# Suicide prevention in cancer care: What are the next steps?

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## Introduction

Living with cancer can be challenging. Recent studies estimate that 40% of cancer patients will experience significant distress during their illness trajectory. Persistent distress is associated with the dissatisfaction of care, lower quality of life, and psychiatric disorders. Some patients will also present an increased risk of wishes to hasten death, suicidal ideations, or completed suicide compared with the general population (McFarland et al., 2019). Though suicide is recognized as a global public health problem, suicide prevention in cancer care has not garnered the same attention (Turecki et al., 2019). Current guidelines promoting systematic screening for distress only recommend suicide risk assessment when anxiety or depression symptoms are detected. Although speculative, this potential risk begs the question of which the next steps should be considered for suicide prevention for this specific high-risk population. The COVID-19 pandemic has led mental health experts to anticipate an increase in distress and suicide risk among the general population (Gunnell et al., 2020). For cancer patients, the pandemic brings forward significant new challenges, such as difficulty or inability to access cancer treatments, strict isolation measures which limit their social support and of course fear of contamination which is associated with higher mortality and morbidity in cancer patients. Little is known of the impact, this pandemic will have on distress or the prevalence of mental illness, and of suicide in cancer patients.

### Suicide risk in patients with cancer: should we be more vigilant?

Despite the high prevalence of distress and comorbid mental illnesses, depression and anxiety remain underdiagnosed and undertreated in cancer patients. Existing data showed that depressive symptoms, especially when severe, are associated with poor quality of life, a feeling of hopelessness and can be associated with suicidal ideation, leading to a higher risk of attempted or completed suicide compared with the general population.

Cancer patients who experience intolerable suffering may express a wish to hasten death (WTHD) or request physician-assisted death if accessible. WTHD is conceptualized as a desire for death before its natural occurrence and is considered a response to unrelieved suffering. When such desire is expressed, medical teams are left with the responsibility of assessing the patient's state and ensuring access to appropriate care. Depression has been found to be an important predictor of both WTHD and suicidal ideation among cancer patients. Psychiatric disorders are frequently found among patients who request physician-assisted death, especially at advanced stages (Canadian Association of Psychosocial Oncology (CAPO), 2017). For those who are not deemed candidates, the refusal may also lead to abstaining from eating or drinking, a suicide attempt, or threatening their medical team of such behaviors if they do not obtain physician-assisted death (Isenberg-Grzeda et al., 2020).

Although it remains a rare phenomenon, it is more prevalent among cancer patients compared with the general population with a reported standardized mortality ratio (SMR) of approximately 2 (McFarland et al., 2019). Through variability in study design, the time period of the study and populations studied, data have shown different averaged SMRs from 1.55 in a systematic review and meta-analysis from 2019, up to 4.44 in a 2019 U.S. populational study (Zaorsky et al., 2020). The discrepancies in reported SMRs may reflect that cancer patients constitute a heterogeneous population. For instance, head and neck cancer patients were reported to have up to three times the incidence of suicide when compared with the general population Patients with lung cancer and Hodgkins lymphoma have shown SMRs as high as 25 and 26, respectively, within the first year of diagnosis (Zaorsky et al., 2020), and prostate cancer has been associated with a high suicide mortality rate. Compared with patients with severe mental illnesses (such as major depression and psychosis), these suicide risk remains low. Nonetheless, even if it is rare in cancer care, suicide is an emotionally distressing negative outcome for the family and medical teams.

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Well-known risk factors for suicide have been studied in the general population: male gender, a history of or current psychiatric disorder, past suicide attempts, cognitive impairment, the presence of hopelessness, barriers to accessing mental health care, loss or bereaved state, social isolation, and ease of access to lethal means such as a firearm (McFarland et al., 2019). In the cancer patient population, additional cancer-specific risk factors for suicide have been documented. The highest risk period appears to be within the first 6 months and up to 1 year after the cancer diagnosis (McFarland et al., 2019; Saad et al., 2019). Comorbid mental illness, functional impairment, symptom burden, and loss of dignity are also reported to be independent risk factors for suicide. Advanced stages of disease constitute a vulnerable time for cancer patients. This constellation of factors is often present for high-risk tumor sites such as head and neck, gastric, pancreatic, and lung cancers (McFarland et al., 2019). Protective factors such as social connectivity and support, access to services, and faith or spirituality have been identified; though these factors may be of limited value depending on the patient's circumstances. For instance, some may suffer from isolation, have limited access to medical and/or psychological services in their geographical area, or have a faith/spiritual crisis in the face of their cancer diagnosis which could contribute to their risk for suicide (McFarland et al., 2019).

### Suicide prevention strategies: how to predict the unpredictable?

Suicide prevention is an important goal in public health. In fact, suicide remains a leading cause of death worldwide (Turecki et al., 2019). In 2013, the World Health Organization (WHO) elaborated a mental health action plan to decrease suicide rates by 10% by 2020 with prevention strategies for vulnerable population groups and intervention plans for at-risk individuals. Several countries have also published frameworks for suicide prevention (such as the United States, the United Kingdom, and Canada). Few suicide prevention strategies were recommended for comorbid populations, including for cancer patients in these reports.

While suicide is by definition unpredictable, most patients who die by suicide have tried to obtain help from a healthcare service in the year before their death and often have sought care in the month prior to suicide. Despite this important public health issue and recent research, little is yet known about which effective preventive efforts should be implemented in everyday clinical practice, especially in cancer care. Some experts estimate that suicide prediction tools have little clinical value and do not include them in guidelines. These tools have also been critiqued for endowing clinicians with a false sense of security or having a negative impact on the therapeutic alliance and that its predictive value in the general hospital is very limited for completed suicides.

No substitute for a thorough suicide risk assessment by a trained clinician should exist. In cancer care, such tools have not been validated for clinical use to our knowledge, although some tools have been developed and used for research on WTHD among patients with advanced illnesses, such as the Desire for Death Rating Scale (DDRS), Schedule of Attitudes Towards Hastened Death (SAHD), and the Demoralization Scale.

### Distress screening and suicide risk management in cancer care: where do we go now?

Frequently under-recognized among cancer patients, it is widely recommended for oncology professionals to systematically monitor for distress through regular screening in routine cancer care. Guidelines on screening for distress usually outline moments of vulnerability for patients along the cancer care continuum. The identified level of distress subsequently stratifies the appropriate management. In the presence of anxiety and depression, it is recommended to assess for any safety risk. If such risk is identified, good practices include managing symptoms, initiating psychosocial care, or providing crisis interventions (reducing access to lethal means, increasing social support, and inpatient admission to ensure the patient's safety). Based on the knowledge gaps identified above, some researchers recently formulated some initial recommendations on suicide prevention for cancer sites at higher risk, especially for those with high suicide rates (lung, prostate, pancreatic, esophageal, stomach, head, and neck). Others recently made the assumption that mental health screening alone may not be sufficient to prevent suicide, as cancer patients that commit suicide tend to have different characteristics, such as being older and less likely to have psychiatric problems (Men et al., 2020).

Some data highlights inconsistent methods utilized by multidisciplinary oncology teams for suicide risk assessment. In the absence of a framework for suicide prevention, establishing and promoting a suicide prevention culture can be challenging (Senf et al., 2020). System-related barriers, such as a shortage of system resources, lack of time, personal fear or discomfort in addressing suicide, and the stigma surrounding mental illness and suicide, could also contribute to this problem (Granek et al., 2018). Though suicide prevention needs to be the responsibility of all cancer care providers, such factors may hinder a suicide prevention mentality within cancer care centers.

## Conclusion

Cancer patients are at an increased risk for significant distress, psychiatric disorders, wish to hasten death, suicidal ideation, suicide attempts, and completed suicide. To best support, the care of cancer patients, distress screening and management guidelines should include the basic elements of suicide screening and risk management. Few specific suicide prevention strategies have been published for cancer patients Therefore, reducing the rate of suicides remains a challenge in cancer care. The question of whether we could adopt selective suicide prevention strategies for this vulnerable population, especially in the context of a pandemic, remains unanswered and deserves the attention of both researchers and clinicians.

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