are encouraged to reach out to their gun-owning friends and family members who may be in crisis, words are even more loaded and important. If someone is having a tough time and is not themselves or not thinking rationally, "can I take your guns?" is unlikely to be helpful. A fellow gun-owner is likely to be the best possible person to offer to hold onto guns for someone in crisis – he is likely to be someone who best knows how to care for and store guns, and has the appropriate ability to do so.

Words and phrases that might trigger reactions, and possible alternatives, follow.

POSSIBLE TRIGGER	POTENTIAL ALTERNATIVE
Lethal Means *Restriction*	*Protecting* your family and friends
Lethal Means (when you mean guns)	*Guns*
If you think a friend might be suicidal, can you *take his guns* for him?	*You know* how important his firearms are to him. If he's not doing well, can you *offer to hold his guns* for him until he feels better? …can you *suggest* he let a *friend hold his guns* for a few days, until he feels better?
Don't *let your guns* get in the *wrong hands*.	*Secure* your guns to *protect* yourself and your family.
Lock up your guns.	*Keep* your guns safe with a good lock.
Lock up *all* firearms.	Keep *your* guns safe with good protection.
Store your ammunition *away from* your guns.	*Keep* your ammo and your guns safe – in two places apart from each other is best. *You know* where you *need* your guns and ammo to be. *Two separate places* that *you control* are recommended.
Never keep your guns loaded. –or– *Don't keep* your guns loaded.	*The NRA recommends* not loading your gun *until you are ready to use it*.
Gun owners are *at high risk* for suicide.	Gun owners *like your friends* can *have hard times* just *like everyone else*, that can lead to thoughts of suicide and even suicide attempts.
Having guns around makes *suicide easier*.	Suicide attempts often happen during a *brief, intense* feeling of hopelessness – *as you know*, guns are quick and don't leave time for second thoughts. If we can *offer even a little more time* between the moment a person feels the worst and when they act, we could save a friend's life.

VI. BIBLIOGRAPHY

1. *2011 National Survey of Fishing, Hunting, and Wildlife-Associated Recreation – Vermont*. U.S. Fish and Wildlife Service & U.S. Census Bureau.

2. *AAPM Facts and Figures on Pain*. American Academy of Pain Medicine. <www.painmed.org>

3. Ahmedani, PhD, Brian K.; Gregory E. Simon, MD, Christine Stewart, PhD, Arne Beck, PhD, Beth E. Waitzfelder, PhD, Rebecca Rossom, MD, Frances Lynch, PhD, Ashli Owen-Smith, PhD, Enid M. Hunkeler, MA, Ursula Whiteside, PhD, Belinda H. Operskalski, MPH, M. Justin Coffey, MD, Leif I. Solberg, MD. "Health Care Contacts in the Year Before Suicide Death." *Journal of General Internal Medicine*. DOI:10.1007/s11606-014-2767-3.

4. *Alcohol Abuse and Suicide*. Webinar. Injury Control Research Center for Suicide Prevention. 29 January 2014.

5. American Association for Suicide Prevention. Treatment. <https://www.afsp.org/preventing-suicide/treatment>

6. Armslist.com. <www.armslist.com>

7. Azrael, Deborah, MS; Matthew Miller, MD, MPH, ScD; David Hemenway, PhD. "Are Household Firearms Stored Safely? It Depends on Whom You Ask." Pediatrics Vol. 106 No. 3, 1 September 2000.

8. Barrett, Paul M. "Guns, Children and Accidents: Four Blunt Points." BloombergBusinessWeek. 30 September 2013. <http://www.businessweek.com/articles/2013-09-30/child-gun-deaths-there-are-encouraging-trends-too-statistics-show>

9. Behavioral Risk Factor Surveillance System. <http://www.cdc.gov/brfss/>

10. Bialik Carl. "Guns Present Polling Conundrum." *Wall Street Journal*. 22 March 2013. <www.blogs.wsj.com/numbersguy/guns-present-polling-conundrum-1223/>

11. *Big Game Management Plan 2010 – 2020: Creating a Road Map for the Future*. Vermont Fish & Wildlife Department. December 2009. <www.vtfishandwildlife.com/library/reports_and_documents/Hunting_and_Trapping/big_game/Big_Game_Management_Plan>

12. Braden, Ann. Interviews. 3 March 2014; 15 May 2014.

13. *CALM: Counseling on Access to Lethal Means.* Best Practice Registry, Section III. Suicide Prevention Resource Center.

14. Carlson, Kristin. "Shumlin tweaks gun control message for national audience." 26 February 2013. <www.WCAX.com>

15. Correspondence from Representative Patrick Brennan to Agency of Transportation Secretary Brian Searles. 7 May 2014.

16. Correspondence from the Vermont Suicide Prevention Coalition to Representative Patrick Brennan, Chair, Transportation Committee, Vermont Legislature.

17. "Contact with the criminal justice system may be associated with suicide risk." *Journal of the American Medical Association*. 8 February 2011. Study cited: Roger T. Webb; Ping Qin; Hanne Stevens; Preben B. Mortensen; Louis Appleby; Jenny Shaw. "National Study of Suicide in All People With a Criminal Justice History." *Archive of General Psychiatry,* 2011; DOI: 10.1001/archgenpsychiatry.2011.7

18. *Crime in the United States.* Federal Bureau of Investigation. <http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s.>

19. Criminal Division to the United States Attorneys' Offices Statement upon the passage of Title 18, United States Code, Section 922(g)(9) (the Lautenberg Amendment). Fall 1996.

20. Dahlberg, Linda L., Robin M. Ikeda, Marcie-jo Kresnow. "Guns in the Home and Risk of a Violent Death in the Home: Findings from a National Study." *American Journal of Epidemiology*. 2004. 160 (10): 929-936. doi: 10.1093/aje/kwh309

VI. BIBLIOGRAPHY

21. *Developments in Mental Health Law.* Volume 33, Issue 1. February 2014. Published by the Institute of Law, Psychiatry, and Public Policy at the University of Virginia. <www.dmhl.typepad.com>
    - "Risk-Based Firearms Policy"
    - "Mental Health Firearms Prohibition and Reporting Requirements"
    - "Clear and Present Danger"
    - "Recently Decided and Pending Cases"

22. *Domestic Violence Fatality Review Commission 2013 Report.*

23. "eBay To Stop User Listings Of Firearms And Ammunition On The Site." Press Release. 19 February 1999. <www.eBay.com>

24. *Facts Hurt: A State-by-State Injury Policy Prevention Report*, The. Trust for America's Health & Robert Woods Johnson Foundation. January 2013 (update).

25. Fazel M.B.Ch.B., Seena, M.R.C.Psych., M.D.; Martin Grann, C.Psych., Ph.D. "The Population Impact of Severe Mental Illness on Violent Crime." *American Journal of Psychiatry*. Vol. 163, No. 8. 2006;163:1397-1403. doi:10.1176/appi.ajp.163.8.1397

26. Federal Statutes. <www.justice.gov> Accessed: April & May 2014
    - <www.justice.gov/usao/me/docs/Summary%20of%20Firearms%20Laws%20-%202010.pdf.>
    - Possession of Firearms by Prohibited Persons; 18 U.S.C. § 922 (g).

27. "Fibromyalgia." Mayo Clinic. <www.mayoclinic.org/diseases-conditions/fibromyalgia/basics/>

28. "Fibromyalgia." MedLinePlus. National Institutes of Health. <www.nlm.nih.gov/medlineplus/fibromyalgia>

29. Firearm-Related Injuries Affecting the Pediatric Population. Policy Statement of the American Academy of Pediatrics. Council on Injury, Violence and Poison Prevention Executive Committee. 18 October 2012.

30. *Firearm-Related Injuries among Youth Ages 15 Through 24*. March 2014. Children's Safety Network. Education Development Center. Waltham, MA. <www.childrenssafetynetwork.org>

31. *Fix NICS Campaign.* "A national campaign of the National Shooting Sports Foundation." <www.fixnics.org>

32. Frank, MHS, Elaine; Cathy Barber, MPA; Eliot Nelson, MD; Elizabeth Fenner-Lukaitis, MSW. Interview. February 20, 2014.

33. Freed, Betsy Bates and David. "Aversion to Therapy: Why Won't Men Get Help?" *Pacific Standard*: *The Science of Society*. 25 June 2012.

34. Freeman, Ali. "Vermont Fish and Wildlife deals with declining licenses." WCAX. 22 February 2013. <www.wcax.com/story/21311652/declining>

35. Garbitelli, Beth. "Vermont restricting access to powerful painkillers." Associated Press. *Washington Times*. 3 April 2014.

36. *GUN CONTROL: Sharing Promising Practices and Assessing Incentives Could Better Position Justice to Assist States in Providing Records for Background Checks*. Government Accountability Office Report to Congressional Requesters. July 2012. GAO-12-684.

37. Gun Sense Vermont. <www.gunsensevt.org> Accessed: April & May 2014.

38. *Gun Shop Project*. Webinar. 26 March 2014.

39. Hallenbeck, Terri. "Can you say gun control in Vermont? Not very easily." *Burlington Free Press*. 17 December 2012. <www.burlingtonfreepress.com>

VI. BIBLIOGRAPHY

40. "Health Insurance Portability and Accountability Act Privacy Rule and the National Instant Criminal Background Check System." Office of the Federal Register of the United States Government. <www.federalregister.gov/articles/2014/01/07/2014-00055>

41. Hepburn L, M Miller, D Azrael, and D Hemenway. "The US gun stock: results from the 2004 national firearms survey." *Injury Prevention.* February 2007; 13(1): 15–19. doi: 10.1136/ip.2006.013607

42. *Hunting: Participation and Injury Data 2010*. National Shooting Sports Foundation. 2010.

43. *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Washington (DC): National Academies Press (US); 2006.

44. *Injury in Vermont*. Vermont Department of Health. Injury Prevention Program. June 2008.

45. Johnson, Renee M., PhD, Matthew Miller, MD, ScD, Mary Vriniotis, MS, Deborah Azrael, PhD, and David Hemenway, PhD. "Are Household Firearms Stored Less Safely in Homes With Adolescents? Analysis of a National Random Sample of Parents." *Archive of Pediatric Adolescent Medicine*. August 2006; 160(8): 788–792. doi: 10.1001/archpedi.160.8.788

46. Jones, Jeffrey. "Men, Married, Southerners Most Likely to be Gun Owners." Gallup Politics. 13 February 2013. <www.gallup.com/poll/160223/men-married-southerners-likely-gun owners.aspx>

47. Krantz, Laura. "Deal on gun storage reached in conference committee." *Vermont Digger*. 7 May 2014. <www.vtdigger.org>

48. Krantz, Laura. "Lawmakers: Deal with Shumlin preempted other gun control measures this session." *Brattleboro Reformer*, as posted on <www.vtdigger.org> 8 March 2014.

49. Krantz, Laura. "VTdigger/Castleton poll: Vermonters support concealed carry permit for guns." 28 April 2014. <www.vtdigger.org>

50. Law Center to Prevent Gun Violence. <www.smartgunlaws.org> Accessed: April & May 2014. <www.smartgunlaws.org/prohibited-people-gun-purchaser-policy-summary>

51. Luoma JB, Martin CE, Pearson JL. "Contact with mental health and primary care providers before suicide: a review of the evidence." *American Jounral of Psychiatry*. 2002; 159(6):909-16.

52. Means Matter. <http://www.hsph.harvard.edu/means-matter/>

53. *Men and Depression*. National Institutes of Mental Health. U.S. Department of Health and Human Services. Screening for Mental Health. <http://www.nimh.nih.gov/health/topics/depression/men-and-depression/men-and-depression-screening-and-treatment-in-primary-care-settings.shtml> <www.mentalhealthscreening.org/screening/resources/men-and-depression.aspx>

54. Miller, Matthew, Catherine Barber, Richard A. White and Deborah Azrael. 2013. "Firearms and Suicide in the United States - Materials and Methods." *American Journal of Epidemiology*; Vol. 178, No. 6, p. 947. Baltimore MD: Oxford Journals / Oxford University Press. 23 August.

55. National Conference of State Legislatures. <www.ncsl.org>

VI. BIBLIOGRAPHY

56. National Rifle Association. <www.nra.org> Accesssed: April & May, 2014.
- Kopel, David. "Will Gun Shows Become Extinct?" 28 June 2010.
- <www.explore.nra.org>
- <www.nraila.org/gun-laws/state-laws.aspx>
- <www.nraila.org/gun-laws/articles/2010/compendium-of-state-firearms-laws.aspx>
- <http://www.gunbanfacts.com/universal-background-checks.aspx>
- <www.nrainstructors.org/CourseCatalog.aspx>
- <www.nrainstructors.org/searchcourse.aspx>

57. *National Health Interview Survey*. Department of Health and Human Services Report (23).

58. National Conference of State Legislatures. <http://www.ncsl.org/research/civil-and-criminal-justice/possession-of-a-firearm-by-the-mentally-ill.aspx> Accessed 1 October 2014.

59. National Institute of Health, National Institute of Arthritis and Musculoskeletal and Skin Diseases. <www.niams.nih.gov/Health_Info/Fibromyalgia/>

60. Nelson, Eliot, MD. Personal Interview. 23 January 2014.

61. Nelson, Eliot, MD. Testimony before US Senate Judiciary Committee, 17 February 2013.

62. Nicas, Jack. "Mental Health Records Missing from Gun Dealer Database." *Wall Street Journal*. 20 December 2012. <www.online.wsj.com>

63. Okoro, Catherine A., David E. Nelson, James A. Mercy, Lina S. Balluz, Alex E. Crosby and Ali H. Mokdad. "Prevalence of Household Firearms and Firearm-Storage Practices in the 50 States and the District of Columbia: Findings From the Behavioral Risk Factor Surveillance System, 2002." *Pediatrics*. 2005;116;e370. <http://pediatrics.aappublications.org/content/116/3/e370/T1.expansion.html%20for%202002>

64. Picard, Ken. "Home for the Range?" *Seven Days*. 22 September 2010.

65. Picard, Ken. "Many "Prohibited Persons" Still Have Guns Because Cops Have Nowhere to Put Them." *Seven Days*. 8 May 2013.

66. *Portrait of Hunters and Hunting License Trends: National Report.* Southwick Associates for the National Shooting Sports Foundation. <www.nssf.org/PDF/HuntingLicTrends-NatlRpt.pdf>

67. *Public Opinion on Wildlife Species Management in Vermont*. 2007. Conducted for the Vermont Fish and Wildlife Department by Responsive Management. <www.vtfishandwildlife.com/library/Reports_and_Documents/Fish_and_Wildlife/Vermont_Game_Management_Report>

68. Reed, PhD, MSW, Jerry. "Primary Care: A Crucial Setting for Suicide Prevention." *E-solutions Newsletter*. Suicide Prevention Resource Center. http://www.integration.samhsa.gov/about-us/esolutions-newsletter/suicide-prevention-in-primary-care.

69. Robinson, Kate. "Gun safety law is in limbo, despite recent teen suicides." *VTdigger.* 4 March 2011. <www.vtdigger.org>

70. Rucker, Philip. "Study finds vast online marketplace for guns without background checks." *Washington Post*. 5 August 2014. <www.washingtonpost.com>

71. Rudarakanchana, Nat. "Leahy Chairs First Congressional Hearing On Gun Control." 30 January 2013. *Vermont Digger*. <www.vtdigger.org>

VI. BIBLIOGRAPHY

72. Saad, Lydia. "Self-Reported Gun Ownership in U.S. Is Highest Since 1993." 26 October 2011. Gallup Politics. <www.gallup.com/poll/150353/Self-Reported-Gun ownership-Highest-1993.aspx>

73. *SAMHSA News*. Spring 2014, Volume 22, Number 2.

74. Samuel, Dave. "Which State has the Highest Percentage of Hunters?" *The Sportsman's Guide*. 2012. <www.sportsmansguide.com/Outdoors/Subject/SubjectRead.aspx>

75. "Shumlin unsure on enforcing certain firearm laws." *Rutland Herald.* 18 March 2013. <www.rutlandherald.com/article/20130318/NEWS03/703189828>

76. Simpson, Joseph R., MD, PhD. "Bad Risk? An Overview of Laws Prohibiting Possession of Firearms by Individuals With a History of Treatment for Mental Illness." *Journal of the American Academy of Psychiatry and the Law Online*. September 2007. 35:3:330-338.

77. Smart Gun Laws.
    - <http://smartgunlaws.org/prohibited-purchasers-generally-in-vermont/>
    - <http://smartgunlaws.org/mental-health-reporting-policy-summary/#footnote_83_5725>

78. Smith, Brendan L. "Inappropriate prescribing." *APA Monitor*. June 2012, Vol 43, No. 6. http://www.apa.org/monitor/2012/06/prescribing.aspx.

79. *Surprising Health Disparity: Men in their Middle Years*. Webinar. Injury Control Research Center for Suicide Prevention. 11 March 2014.

80. Stobbe, Mike. "Drug overdose deaths spike among middle-aged women." *The Big Story*, AP.org. <www.bigstory.ap.org> 2 July, 2013.

81. *Target Shooting in America*. Southwick Associates for the National Shooting Sports Foundation. <www.nssf.org/PDF/research/TargetShootingInAmericaReport.pdf>

82. "Twenty Years After U.S. Requires Gun Background Checks, New FBI Data Shows Vermont Undermines Gun Background Check System By Failing To Submit Records On Dangerously Mentally Ill." Mayors Against Illegal Guns. 21 November 2013.

83. United States Preventive Task Force. Recommendations. www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/suicide-risk-in-adolescents-adults-and-older-adults-screening. 2 October 2014.

84. *Use of Opioid Analgesics in the Treatment of Chronic Pain*. Vermont Board of Medical Practice Policy Amendment. April 2014.

85. *Using Online Communications Approaches for Suicide Prevention: An Overview of Communication Planning for Prevention and an Applied Example from Colorado's ManTherapy.org.* Webinar. South by Southwest Injury Prevention Network. 14 January 2014.

86. Vermont Child Health Improvement Program.

87. Vermont Department of Health: Vermont Prescription Monitoring System.

88. Vermont Firearm Statutes. <www.atg.state.vt.us/issues/gun-laws.php> Accessed: April, May & October 2014.

89. Vermont Network Against Domestic & Sexual Violence. <www.vtnetwork.org>

90. Vermont Statutes Online, Title 13: Crimes and Criminal Procedure; Chapter 85: WEAPONS; 13 V.S.A. § 4013; and Title 10: Conservation and Development; Chapter 113: GAME; §4704 and 4705. <www.atg.state.vt.us>

91. *Vermont Suicide Prevention Brief.* December 2013. Vermont Department of Health.

92. Vermont Fish and Wildlife. <http://www.vtfishandwildlife.com/edu_hunter.cfm>

VI. BIBLIOGRAPHY

93. Vermont Vital Statistics System.

94. Vital Signs: Overdoses of Prescription Opioid Pain Relievers – United States, 1999—2008. *Morbidity and Mortality Weekly Report*; 60(43); 1487 – 1492. 4 November 2011.

95. Web-based Injury Statistics Query and Reporting System. (WISQARS) Centers for Disease Control. <http://www.cdc.gov/injury/wisqars>

96. Webster, ScD, MPH, Daniel W.; Jon S. Vernick, JD, MPH; April M. Zeoli, MPH; Jennifer A. Manganello, PhD, MPH. "Association Between Youth-Focused Firearm Laws and Youth Suicides." *Journal of the American Medical Association*. Vol 292, No. 5, 594-601. 4 August 2004.

97. Wenjun Zhong, PhD, Hilal Maradit-Kremers, MD, MSc, Jennifer L. St. Sauver, PhD, MPH, Barbara P. Yawn, MD, MSc, Jon O. Ebbert, MD, Véronique L. Roger, MD, MPH, Debra J. Jacobson, MS, Michaela E. McGree, BS, Scott M. Brue, BS, Walter A. Rocca, MD, MPH. "Age and Sex Patterns of Drug Prescribing in a Defined American Population." *Mayo Clinic Proceedings*. 21 June 2013. <www.mayoclinicproceedings.org>

98. Winerman, Lea. "Helping Men Help Themselves." *Monitor on Psychology*. American Psychological Association. Vol 36, No 6. June 2005.

99. Women's Law. Accessed: May 2014. <www.womenslaw.org>

100. Zero Suicide. <www.zerosuicide.actionallianceforsuicideprevention.org>