FAQs

1. **Why aren't the stats more current?**
   Most of the statistics come from the CDC - either WISQARS or WONDER.
   Typically they are two years behind due to the need to gather and "clean" the data from each of the states.
   Other data come from specific studies and reflect the data used at the time the study was done.

2. **Why are suicide rates increasing?**
   Just as there is no single reason why someone considers or makes a suicide attempt, there is no single reason that is causing the increase. Changes in mental health status, substance misuse, economic patterns, social connectedness, demographics, media attention and other factors may all play a part--but we don't actually know the reason.

3. **What are the statistics on male vs female suicide deaths? What about non fatal self-harm? Is this all about means used?**
   In the US in 2016, 77% of the suicide deaths were among males. This proportion is decreasing.
   60% of non-fatal self-injuries were among females.
   The choice of methods is likely part of this difference and of the trends.

4. **Isn't it true that someone who is intent on taking their life can find a way?**
   While this may be true, many suicide deaths are the result of a quick decision without much planning. In many of these cases, the person will use what is easily accessible to them which is why we urge people to put time and distance between lethal means and a person at risk for suicide. About 60% of suicide deaths occur on the first attempt and about 90% of those who survive an attempt do not go on to die by suicide.

5. **Why isn't there more emphasis on medications?**
   There are several reasons for this**.** Given the current opioid crisis, there is a great deal of information and resources available on reducing access to dangerous drugs including keeping abuse prone drugs locked up, drug drop boxes and drug take back days. In addition, while some drugs (and drug combinations may be lethal, most are not.Also, an attempt using medications can be discontinued once begun and the person can often be treated. Finally, given the vast number of medications and other drugs in use, it is difficult to provide effective guidelines for means reduction in a general workshop. Specific recommendations may be obtained from a pharmacist or from the Poison Control Center.

6. **Why don't you recommend reducing access to means of suffocation or hanging?**
   We do recommend it if there is a specific item or location that someone is intent upon using. For example, if someone seeks to obtain a helium tank. In any other case, there are just too many and too varied a list of items that could be used for hanging oneself that it is virtually impossible to reduce access to all of them. Fortunately, in many cases, an attempt at suffocation can be halted with little or no ill effect. On the other hand, suffocation is the second leading method of

suicide which is highly concerning. Therefore, other aspects of safety planning should be emphasized including maintaining physical and emotional contact while the individual is at risk.

7. **What about cutting?**

Like suffocation, it is nearly impossible to remove all means for people to cut themselves if they wish to self-injure or attempt suicide. Unlike suffocation, however, cutting is rarely the method used in fatal suicidal behavior. Therefore, removing sharps from the environment is going to be highly inconvenient for patients and their families and is unlikely to result in many lives saved. If an individual is intent on using sharp instruments in suicide attempts, or self-harming behavior is escalating, steps should be taken to reduce access as much as possible. As with suffocation, other parts of safety planning should be emphasized.

8. **Are people who engage in self-harming behavior more likely to die by suicide?**
   According to a study by Matt Miller et. al. "Intentional self-harm predicts suicide better than any other known risk factor," though the vast majority of those who self-harm never go on to die by suicide. With regards to Lethal Means Reduction, the research shows that most of those who do eventually die by suicide switched from a less to a more lethal method between their index self-harm event and their eventual suicide death.

9. **What about the role of the misuse alcohol and other drugs in suicide?**
   This is a complex question due to the tremendous overlap between the risk factors and consequences for substance misuse and suicidal behaviors including depression and other mental health issues, impulse control, socio-economic factors and so forth. Therefore, it may be difficult to distinguish between cause and effect when these conditions co-occur. Recent data indicates that alcohol or other drugs (not **directly** involved in the suicide attempt) were present in xx% of suicide decedents and xx% were identified as having substance misuse issues.

10. **Where can I learn more about firearms?**
    It is highly recommended that clinicians who are not familiar with firearms obtain some instruction on how they operate in order to increase their comfort and effectiveness in discussing means reduction with their patients and families. Basic instruction is available through many gun shops and shooting clubs. Hunter Safety classes are offered throughout the country. Classes vary from 2 hour introductory sessions, often for free, to all day classes with and without hands-on range experience. In addition, there are on-line resources available that can help with basic nomenclature and may be useful to learn how to use various safety equipment. All of these can vary widely in the quality of the instruction provided.

11. **What should I do if the client refuses to discuss Lethal Means Reduction?**
    Most won't. If they do, remember that while LMR is an important part of suicide prevention, it is certainly not the only strategy and should not be allowed to derail other treatment options or Safety Planning. If you meet resistance, go on to other areas where you can reach agreement, returning to LMR either later in the encounter or at a later session. Before you return to the topic, consider your approach making sure that it was not anti-gun and was collaborative and

respectful of the individual's autonomy. You may want to brainstorm with a colleague or supervisor to identify other approaches or options before returning to the question.
If the risk is severe and/or imminent take additional steps before releasing the client.

12. **Can I charge for doing CALM Workshops?**
    There are several aspects to this question. The first is that you should probably do several workshops for free (in your own agency for example) before you charge for doing them. Secondly, you should follow the policies of your employer with regard to this question particularly if outreach and training are part of your job. Finally, if you are getting paid for doing workshops outside of paid employment, you should consider tax and liability issues.

13. **Can I offer CEUs for the training?**

Yes, but each instructor must obtain their own certification. Many professional organizations offer them.

14. **Where can I learn more about…?**
    Hopefully, the materials and resources you have been provided will be able to answer most of your questions. You should always feel free to contact the Master Trainers who have trained you and/or the developers of CALM if you have any further questions.

Q 8 MMiller et al, ***Method Choice in Non-Fatal Self Harm*****. AJPH June 2013 103(6) e61-e68.**