

## **Restricting Access To Lethal Means**

By Ken Norton LICSW

If ever there was a mouthful of professional jargon this is it. Yet suicide prevention literature including the National Suicide Prevention Strategy is replete with this terminology. Put in common parlance it means you can prevent suicide by reducing, removing or eliminating the methods people use to kill themselves. It is also known as “means restriction.” Research has repeatedly demonstrated that this is an effective suicide prevention strategy across different countries and cultures. .

Restricting access to lethal means can take many forms. Some are based on a universal public health approach and are spread across the population such as placing barriers on bridges, rooftops or other high places, having mandatory waiting periods for firearm sales and selling toxic over the counter medications in smaller quantities and individually packaged “blister packs” which make it more difficult to take by the handful. After a dramatic increase in suicides using gas from cooking stoves in the United Kingdom during the 1950’ they were able to dramatically reduce suicides by adding a noxious smelling additive to the natural gas. In many agrarian countries/cultures, lethal means restriction involves locking up fertilizer and pesticides.

Other more selected forms are used for individuals that have been identified as at significant risk for suicide. These methods can include limiting the quantity of prescribed medication so the individual does not have a lethal dose on hand (an especially good idea with anti depressants), and temporarily removing firearms from homes until the risk of suicide has passed. It may also include removing razor blades/knives, poisons from a home or even taking away the keys to an automobile.

Lethal means restriction actively confronts many of the pervasive myths about suicide such as that you can’t really stop a suicidal person from killing themselves. The reality is that most suicidal people are ambivalent about dying (and living). This is best demonstrated by the fact that 85% of people who survive a suicide attempt do not go on to die by suicide at a later point in time. Suicidal individuals just want the psychic pain they are in to stop. The first line of suicide prevention is recognizing people at risk before they attempt. Psychological autopsies indicate almost 80% of people who die by suicide verbalized severe hopelessness or expressed a desire to die which went unrecognized. Intervening with people and getting them help typically results in a saved life. Means restriction is an important component of the intervention process

Research indicates that while people may contemplate suicide over time, the actual decision to take their life is often impulsive. This is a strong argument for restricting access to lethal means. With firearms accounting for over 50% of the suicides in both New Hampshire and the United States, questioning an individual at risk (and/or family) about access to firearms and reducing that access is a key means restriction strategy.

With asphyxiation (hanging) being the second leading cause of death, some people argue that you can not possibly remove all the possible ligatures to prevent a hanging, however there is everything to be gained by trying. 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. These details can offer the opportunity to prevent hangings as well. 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.

Case Example: there are two bridges near Dupont Circle in Washington, DC spanning Rockville Creek. They are several hundred yards apart and take 3-4 minutes to walk from the center of one bridge to the center of the other. One bridge had an average of approximately 3.25 suicide deaths per year, the other an average of 1.75 deaths per year (for an average total of 5 suicides per year). A DC family who lost a loved one to suicide off the bridge in the early 1990’s petitioned for a barrier to be erected. Opponents argued suicidal individuals would just go to the other bridge. A barrier was constructed on the more frequently used bridge and after 5

years there no deaths on that bridge and an average of 2 deaths per year on the other bridge (not a statistically significant increase). Overall there was a net reduction of 3 deaths per year.

Reducing access to lethal means should be done by any social worker dealing with or assessing an individual at risk for suicide. However, it can also be done by anyone with a little basic knowledge of how to do it. If you are concerned or worried that someone is contemplating suicide, asking them directly “are you thinking of killing or hurting yourself” is essential. A follow up question would be “Do you have a plan of how you would kill yourself?” You should also ask what if you weren’t able to do X what would you do then? The more details that can be obtained about the plan, the easier it will be to determine how to reduce the individual’s access to lethal means. The next step is to work with the individual to remove those means. Involving family or friends in this process can increase the likelihood of a positive outcome as well as engage natural supports who can monitor and support the person.

New Hampshire is at the forefront nationally on putting lethal means restriction into practice. NAMI NH’s Frameworks Suicide Prevention Project (now The Connect Project) is a nationally designated Best Practice program which developed specific protocols for key service providers in suicide prevention and intervention. The protocols include a specific protocol for lethal means restriction. Instruction in lethal means restriction is also imbedded into all Frameworks (Connect) training.

Generating a great deal of local and national interest is the CALM (Counseling on Access to Lethal Means) program. CALM was developed and is co-facilitated by Elaine Frank from the Injury Prevention Center at CHAD and Mark Ciocca from Capital Valley Counseling Associates. CALM teaches health care providers why and how to restrict access to potential lethal means for an individual who is at risk for suicide. Outcomes from the first year of the project are very positive and indicate that 65% of participants had counseled clients about access to lethal means in the six weeks following the workshop. CALM training has been provided to NH’s Community Mental Health Centers and is currently being offered to primary care providers and Emergency Departments. For more information, contact Elaine Frank (603) 653-1135 or [elaine.m.frank@dartmouth.edu](mailto:elaine.m.frank@dartmouth.edu).

You can help to save lives by incorporating lethal means restriction into your everyday practice with clients who may be at risk for suicide, or if you work in an agency, by insuring that policies and procedures require a review/discussion of lethal means restriction for people at risk and by making sure that staff are trained and familiar with the concept of means restriction.

This is the fourth in a series of articles for the NH NASW newsletter on suicide prevention. Series articles include: Suicide Prevention: A Public Health Issue, Suicide Prevention Efforts in NH, Survivors of Suicide, Suicide Prevention and Veterans, No Harm Contracts, Suicide and Older Adults, Suicide Risk in Lesbian, Gay and Transgender Youth, Clinicians as Survivors, Suicide and the Economy, and Media, New Media, Safe Messaging and Suicide Prevention. These articles can be viewed in the Newsroom/Articles section of the Connect website at [www.theconnectproject.org](http://www.theconnectproject.org). Ken Norton is the Director of NAMI NH’s Connect Suicide Prevention Project and can be reached at (603) 225-5359 or [knorton@naminh.org](mailto:knorton@naminh.org).