An Introduction to Saving Lives Through Preventing Suicides

For Pharmacists and Related Professionals

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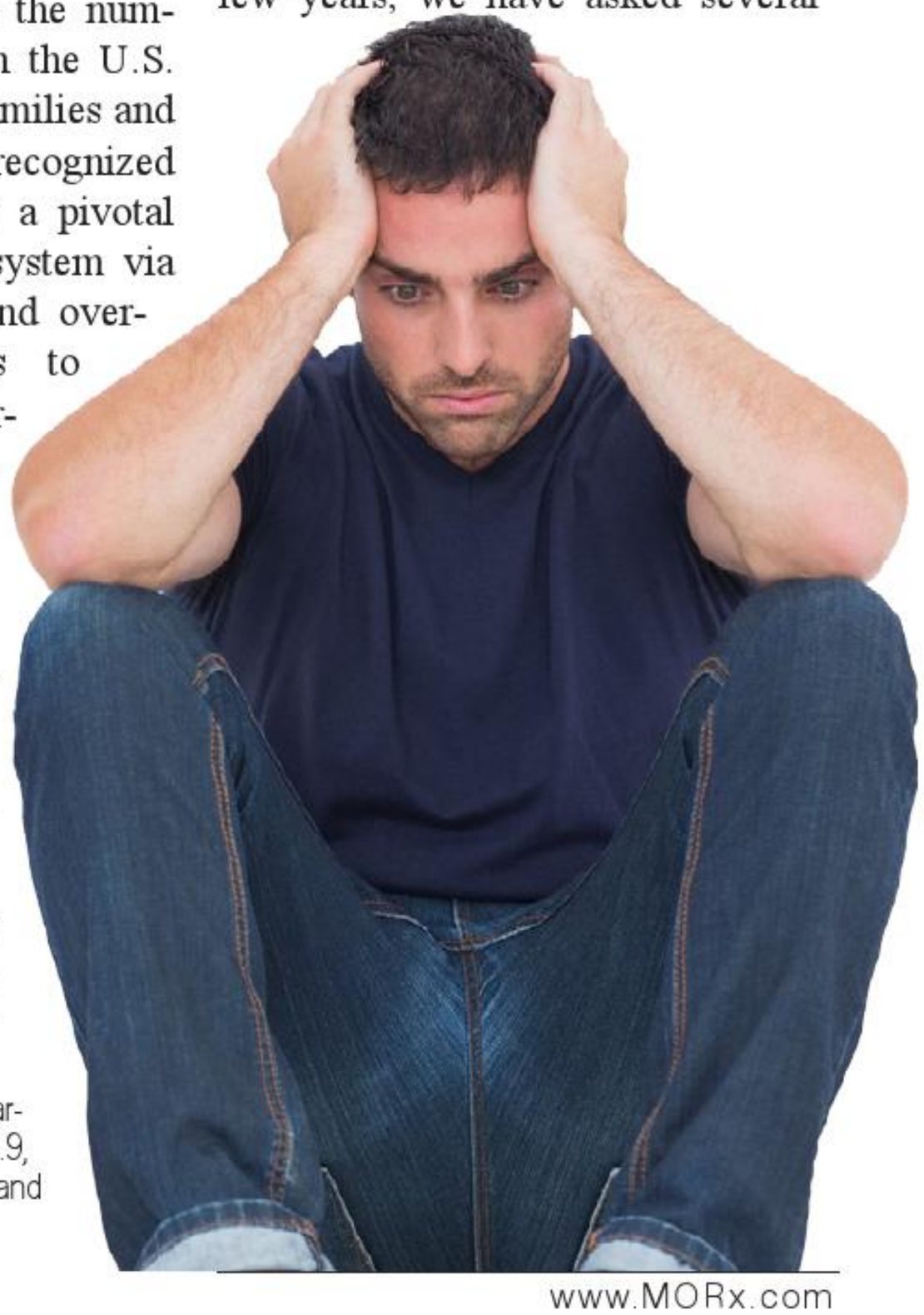
The intent in writing this article is to give pharmacists and related professionals in Missouri and elsewhere an introduction to the subject of suicidality (the study of self-inflicted fatalities and their associated causes, actions and outcomes) and suicide prevention. It is not a new subject, as self-inflicted harm and deaths have been a part of the human condition throughout history. Preventing such deaths on a nationwide, organized, and informed effort, however, is relatively new in the U.S. Official federal and government-funded organizations and efforts to prevent such actions—by those attempting and often successfully completing death by suicide—are a relatively new phenomenon. The first U.S. Surgeon General's proclamation of a nationwide program to reduce the rate and incidence of suicides was initiated about 20 years ago. Regarding pharmacy in the U.S., the first "official" pronouncement that pharmacists should be educated, trained and involved in suicide prevention was published over 42 years ago in the Journal of the American Pharmaceutical Association. It was entitled, "Suicide and the Role of the Pharmacist," by Dr. Melvin R. Gibson, who was executive director of the American Association of Colleges of Pharmacy at the time, and his colleague, Dr. Rex S. Lott.[1] Their paper described several specific actions which community and institutional pharmacy colleges and organizations across the country should pursue to reduce the number of suicidal deaths in the U.S. as well as to help their families and patients. These authors recognized that pharmacists occupy a pivotal role in the health care system via providing prescription and over-the-counter medications to their patients. These pharmacists are uniquely positioned to assist in preventing many of these tragedies each year; as a key provider of such interventions, the stature and recognition of the profession of pharmacy and its members is enhanced—safeguarding patients' safety, health, and quality of life outcomes.

Unfortunately, our group of pharmacy practitioners, educators, researchers and pharmacist-counselors has been able to find little evidence that practicing pharmacists are educated, trained, and equipped to take professional actions to identify, assess, and intervene with families and patients at risk of taking their own lives. Over the last few years, we have asked several



[1] Suicide and the Role of the Pharmacist, JAPhA, Vol. NS12, No.9, Sept., 1972, Melvin R. Gibson and Rex S. Lott

hundred pharmacists, technicians, pharmacy students, and other health professionals if they have had formal education or continuing education programing on the subject of suicide prevention; responses in the affirmative have been negligible to nonexistent. Herein we will address only an introduction to three basic components of suicide prevention, as suicide itself and preventing it (on a case-by-case basis) is a complex and sometimes difficult task; nevertheless, a short but effective intervention plan can save lives. The three components described briefly here are identification, assessment, and actions to help prevent suicides among patients taking antidepressants and other mood-altering medications. Readers can find a wealth of information and data regarding suicide prevention, organizations, training sessions, and other resources by visiting Pharmacists Preventing Suicides' website at www.PharmacistsPreventingSuicides.com.

The Magnitude of the Suicide Problem in the United States

Pharmacists, instructors in colleges of pharmacy, and other related persons may be surprised to learn that the number of suicides in the U.S. now exceeds even the number of deaths by automobile accidents for the first time in our history. Suicide ranks as the 10th leading cause of death in the U.S., ahead of septicemia, chronic liver disease and cirrhosis, homicides or murders, Parkinson's disease and other commonly-known diseases.[2] There were almost 39,000 reported suicides in 2010, though it is well-known that suicide deaths are not always reported as such, so the number may be as high as 50,000 each year. In Missouri, suicides also rank as the 10th leading cause of death, numbering about 1,000 deaths per year, or 14.3 per 100,000 per year, 15 percent greater than the U.S. average of 12.[4] per 100,000 people per year. Why this disparity exists is largely unknown and not investigated to date.

Identification of Patients Possibly At-Risk to Take Their Own Lives

While a small percentage of depression patients attempt or complete suicide, it is between 60 percent and 80 percent (possibly as high as 90 percent) of suicide victims who were diagnosed with major depression disorder (MDD), bipolar disorder or manic-depressive syndrome, schizophrenia, major anxiety disorder or other mood disorders prior to their deaths—though drug abuse, when associated with these mood disorders, increased the risk. It is certain that depression plays a major part in the mental health status and deaths of most of these victims. Experts in forensic psychology have found that most of those who attempt to take their own lives but live through the event had mixed emotions and were bivalent at the time of the attempt. Out of seven "attempters" who lived through jumping from the Golden Gate Bridge in San Francisco, CA and were interviewed, all seven said that they changed their decision on the way to the water. It is reported by researchers that up to 80 percent of suicide victims tell others that they are planning to take their own lives ahead of their deaths. Talking with them does not increase their risk. AARP has reported that over 70 percent of elderly suicide victims have visited their doctor (and possibly pharmacist) within a month of their deaths. Pharmacists, as the most trusted and most accessible health professional (according to annual consumer studies), can learn about these intentions.[3] Those patients who have attempted taking their own lives must be monitored; additionally, those who state their intentions directly (or indirectly via a family member or significant other) to their pharmacist should likewise be watched carefully. Our "Slide to Suicide" chart shown on the next page is indicative of the path that most depressed suicide victims follow to their ideation, suicide attempts, and completions. When a health professional observes a depressed patient behaving in these ways, the patient and their family should be advised to seek appropriate help—particularly mental health doctors, mental health clinics, or hospitals. The HIPPA Act does not prevent health professionals, including pharmacists, from reporting to anyone who might reduce the risk that a patient may be in danger of harming themselves or others.[4] The Slide to Suicide chart depicts a series of events and behaviors often characteristic of patients suffering from major depression disorder,

[2] Center for Disease Control/NCHS, National Vital Statistics System, "---Death Rates for the 15 Leading Causes---", 2012 for 2010

[3] Gallop Poll: "Honesty/Ethics in Professions, Nov. 26-29, 2012, p. 26

[4] "Message to Our Nation's Health Care Providers", a letter from the Director of the Office for Civil Rights of the Department of Health & Human Services, Washington, D.C., Leon Rodriguez, January 15, 2013

The Slide to Suicide

Adverse Event Mood **Trigger** ⟶ **Any** upsetting event

Loss of Self-Esteem →

Loneliness and Isolation →

Frustration and Anger → DEPRESSIVE RESPONSE

Prolonged Depression →

Helplessness → SELF-DEPRECATION

Worthlessness →

Burdensomeness →

Hopelessness → ABNORMAL

Suicidal Thoughts → BEHAVIORS

Ideation

SUICIDE

which is a severely melancholic, sad, debilitating, discouraging, and sometimes fatal disease when patients view taking their own life as "the only way out of their misery." Correct diagnosis and use of pharmaceuticals (to correct the chemical imbalances in the brain) plus talk therapy is often more effective than either treatment alone, while other means may prove beneficial for patients who do not respond well to medicines. There are many treatment options that can restore most of these patients to a normal life, and pharmacists (and others) should be knowledgeable about these alternatives in order to offer help and hope.

The question for pharmacists and their colleagues is which patients are at the most risk? Certainly, those who have made prior attempts and those who tell others they plan to take their own lives are at high risk. Men commit suicide more than women, though frequency varies greatly among race, location, health status, sub-culture, age, economy, social class, and other socio-behavioral factors. The largest group of attempters is young people aged 15 to 34; the largest group of completers is the elderly, especially those who are physically ill and believe they are terminal. The suicidal signs are similar, but some differences exist that should be watched closely. Major signs for each of the two largest patient groups are listed below, though the largest increases in both numbers and rates in the last three to five years have been among middle-aged women. Awareness of suicide as the major problem and/or side effect of depression (and other mood disorders and their treatments) will be very helpful for pharmacists to save lives. The signs of suicide can be readily found on-line.

Signs for pre-teens, teens and young persons include but are not limited to: drug and alcohol use/abuse; isolation and withdrawal from family/friends/usual activities; giving hints such as "it's no use" or "I'm going to heaven;" separation or loss of another person or role model and excessive grief actions; persistent boredom, a decline in school or work performance, poor concentration, etc.; attempting to purchase weapons, explosives, armor, uniforms or stockpiling drug supplies and medicines; getting their "affairs" in order; giving away valued items; dramatic changes in eating or sleeping patterns; and other abnormal actions.

Signs for senior persons, particularly those over age 60, include over three months of functional impairment from depression or grief; expressing hopelessness or burdensomeness; wishing for an early death or expressing a lack of meaning to life; sudden weight loss with periods of food deprivation; personal or family history of suicide attempts; alcohol or drug overuse; refusal of life-preserving medical care such as oral anti-diabetic medication or insulin, I.V. fluids; refusal of friends and family visits; and other abnormalities.

Assessment of the Patient for Degree of Risk of Suicide

We have said that those who are at serious risk often tell others about their objective – friends, family, health care providers, local law enforcement officers, teachers and others. These threats must always be taken seriously and regarded as potentially harmful to the patient and others. About one thousand to

fifteen hundred murders occur each year by persons who then take their own lives in a violent fashion. For health care workers, there are rating scales for risk assessment available that have been widely used by psychologists, psychiatrists, social workers, mental health case managers and others. Some of these question-based tests can be found online for self-administration or administered by trained health professionals. Some caregivers prefer particular rating scales, but some mental health practitioners regard any of the acceptable scales as helpful, though the diagnosis depends on the clinical assessment of the patients, the patient's mental state (both at a particular time and over a period of time), and specific laboratory tests. Pharmacists are not usually equipped to diagnose their patients with rating scales, though we believe they can learn to use and report the results of depression and suicide rating scales in monitoring the effectiveness and value of the patients' ongoing medication (and other) treatments. We at PPS© do not recommend particular tests, though the Sheehan Rating Scale is reported to be a good test for patients with panic disorder; the Beck Depression Inventory II has been received favorably by mental health caregivers for many years for use in adults and teenagers over the age of 13. We have also developed a Cooperative Care Agreement or contract which pharmacists in Missouri, MMS-qualified pharmacists, and certified Psychiatric Pharmacists can evaluate for use in cooperative clinical practice arrangements with physicians. These cooperative practice activities are permissible under the new laws and regulations in our state [Missouri] permitting pharmacists to be hands-on with select patients under the supervision of a Missouri physician. The draft agreement can be seen on the PPS© website.

Actions Pharmacists Can Take To Help Prevent Suicides

Pharmacists in the U.S. have many patients in their care requiring mood-disorder treatment. Reports indicate that there are over 21 million people suffer from depression in the U.S. Some resources report that only half of patients with a confirmed diagnosis of depression are receiving treatment. In 2012, IMS Health reported antidepressants to be the number one prescription drug category among all drugs, with over 270 million prescriptions.[5] The number of pharmacists in active practice in the U.S. varies from day-to-day, with estimates from the National Association of Boards of Pharmacy (NABP), the Food and Drug Administration (FDA), and the U.S. Labor Department of between 260,000 and 270,000. In our view, these numbers indicate that pharmacists have had more than 270 million opportunities to talk to patients and their families who may be at risk each year! Pharmacists can and must take responsible action to assist patients taking these depression and/or mood disorder medications; these actions may include, but are not limited to, a formal risk assessment. Pharmacists should have a follow-up plan to monitor the patients' compliance to the prescribed medication regimens as well as their progress on health and wellness outcomes. A 2005 JAPhA article gives a detailed example of this type of follow-up plan that may prove useful for both institutional and community pharmacy practices.[6] A more personal and perhaps helpful approach, particularly if the patient could be at immediate risk and danger, is for the pharmacist to ask questions and respond appropriately. This program is outlined in PPS© Pocket Cards for pharmacists and their patients on our website. Pharmacists should counsel each patient taking depression medications using questions such as: "How are you doing?", "Are you making progress with your condition?", and "Have you had any thoughts of harming yourself or others?" If the answers to these or similar questions are negative or indicate probable or immediate risk of harm to the patient or others, the pharmacist should then ask, "Do you have a plan to carry out this or these intentions?" If the patient has a plan, then the pharmacist should refer the patient to their physician or mental health professional for an immediate visit. The pharmacist should confirm that the patient will keep the appointment or even arrange transportation for them to the physician's practice location. Doing so may very well save your patient's life! We at PPS© feel that all pharmacists will agree that *SAVING ONE LIFE WILL BE WORTH THE EFFORT.* Readers can find more help at pharmacistspreventingsuicides.com.

[5] IMS Institute for Healthcare Informatics, "Top 10 Therapeutic Classes by U.S. Dispensed Prescriptions," 2-23-2012

[6] Pharmacists Telemonitoring of Antidepressant Use: Effects on Pharmacist-Patient Collaboration," N.A. Rickles, et.al., JAPhA, Vol.45, No. 18, May/June 2005., p. 342ff.