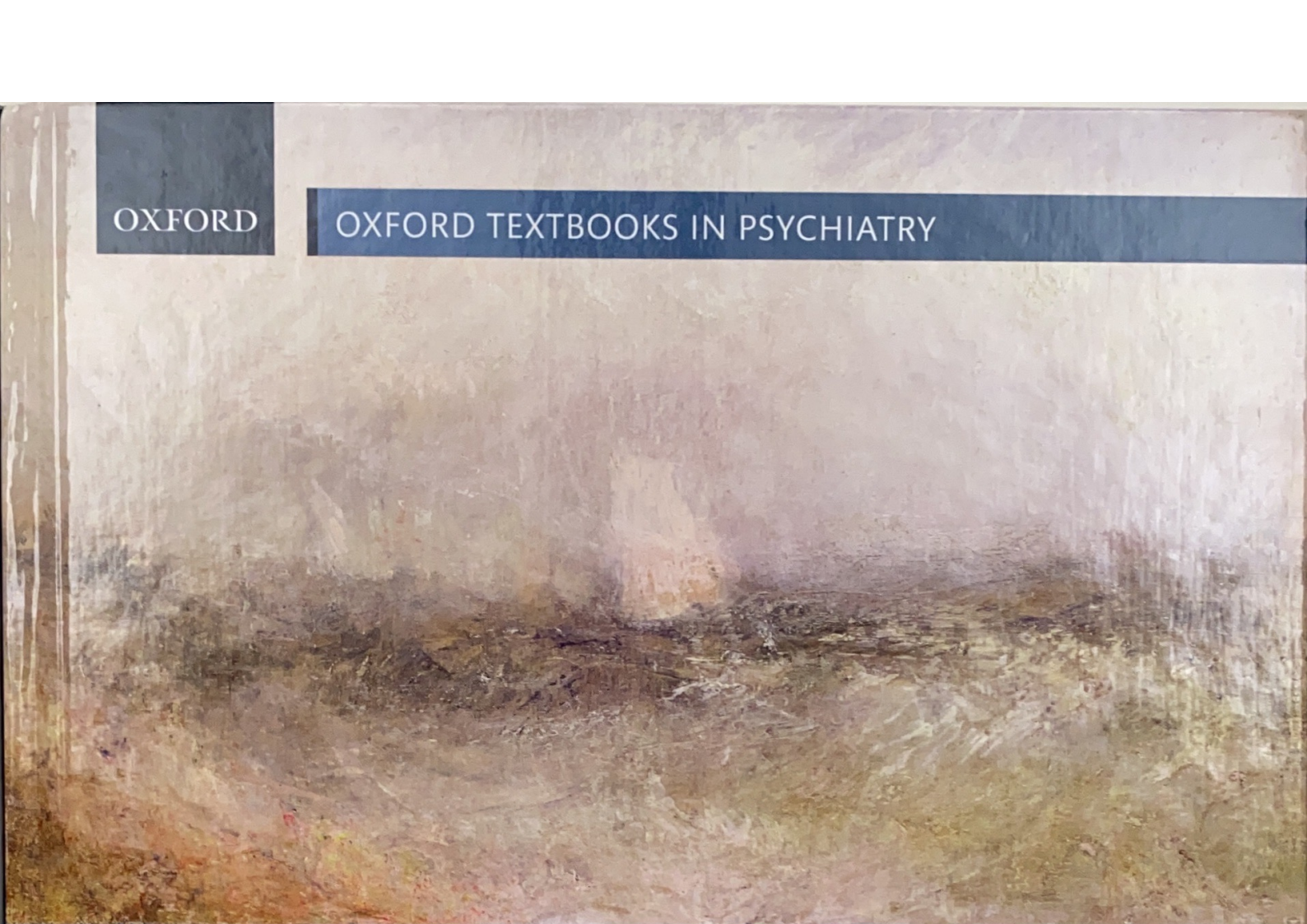


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An impressionistic painting of a landscape, featuring a path leading through a field towards a distant, hazy horizon. The colors are muted, with earthy tones of brown, green, and grey, and a soft, atmospheric light. The brushstrokes are visible, giving the scene a textured and somewhat somber feel.

Oxford Textbook of  
**Suicidology and  
Suicide Prevention**

SECOND EDITION

EDITED BY  
**Danuta Wasserman**

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# Oxford Textbook of Suicidology and Suicide Prevention

Over 800,000 people commit suicide worldwide annually and, according to different estimates, up to 20 times more attempt suicide each year. Suicide is a major public health problem throughout the world, and major efforts are currently being made to help reduce these numbers. However, suicide is the result of complex interactions between a range of factors, including historical, psychological, cultural, biological, and social, and any approach to treating the problem of suicide has to consider all these aspects.

This new edition of the *Oxford Textbook of Suicidology and Suicide Prevention* has been thoroughly updated and expanded since publication of the first edition in 2009. This comprehensive resource covers all aspects of suicidal behaviour and suicide prevention from a number of different perspectives, including its underlying religious and cultural factors; its political, social, and economic determinants; its psychiatric and somatic causes; and its public health impacts. The new edition includes several new clinically focused chapters devoted to major psychiatric disorders and their relation to suicide, including mood and anxiety disorders, substance use, psychosis/schizophrenia, bipolar disorder, eating disorders, and personality disorders. It also includes a fully updated section on psychometric scales used for measuring suicidal behaviour and instruments used in suicide preventative interventions, as well as descriptions of the methods used in schools, as suicide is the second leading, and in some countries first, cause of death for young people.

Part of the authoritative *Oxford Textbooks in Psychiatry* series, this second edition will continue to serve as the key reference source for both researchers and professionals working in the areas of suicidology and suicide prevention, including psychiatrists, clinical psychologists, public health specialists, and neuroscientists.

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# The role of restricting access to potentially lethal medication in suicide prevention

Cyril Höschl and Pavla Čermáková

## Introduction

The wide international variation in the way people die by suicide suggests that suicidality is closely associated with access to specific methods (Ajdacic-Gross *et al.* 2008). In the case of sudden, impulsive, or briefly planned suicidal attempts, individuals may use a method that is the most accessible to them. When the access to a potentially lethal method is restricted, the suicidal attempts may be postponed, suicidal impulses pass, and the suicide act may not be committed (Hawton 2007). A systematic review of suicide prevention strategies carried out by Mann *et al.* (2005) identified that restricting access to lethal means is a powerful and effective strategy to prevent suicides. Evidence about the effectiveness of this approach has been further substantiated in the more recent systematic review conducted by Zalsman *et al.* (2016).

Intentional overdose with medications is usually a common method of suicide, particularly in high income countries and among women (Ajdacic-Gross *et al.* 2008). Although the overall case fatality rate for medication is rather low, some drugs are more lethal than others and significantly contribute to suicide rates (Barber and Miller 2014). Common drugs used for intentional overdose include sedatives, analgesics, antidepressants, antipsychotics, and anticonvulsants (Sheridan *et al.* 2017). The ease of use and accessibility of potentially lethal medications may facilitate unplanned suicide acts (Conner 2004). Evidence shows that restricting access to such drugs is a feasible strategy, which, if part of a comprehensive nationwide preventive policy, could contribute to the reduction of suicide rates.

## Evidence about restriction of access to medications

### Barbiturates

The first studies that linked easily accessible and potentially lethal drugs to suicides were conducted in Australia (Oliver and Hetzel 1972; Whitlock 1975). Oliver and Hetzel (1972) found an association between rising suicide rates and increasing availability of

barbiturates in the second half of the twentieth century. They also showed a marked decrease in suicide rates after the implementation of a law in 1967, which largely restricted the access to other barbiturates, by reducing their allowable quantity, controlling for their strength, and allowing no repeats of their prescriptions (Oliver and Hetzel 1972). Another study from Australia showed that a decline in suicide rates occurred with the introduction of safer benzodiazepines, which replaced the previously prescribed and more hazardous barbiturates (Whitlock 1975).

Early findings from Australia were soon replicated through research in several other countries around the world. In Japan, barbiturates were freely available over the counter until 1961. However, when legislation was introduced that required a prescription for barbiturates, a rapid decline in suicides was the outcome. The research also showed that people mostly did not switch to other methods for suicide (Lester and Abe 1989). In 1985, researchers from Denmark observed a decrease in the number of cases of poisoning after several barbiturates were withdrawn from the Danish Medical Codex (Nielsen and Nielsen 1992; Nordentoft *et al.* 2007). The authors also found out that the reduction in numbers was more evident for women than for men (Nielsen and Nielsen 1992).

Similarly in Sweden, a decrease in sales of barbiturates was followed by a decline in suicides during the 1970s, particularly in younger and middle-aged men (Carlsten *et al.* 1996). In a Norwegian study, researchers in Oslo found that a withdrawal of four barbiturates from the market resulted in a decisive decrease in barbiturate poisonings (Ekeberg *et al.* 1987). Their findings did not detect any increase in the rate of self-poisonings with benzodiazepines and other hypnotics, but they noted significantly higher rates in suicide attempts with antidepressants and antipsychotics (Ekeberg *et al.* 1987).

### Antidepressants

Several studies from the United Kingdom, Norway, Sweden, and the United States of America revealed that the rising use of antidepressant medication, and in particular older tricyclic antidepressants, was accompanied by increasing trends in suicides (Retterstøl 1989; Kapur *et al.* 1992; Crome 1993; Carlsten *et al.* 1996; Olfson *et al.*



**Box 78.1** Suggestions for restrictive measures to lower suicide rates due to medication overdose

- Prescription of less toxic medications
- Smaller size of prescriptions
- Enclosing pills in plastic blisters
- Prescription as suppositories instead of oral tablets
- Reduction of automatic refills of prescriptions
- Elimination of drug prescription without assessing patient
- Monitoring possible multiple prescriptions by several doctors
- Setting up systems to prevent changing prescriptions by patients
- Monitoring adherence to avoid drug trafficking
- Routine monitoring for signs of misuse of medications

2003; Gibbons *et al.* 2005). The rise in the use of antidepressants as a frequent method of suicide, followed restriction of access to barbiturates (Retterstøl 1989). On the contrary, higher prescriptions of selective serotonin receptor inhibitors (SSRIs) and other new non-SSRIs, were found to be related to lower suicide rates in many countries (Isacsson 2000; Rihmer *et al.* 2001; Hall *et al.* 2003; Kelly *et al.* 2003; Oravec *et al.* 2003; Rihmer 2001, 2004; Grunebaum *et al.* 2004; Gibbons *et al.* 2005; Bramness *et al.* 2007). This positive phenomenon could be explained by several mechanisms; firstly, these drugs possibly improved the efficacy in treating depression; secondly, these drugs resulted in fewer deaths because of their lower toxicity; and thirdly, this finding could also reflect an overall better quality of mental healthcare (Gibbons *et al.* 2005).

**Analgesics**

An older investigation from Denmark revealed increasing suicidal attempts among young women using analgesics, especially paracetamol (Nielsen and Nielsen 1992). Researchers from the United Kingdom and France also showed links between the sales of paracetamol and the rate of suicide attempts (Gunnell *et al.* 1997). To address the problem of self-poisoning with analgesics, the United Kingdom introduced a legislation in 1998 that reduced the size of packages that could be sold over the counter. The law brought significant favourable changes to mortality and morbidity associated with self-poisoning, with few signs of substitution to other methods of suicide (Hawton *et al.* 2001; Hawton *et al.* 2004). Even though some researchers have cast doubt on these early optimistic findings (Bateman 2009), the majority of studies support beneficial effects of smaller packets, and the effectiveness of withdrawing particularly toxic analgesics from the market in suicide prevention (Morgan *et al.* 2007; Hawton *et al.* 2011; Hawton *et al.* 2012; Hawton *et al.* 2013; see also Box 78.1).

**Substitution of methods**

A common concern about restricting the access to potentially toxic drugs, is that it will influence patterns of suicides, but will not prevent them because individuals at risk could switch to other methods of suicide. Some studies found evidence of switching to other drugs after restrictive legislative measures were implemented (Adelstein and Mardon 1975; Ekeberg *et al.* 1987), while other authors did not (Oliver and Hetzel 1972; Lester and Abe 1989; Melander *et al.* 1991; Chen *et al.* 2011). A study from Sri Lanka suggested that restriction

of highly lethal means, such as pesticides, is followed by substitution with less lethal means, such as medications (de Silva *et al.* 2012).

However, it remains largely unclear what happens if access to methods of lower lethality is reduced. It is speculated that the transition between two violent and lethal methods, such as firearm suicide and hanging, is much higher than between medication overdose and a more violent and lethal method (Daigle 2005). Previous studies indicate that substitution of methods is more common in men than in women and, furthermore, women are more responsive to restrictive measures (Yip *et al.* 2012). Globally, medication overdose as a means of suicide is the most common in women from Canada and Northern Europe, and can be often only briefly planned. Thus, when the access to the medication is restricted, the means of suicide is not replaced because the suicidal impulses pass (Ajdacic-Gross *et al.* 2008).

**Methodological considerations**

To the best of our knowledge, there have not been any randomized controlled trials (RCT) that assessed whether restriction to potentially toxic medications leads to lower suicide rates. All aforementioned studies have been observational in nature, in particular ecological and cohort studies, and some were quasi-experimental. The lack of RCTs performed within this context precludes establishing causality, due to confounding and other sources of bias. Other factors, such as changes in mental health conditions over time, increasing treatment of depression, and improvements in socioeconomic status, may have accounted for the decreasing suicide rates that followed implementation of legal restrictive measures.

In addition, few investigators have critically evaluated the magnitude of effect of different restrictive measures in lowering suicide rates. Even though data suggest a significant population effect after some measures have been introduced, benefits for most individuals will be small. Restriction of access to medications will have a large effect only when the method is very frequent and lethal, and thus, accounts for a substantial proportion of deaths in the population (Yip *et al.* 2012). If this is the case, restrictive preventive strategies that target the whole population, can broadly reduce suicide rates, as many people at low risk could give rise to more cases than a small number of individuals at high-risk would (Knox *et al.* 2004). In particular, nationwide restrictive preventive strategies benefit people whose suicide risk would go unnoticed because they do not seek professional help for mental health problems.

The aforementioned studies have been conducted in Australia, the United States, the United Kingdom, Norway, Denmark, Sweden, France, and Japan, which limits the generalizability of the findings to other countries. Furthermore, more than 75% of suicides occur in low- and middle-income countries (LMICs) (Bantjes *et al.* 2016). In LMICs, many potentially lethal medications may be accessible in pharmacies without prescription, however, they may be too expensive to be widely utilized as a means of suicide. Several studies report that medication overdose is not as prevalent as a mean of suicide in low-income settings (Ajdacic-Gross *et al.* 2008; Radhakrishnan and Andrade 2012). A lack of reliable data within this context precludes determining if restriction of access to medications could have a benefit in LMICs. It is also difficult to see which restrictive strategies could be feasible, in light of the fact that there may be a significant



lack of central regulatory mechanisms in place. However, in LMICs, other lethal means for suicide are a problem, such as pesticides, and evidence has shown that restriction of access to those methods have preventive effects.

## Conclusions

The lack of RCTs is a barrier to establishing causal effects of restriction to potentially lethal medications on suicide rates. It is also a major limitation in the evaluation of such preventive initiatives, if they are implemented. Even though there are unresolved issues concerning substitution of suicide methods if access to a specific drug is restricted, many studies suggest a life-saving potential of restricting potentially lethal drugs. Preventive efforts with drug restriction will have the greatest impact on individuals that carry out briefly planned impulsive acts (Ajdacic-Gross *et al.* 2008). Nationwide preventive strategies need to be implemented in a context-specific way, as they will have a large population effect only if the drug is commonly used as a method of suicide and is highly lethal. In the quest to find effective suicide prevention strategies, no single method clearly stands above the others (Mann *et al.* 2005; Zalsman *et al.* 2016). Furthermore, it is unlikely that a large effect can be achieved by implementing only one measure. However, when combined together with other nationwide interventions, restriction of the access to potentially lethal medications is an effective and feasible public health strategy of suicide prevention.

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