SUICIDE RISK in PALLIATIVE CARE PATIENTS

What is known about suicide in patients with life-limiting illness? [1] [2] [3]

- The frequency of suicide in the cancer population is higher than in the general population with the highest risk in the months after diagnosis
- The risk decreases with survival time and is low in the terminal phase
- Depression is a factor in at least 50% of all suicides
- Treatment of depression can diminish desire for death
- Feelings of hopelessness – loss of purpose in living – may be associated with suicide intent independently of depression
- Completed suicide is rare in cancer patients
- Suicidal thoughts are common in terminally ill patients but are usually fleeting & are often associated with feelings of loss of control & anxiety about the future
- The desire to hasten death in not necessarily synonymous with a request to hasten death

Recognising patients who may be at risk of suicide

Depression is common in the general community and more so in patients with advanced illness. In one study 5 – 15% of cancer patients met the criteria for major depressive disorder. Separating the clinically depressed patient from the person overwhelmed or despairing of their illness and circumstances may not be easy.
Simple screening questions such as “Are you depressed?” or “Recently have you often been bothered by feeling down, depressed or hopeless? and “During the last month have you often been bothered by little interest or pleasure or doing things?” have been shown to be reliable indicators of patients who may need further exploration of their depressive symptoms and possible treatment. [4] [5]

It is OK to ask about suicidal thoughts or feelings of hopelessness with general questions such as “Have you felt things getting too much for you?” or “Have you been scared you might harm yourself” or “Do you feel you have lost your purpose in life?” It is also OK to reassure patients that many people in their circumstances feel this way at times but these thoughts are often fleeting and diminish with time

The desire to hasten death and talking about this is common but does not necessarily indicate a request to hasten death or suicide intent.

Response to possible suicide risk

If you have concern about a patient who you consider to be a suicide risk, discuss this with your team leader, and in the case of community patients, the patient’s GP
Treatment of an underlying depression is likely to be the most effective intervention available
For a patient who has persistent suicidal thoughts in the absence of an underlying depression, intervention and support from the family support team or community mental health services may be advisable
If there is concern that this an emergency and the patient is at immediate risk, contact your

Mental Health Crisis Team

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[1] Macleod Sandy. The Psychiatry of Palliative Medicine. Oxford: Radcliffe Publishing, 2007 pp 65 - 66
[2] Chochinov HM Wilson KG Enns M. Depression, Hopelessness and Suicidal Ideation in the Terminally Ill. Psychosomatics 1998; 39: 366 - 370
[3] Misono S, Weiss NS, Fann JR & Yueh B. Incidence of suicide in persons with cancer. J Clin Oncology 2008; 26: 47231 - 38
[4] Chochinov HM et al. “Are you Depressed? Screening for Depression in the terminally ill. Am J Psychiatry 1997;154:674 - 676
[5] Arroll B et al. Screeing for depression in primary care with two verbally asked questions: cross sectional study. BMJ 2003;327: 1144- 1146

Documentation

Concerns about possible suicide risk should be entered in the patient notes in the same manner as other clinical information. This should include who was informed and the action taken. The entry should be along the lines of

"I had concerns that XX may be at risk of suicide because …… I subsequently discussed this with …… and we agreed that we should take the following actions
1.
2.
3.
Responsibility for following this up lies with……."

SUSPECTED SUICIDE

The Coroners Act requires that deaths that are without known cause, suicide, or unnatural or violent are reported to the police as the coroner's agent.

While most deaths in the palliative care setting follow an anticipated course, there are occasional circumstances where a death may appear sudden or out of keeping with the nature of the underlying illness. In the majority of such cases the death is likely to be from an incidental natural cause or known disease co-morbidity. (E.g. acute myocardial infarct, CVA, pulmonary embolism, acute haemorrhage)

If, however, you are concerned that the death may be an unnatural one or suicide, there is an obligation to report this to the police. Most such instances arise from concern about inappropriate or excessive medication use. Legal advice is that there should be reasonable probability of unlawful death, rather than a suspicion.

The circumstances should be discussed with your team leader, who will take further advice if necessary and assume responsibility for further action

Documentation

Concerns about possible suicide should be entered in the patient notes in the same manner as other clinical information. This should include who was informed and the action taken. The entry should be along the lines of

"I had concerns that the death of XX may have been the result of suicide because …… I subsequently discussed this with …… who assumed responsibility for following this up and taking further action"