Suicide is a significant and potentially preventable public health problem worldwide. Men are more at risk, with a suicide rate of up to five times that of women, making suicide a clinically relevant topic for all practitioners in men’s health.

Suicidal behaviours can be viewed on a continuum ranging from suicidal thoughts to suicide attempts and finally completed suicide. The aim of suicide first aid should be to intervene as early as possible on the spectrum, before the person comes to harm. Cancer increases risk on all points of the continuum.

RISK FACTORS FOR SUICIDE
Mental and substance use disorders are the greatest risk factor for suicide, affecting up to 90 per cent of all those who die by suicide. However, physical illnesses, particularly cancers, are also important and approximately double the risk of suicide. The risk may be even greater in older adults with physical illness. One large epidemiological study showed a specific increase in suicide risk for men with cancer.

Men are at far greater risk of dying by suicide than are women, but are less likely to seek help. With adequate knowledge of relevant risk factors and warning signs, coupled with basic skills in suicide intervention and knowledge of appropriate referral pathways, practitioners in men’s health are ideally placed to reduce the risk of suicide in this vulnerable population.

Suicide in men with cancer: recognising and responding to the warning signs

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of approximately 50 per cent in the first year after prostate cancer diagnosis.¹ Chronic pain conditions are also associated with suicidal ideation and attempts.² In addition, physical illnesses, particularly those that are chronic, increase the risk of mental disorders including major depressive disorder.³

Additional risk factors for suicide include being unmarried, widowed or divorced, of older age, and being unemployed.⁴ Any history of suicide attempts increases risk dramatically.⁵

The rate of suicidal ideation in cancer patients is high, but has not received adequate research focus. In one study, 8 per cent of cancer patients reported having thought they would be ‘better off dead’ or had thoughts of ‘hurting themselves’ over the past two weeks.⁶ In another study, ten of a consecutive 100 cancer patients presenting to a single clinic had made a plan for suicide, and an additional six had a desire for death.⁷

Men are less likely than women to seek help for mental disorders or thoughts of suicide. This means that practitioners in men’s health may assist by making mental health referrals where appropriate, particularly when assisting patients with suicide risk factors.

GUIDELINES FOR EARLY INTERVENTION
Suicide prevention activities can reduce the overall risk in a specific population, but early intervention with suicidal individuals is an important activity as well. Guidelines have been developed by Mental Health First Aid for use by any non-mental health specialist to identify suicide risk and intervene (Box 1).¹⁰ These guidelines are designed to help members of the public (including medical professionals and allied health professionals who are not mental health practitioners) to provide first aid to someone who is at risk of suicide. They were developed using the Delphi methodology, a method for reaching consensus within and between groups of experts.¹¹

How can I tell if someone is feeling suicidal?
Patients may show one or many of the warning signs of suicide listed in Box 2, but some may show signs not on this list. For people with serious physical illness, such as cancer, the most significant warning sign appears to be hopelessness.¹²

If you suspect the patient may be at risk of suicide, it is important to ask him directly about suicidal thoughts. Do not avoid using the word ‘suicide’. It is important to ask the question without dread, and without expressing a negative judgement. The question must be direct and unambiguous. For example, you could ask, ‘Are you having thoughts of suicide?’ or ‘Are you thinking about killing yourself?’ If you appear confident in the face of the suicide crisis, this can be reassuring for the patient.

Although some people think that talking about suicide can put the idea in a person’s mind, this is not true. Another myth is that someone who talks about suicide is not really serious. Remember that talking about suicide may be a way for the patient to indicate just how badly he is feeling.

How should I talk with someone who is suicidal?
Tell the suicidal patient that you care and that you want to help him, and express empathy. Clearly stating that thoughts of suicide are often associated with depression or anxiety, both of which are treatable, may instil in him a sense of hope.

Expressions of suicidal feelings are often a plea for help, and suicide may seem a solution to escape from problems and distressing feelings. If the patient is suicidal, you should encourage him to do most of the talking, if he is able to. He needs the opportunity to talk about his feelings and his reasons for wanting to die, and may feel great relief at being able to do this.

It may be helpful to talk about some of the specific problems (both medical and personal) your patient is experiencing, without trying to solve the problems yourself.

How can I tell if the situation is urgent?
First, you need to determine whether the person has definite intentions to take his life, or if he has been having more vague suicidal thoughts such as ‘what’s the point of going on?’ A higher level of planning for his suicide indicates a more urgent risk to
the patient. Ask him if he has made a plan for suicide – the method he would use, when he would carry it out, and whether he has taken steps to secure the means. However, the absence of a plan is not enough to ensure your patient’s safety. All thoughts of suicide must be taken seriously.

If the patient has been using alcohol or other drugs, this may make him more susceptible to acting on impulse. A previous suicide attempt makes a person more likely to act on thoughts of suicide.

How can I keep the person safe?
A person who is suicidal should not be left on his own. If you or a colleague cannot stay with him, you need to arrange for someone else to do so. Internal referral to other parts of your medical practice, or referral to a hospital, are good options. In addition, give the person a safety contact that is available at all times (such as a telephone help line, a friend or family member who has agreed to help, or a professional help giver).

It is important to help your patient to think about people or things that have supported him in the past and find out if these supports are still available. These might include a doctor, psychologist or other mental health worker, family member or friend, or a community group such as a club or church.

Do not use guilt and threats to prevent suicide. For example, do not tell the person he will go to hell or ruin other people’s lives if he dies by suicide.

Individual practitioners will need to adapt their responses according to the availability of mental health care in their own medical practice, clinical setting or hospital. If not already available, action should be taken to develop a referral protocol for suicidal patients.

**CONCLUSION**
Suicide is a major cause of premature death for men, and risk is significantly increased for older men, especially those with physical illnesses, particularly cancer. All practitioners in men’s health should be aware of the warning signs for suicide, and have the basic skills required to intervene with a suicidal patient. Simple guidelines can help medical professionals to identify those at risk of suicide and provide suitable referrals, improving outcomes and reducing the suicide rate in these vulnerable populations.

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**REFERENCES**