

Part II: Suicide Prevention

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Suicide Prevention Pre-test

The following conditions increase the risk of a successful suicide:

- T/F Depression
- T/F Psychosis (schizophrenia, for example)
- T/F Drug-induced delirium
- T/F Alcoholism
- T/F Chronic physical pain
- T/F Asthma

Depression, psychosis, drug-induced delirium, alcoholism, chronic pain and asthma all increase the risk of a successful suicide.

Depression is the number one risk factor.

- T/F Being male
- T/F Being female
- T/F Adolescence and young adulthood
- T/F Old age

Even though females are more likely to attempt suicide, males are 4 times more likely than females to make an attempt that results in death.

Adolescents and young adults have the highest number of attempts and deaths. Older adults have the highest rate relative to population size.

- T/F Adult and married
- T/F Separated
- T/F Divorced
- T/F Widowed

Marriage is a protective factor. Social isolation increases risk. Parental divorce is not a clear risk factor in teens.

T/F Homosexuality

Homosexuality is a risk factor for many age groups and racial groups. Homosexuality is a risk factor for adolescent males and black males. Risk decreases after age 25 for white males. The lifetime rates for homosexual, white males are 5.7 per 100,000 and 12.8 per 100,000 for homosexual, black males.

T/F Protestant

T/F Jewish

T/F Catholic

T/F Atheist

T/F Muslim

Religious affiliation is a protective factor. Atheists have a suicide rate double that of their Christian counterparts. Suicide rates among Muslims are less than 2 per 100,000.

T/F Physicians (especially psychiatrists)

White male physicians are one of the few groups by profession that have an increased risk of suicide. This is believed to be due to the knowledge of and access to lethal means.

T/F Enrolled in a large university

A study of the suicide rate on Big Ten college campuses found the relative rate was 7.5 per 100,000. The suicide rate for youth 15-24 in the same year was 11.4 per 100,000. However, suicide is the second leading cause of death among college students. It is estimated that 1 in 12 college students have a suicide plan.

T/F Firearm

T/F Suffocation

T/F Poisoning

Firearms, suffocation, and poisoning are the three most commonly used means. These means account for over 90% of the methods used by both males and females.

T/F Family history of suicide

Family history of suicide does increase the risk of suicide completion.

T/F Spring

T/F Christmas

December has the lowest suicide rate of any month. The months with the highest rates are May and June.

Epidemiology of Suicide

The Center for Disease Control and Prevention collects information on violent deaths, including suicide as part of the National Violent Death Reporting System.

Suicide in the United States

In 2007, there were 43,598 suicides in the U.S. according to the National Center for Health Statistics. This translates to 95 suicides per day or one suicide every 15 minutes.

The annual suicide rate in the United States is 11.5 per 100,000. This rate can be used for comparison when looking at subcategories and the respective rates.

Suicide rates since 1990 have ranged between 12.4 and 10.7 per 100,000. A slight increase in suicide rates was seen in 2007.

Suicide Means

Firearms are the most commonly used method of completing suicide by all groups. Of the individuals that committed suicide in 2007, more than half used a firearm. In 2001, suicide by poisoning exceeded firearm use and became the most common method for females.

According to the National Institute of Mental Health, males use firearms (56%), suffocation (24%), and poisoning (13%). Females use poisoning (40%), firearms (30%), and suffocation (21%).

Gender and Suicide

Males are four times more likely to commit suicide than females. More males commit suicide than females in all age groups. However, females attempt suicide three times more often than males.

Suicide is the eight leading cause for death of males and the nineteenth leading cause of death for females.

Race and Suicide

Suicide rates vary greatly by race and ethnicity. Whites are 2 ½ times more likely than blacks or Hispanics to commit suicide.

The suicide rate for black females is the lowest of all racial gender groups. In 2007, the suicide rate for black females was 1.7 per 100,000. The suicide rate for black males was 8.4 per 100,000.

The suicide rate for Hispanics of all ages is 5.4 per 100,000 versus 12.53 for Non-Hispanics of all ages.

Among Native Americans and Alaskans teens and young adults, ages 15 to 34, suicide is the second leading cause of death with a rate of 20.0 per 100,000. This is 1.8 times higher than the national average for the same age group, 11.4 per 100,000.

Aging and Suicide

White males over the age of 85 are at the greatest risk of all age-gender-race groups for suicide.

In 2007, the rate for this group was 45.4 per 100,000 which is 2.5 times the rate for white males of all ages, 18.3 per 100,000.

The suicide rate for women tends to decline after age 60. Women are at highest risk for suicide between the ages of 45 and 49.

Older adults attempt suicide less often than those in other age groups, but have a higher completion rate. Firearms are the most common method among the elderly.

Youth and Suicide

In 2007, suicide was the third leading cause of death for the ages of 15-24. Accidents and homicides were the first and second leading causes.

Firearms are the most commonly used method and access and availability of firearms in the home increases risk of suicide in youth. Most adolescent suicides occur in the teen's home after school.

Sexual Orientation and Suicide

The likelihood of suicide attempts is higher in homosexuals and bisexuals than in heterosexuals. Race and age also play a role. Risk is highest in youth for white males. By the age of 25, the risk drops in half.

Geography and Suicide

Suicide rates vary greatly by geographic region. Six out of the ten states with the highest rates of suicide are the mountainous West. The three states with the consistently highest rates of suicide are Nevada, Montana, and Alaska. Idaho, Wyoming, Utah, Colorado, New Mexico, Arizona, and Oregon account for the remaining seven out of ten highest suicide rates by state. The New England states have among the lowest suicide rates of all the states.

Nevada's suicide rate is twice the national average. In 2000, there were 19.1 suicides per 100,000 as compared to the rest of the country with 10.7 per 100,000. In 2007, the suicide rate for seniors in Nevada was the highest in the country with 30.8 per 100,000. Five factors have been suggested to account for the increased rate: social isolation, rapid population increases, addictive behaviors, mental health crises, and a frontier culture.

Mental Illness and Suicide

The following diagnoses tend to have a higher risk: depression, schizophrenia, drug and/or chemical dependency and conduct disorder.

Depression and Suicide

An estimated two-thirds of individuals that commit suicide are depressed at the time of their deaths. Feelings of hopelessness are found to be more predictive of suicide than a diagnosis of depression.

Individuals who are depressed and exhibit the following symptoms are at high risk:

- extreme hopelessness
- lack of interest in pleasurable activities
- heightened anxiety
- insomnia
- irritability
- agitation
- talk of suicide
- history of attempts.

Alcoholism and Suicide

Alcoholism and drug addiction are leading risk factors for suicide. The risk of suicide in alcoholics is 50 to 70% higher than the general population. Alcohol is involved in an estimated 50% of suicides. For adolescents, alcohol or other drug misuse is involved in an estimated 50 to 70% of suicides.

Health and Suicide

A study by the CDC in 2004 examined the toxicology reports and cause of death in 13 states. The toxicology reports of individuals committing suicide showed that 33% tested positive for alcohol, 16.4% tested positive for opiates, 9.4% for cocaine, 7.7% for marijuana, and 3.9% for amphetamine.

Twenty-two percent of individuals that commit suicide have a physical health problem at the time of the suicide according to the Centers for Disease Control and Prevention.

A meta-analysis of 44 medical disorders found an increased risk of suicide in 36 of the 44 studied. Diseases often cited as having an increased risk include: HIV/AIDS, asthma, cancer, multiple sclerosis, peptic ulcer, renal disease, spinal cord injury and lupus. The suicide rate for individuals with Huntington's disease, a neurodegenerative disease, is estimated at 13%.

Social Factors and Suicide

A number of social factors, including isolation, affect suicide rates. Suicide rates are higher among the retired, unemployed, impoverished, divorced, childless, and people who live alone.

It is a myth that more suicides occur around the holidays. Winter is the season with the fewest suicides. Spring and early summer have the most suicides. A study in the 80's showed that 40% of media reports of suicides during the holidays perpetuated the myth.

There is a stronger correlation between suicide and the day of the week than for season. Monday has the highest rate and Saturday has the lowest rate.

Religion and Suicide

Suicide rates are higher in low religious environments. Religious beliefs, religious practice, and spirituality have all been associated with lower suicide risk. Analysis of suicide rates in the 1970's showed that religion affects suicide rates. Catholics and Evangelical Protestants have lower rates of suicide. Institutional Protestants tended to have higher rates.

More recent studies based on statistics kept by the World Health Organization examined countries with dominant religions and respective suicide rates. Muslim countries had the lowest rates. Kuwait has a suicide rate of 1.95 per 100,000. In atheist countries, such as China, the rate is 18.0 per 100,000.

Profession and Suicide

The data on suicide by profession is inconclusive. Studies suggest that white male physicians do have an increased suicide rate. However this may be related to high access and knowledge of lethal means such as medication. Two other professions have a weak but significant increased rate of suicide. Black male guards in a non-prison setting and white female artists both tend to have elevated rates of suicide.

Suicide and Suicide Attempts

It is estimated that there are 25 attempts for each death by suicide. Non-fatal suicide attempts are greatest among youth and females. The ratio of attempted to completed suicide for youth are estimated to range between 100 to 1 and 200 to 1. The ratio of attempted to completed suicide for elderly is 4 to 1.

Warning Signs of Suicide

The warning signs of teen suicide, given the high attempt rate and number of successful suicides, have been studied extensively. Many of the warning signs also apply to adults.

General Warning Signs

- 1) Acting out: aggressive, hostile behavior, sexual promiscuity
- 2) Alcohol and other drug use
- 3) Passive behavior-lethargy
- 4) Changes in eating habits
- 5) Changes in sleeping habits
- 6) Fear of separation

Specific Warning Signs

- 1) Abrupt changes in personality
- 2) Sudden mood swings
- 3) Risky behavior
- 4) Decreased interest in school and poor grades
- 5) Inability to concentrate
- 6) Loss or lack of friends

Final Distress Signals

- 1) Loss of an important person or thing
- 2) Hopelessness
- 3) Obsession with death, suicide talk
- 4) Making a will, giving away prized possessions

The Mythology of Suicide

There are a number of misconceptions about suicide. Misconceptions can interfere with discussing and assessing suicide potential.

Myth - People who talk about killing themselves rarely commit suicide.

Fact - Most people who commit suicide have given some verbal clue or warning about their intentions. 29% of individuals who commit suicide disclosed the intent to someone.

Myth - The tendency toward suicide is inherited and passed from generation to generation.

Fact - Although suicidal behavior does run in families, it does not appear to be transmitted genetically. Approximately 2% of individuals that commit suicide have had a family member commit suicide in the previous five years.

Myth - The suicidal person wants to die and feels there is no turning back.

Fact - Suicidal people are usually ambivalent about dying and frequently will seek help immediately after attempting to harm themselves. For teens and young adults, there are an estimated 100 to 200 attempts for every suicide. For the elderly, there are an estimated 4 attempts for every suicide.

Myth - All suicidal people are deeply depressed.

Fact - Although depression is often closely associated with suicidal feelings, not all people who kill themselves are obviously depressed. In fact, some suicidal people appear to be happier than they've been in years because they have decided to 'resolve' all of their problems by killing themselves. An estimated 44% of individuals that commit suicide have a current depressed mood.

Myth - There is no correlation between alcoholism and suicide.

Fact - Alcoholism and suicide often go hand in hand. Alcoholics are prone to suicidal behavior and even people who don't normally drink will often ingest alcohol shortly before killing themselves. 18% of the individuals that commit suicide are identified as having an alcohol problem. 33% were positive for alcohol and 16% were positive for opiates.

Myth - Suicidal people are mentally ill.

Fact - Psychological autopsy studies suggest that 90 to 95% of individuals that commit suicide have a diagnosable psychiatric disorder. Among the most frequently cited are mood disorders, impulse control disorders, alcohol/substance use disorder, psychosis, personality disorders, and conduct disorder.

Myth - Once someone attempts suicide, that person will always entertain thoughts of suicide.

Fact - Most people who are suicidal are so for only a very brief period once in their lives. If the attempter receives the proper assistance and support, he/she will probably never be suicidal again.

Myth - If you ask someone about his/her suicidal intentions, you'll only be encouraging him/her to kill himself/herself.

Fact - Actually the opposite is true. Asking someone directly about suicidal intent will often lower his/her anxiety level and act as a deterrent to suicidal behavior by encouraging the ventilation of pent-up emotions through a frank discussion of his/her problems.

Myth - Suicide is quite common among the poor.

Fact - Suicide crosses all socioeconomic distinctions and no one economic level is more susceptible to it than another. Unemployment, limited education, homelessness, and contact with the police or justice system are all risk factors.

Myth - Suicidal people rarely seek medical attention.

Fact - Research has consistently shown that about 75% of elderly suicidal people will visit their physician within the month before they kill themselves. For all age groups, 45% of individuals who commit suicide have contacted their physician within one month of killing themselves.

Myth - Suicide is basically a problem that is limited to the young.

Fact - While the number of youth suicides is highest, suicide rates rise with age and reach their highest levels among white males in their seventies or eighties.

Myth - When a depressed person improves, there is the most danger of suicide.

Fact - There are no studies that track symptoms and suicide rates. The belief that suicide rates increase as depressed mood lessens appeared in writing for the first time in 1812. The theory passed down through the generations that deeply depressed individuals don't have the energy to commit suicide. One study by Simon and Savarino (2007) that examined treatment in 100,000 patients treated with anti-depressants found that the attempt rate was highest the month before treatment, second highest the month after treatment, and suicide attempt rates declined thereafter.

Myth - Suicide is a spontaneous activity that occurs without warning.

Fact - Most suicidal people plan their self-destruction in advance and then present clues indicating that they have become suicidal. 34% of individuals that think about suicide make a plan. 72% of persons with a suicide plan make an attempt. 26% of individuals thinking about suicide make an unplanned attempt.

Myth - Because it includes the Christmas season, December has a high suicide rate.

Fact - There is no rash of suicides at Christmas and December has the lowest suicide rate of any month. The months with the highest frequency of suicides are May and June.

Myth - Suicide is a recent phenomenon.

Fact - Suicide occurred even in Biblical times (e.g. Judas, Samson, Saul, etc.). A review of suicide rates in the 20th century suggests that suicide rates are relatively stable over time. The suicide rate in 1900 was 10.2 per 100,000 and in 1999 the rate was 10.6 per 100,000. The highest rate was 18.6 in 1932 and the lowest rate was 9.6 in 1957. With a few exceptions, the rate ranged from 10.2 to 12.7 per 100,000.

Myth - Because they don't like to disfigure themselves, women seldom use guns to commit suicide.

Fact - While poisoning is the most common method. Women use firearms 30% of the time. Firearms, poisoning, and suffocation account for 91% of the suicide methods used by women.

Myth - Suicide is a result of chronic problems.

Facts - Life stressors play an important role. 29% of individuals that commit suicide have had a crisis in the two weeks before. 11% were having difficulty at work. 10% were having a criminal legal problem. 4% were having a non-criminal legal problem. 12% were having a financial problem.

Risk and Protective Factors

The Center for Disease Control and Prevention has identified a number of risk and protective factors. Risk factors are a combination of individual, relational, community, and societal factors that contribute to the risk suicide. They may or may not be direct causes.

Risk Factors

- Family history of suicide
- Family history of childhood maltreatment
- Previous suicide attempt(s)
- History of mental disorder
- History of alcohol and substance abuse
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Cultural and religious beliefs
- Local epidemics of suicides
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)
- Physical illness
- Easy access to lethal means
- Unwillingness to seek help

Protective Factors

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support (connectedness)
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

Determining Suicide Potential

The more information you have, the easier it is to determine who may be potentially suicidal and how serious a person may be who is thinking about or threatening to commit suicide.

On a scale of one to ten with 10 being the most serious, the suicide potential of the following situations.

Exercise #1

Sam, 14 years old, is just barely passing his subjects at school. His performance started to decline four months ago when his parents divorced. This was also the time he began drinking beer but always at home, alone, and when his mother was gone. The second time his mother caught him drinking beer, she took him to a counselor. Subsequently his father also talked to him. Sam was always willing to answer questions although he listened more than he talked to the counselor or his parents.

Rating _____

Exercise #2

“My mother makes me so mad,” Sheila told her girlfriend. “I just feel like hanging myself in her bedroom so she’d never forget what she does to me.”

“Yeah, wouldn’t that be the kicker,” Theresa said jokingly.

Rating _____

Exercise #3

Joe was a good student, a decent boy. Two weeks ago he failed to make the basketball team. Like a good kid he joked about it. “Win some, lose some,” he said.

One week ago, his girlfriend of four months broke off their relationship for someone else. “There are plenty of others out there,” he told his friend. “When have you seen me without two girls?” he quipped with confidence.

His father called him a resilient kid. His mother called him mature. His friends admired his spirit. Yesterday Joe came to school with some of his records and sci-fi books he collected over the years and gave them away to friends. “I don’t need them anymore,” he said, “You guys enjoy them.” “If only all the kids were like Joe,” one of his teachers commented in the teacher’s lounge later that day.”

Rating _____

Exercise #4

Susie was clearly depressed. She even looked sad. “Everyone would just be better off without me,” Susie tells a friend. “Don’t be silly. It’ll get better Susie. Remember, that’s what you told me last year when I was having a hard time.”

Rating _____

Exercise #5

Steve was always hard to handle. The past two months he kept his fights confined to kids his own age. This past week, however, he turned on his father twice for some stupid reason he couldn’t remember. His dad wasn’t a man of words until the last fight. “I’ve had it with you kid. You try that shit again and mother or no mother, you’re out of this house for good.”

Rating _____

Exercise #6

Gail is an 18-year old, average student. The past few weeks she has been sent to the school nurse multiple times for headaches. At other times the teacher had noticed her daydreaming. Both behaviors are new. When Gail was asked if something was wrong, she would say, “Oh, nothing. I’m ok.”

Rating _____

Exercise #7

There’s a lot of trouble at Jake’s home. After school one night he takes up his friends’ offer to smoke some weed. “My old lady and old man don’t give a shit about me. All they care about is themselves,” he tells his buddies. Soon after Jake hears his mother, “If it weren’t for the kid I would have been gone years ago”, the mother yelled at his mother while they were having a fight last night. He tells his friends this and they tell him all parents are like that. Jake says he feels he just can’t take it anymore. One of his friends knows Jake’s dad is a hunter and has guns in the house. He is alert enough to get serious and walks home with Jake to talk with him. Jake promises not to do anything dumb. “They ain’t worth it,” his friend tells him. “I know,” Jake says, “Besides I hate guns.” “I’ll be okay,” he reassures his friend, “my parents are taking off on vacation for a week, but I’ll be okay.”

Rating _____

Exercise #8

Claude had a period when everything seemed to go wrong. School was hard for him but he was making progress. He had made a few indirect references about dying during this time but never acted on them. He was now finally coming out of it and had started participating in different activities and taking an interest in friends again.

Rating _____

Exercise #9

Pat's father is a city executive. His mother works for a technology company. Pat is the only boy. He has two sisters already in college: one in law school and the other majoring in engineering. He's on his way to college next year after being an honor student for four years. He's definitely is not a "jock" but is a "whiz" with computers. He's not anti-social, but preoccupied with his studies. Most of his time is spent at home where his parents see to it he has all the time he wants to study. In return for his dedication, they see to it he doesn't have to worry about chores and earning money. "That kid of ours is going places," his father tells his mother.

Rating _____

Exercise #10

Jason is eight years old. He had recently been punished by his mother for starting a fire in the garage. His mother is now dating a man who has two well-behaved young sons from his previous marriage. Jason didn't like this man or his sons, but didn't feel he could tell his mother about this. She had taken care of Jason by herself for three years. Her frustrations got the best of her last night and she exploded. Jason ran away. He was found four hours later and returned, but wouldn't talk.

Rating _____

Each one of the previous ten examples, are the stories of successful suicides. While risk factors and warning signs are present in most of the scenarios, these examples illustrate that need to take all potential suicides seriously.

Suicide Assessment

There are a number of suicide assessment tools available. Each method of assessment provides a framework for discussing suicide ideation and suicide potential.

SLAP Method

SLAP is a suicide assessment used when an individual expresses suicide ideation. It is designed to determine how dangerous or lethal the suicide plan is based on the increased risk of a plan that is Specific, Lethal means, Available, and Proximity to others is low.

The specificity of the plan relates to how detailed is the individuals plan. Does the plan include a time, place, means? Specific plans are more lethal than vague plans.

The lethality of means relates to how effective at causing death and can it be reversed once started? Guns and jumping from a significant height both have a high level of lethality. Both have a high likelihood of causing death and once started cannot be reversed. Cutting and overdosing are considered less lethal because suicidal individuals can change their minds. The more abrupt the plan the more it is considered lethal.

The availability of means relates to the associability of self harm. Does the suicidal individual have the weapon or other means identified in the plan? Do they have to engage other to gain access to the means? Do they have to steal, purchase, or borrow? Self harm with a means already in the possession of the individual is considered to be at higher risk.

The proximity to other determines how likely the plan is to be interrupted or rescued. Individuals with fewer significant relationships are at higher risk for suicide. Social connections are a protective factor. The more isolated the plan, the lower the likelihood of interruption.

SLAP Scale is not recommended with individuals that are psychotic or active substance abusers. Both these factors represent an increased risk and distorted judgment.

SAD PERSONS Method

The SAD PERSONS scale was developed by Peterson and Dohn in 1983 for use by healthcare providers to determine suicide risk. The scale considers correlates and risk factor for high suicide risk. One or two points are given for each correlate or risk factor.

The scoring for this is as follows:

- 0-2 equals little risk,
- 3-4 equals following patient closely,
- 5-6 equals strongly considering hospitalization, and
- 7-10 equals a very high risk, hospitalize or commit.

S - Sex	1 if male
A - Age	1 if teen, young adult, elder
D - Depression or hopelessness	2 if present
P - Previous Attempt	1 if present
E - Ethanol Abuse	1 if present
R - Rational thinking loss	2 if psychotic for any reason
S - Social isolation	1 if lacking especially with recent loss
O - Organized plan	2 if plan made and method lethal
N - No Spouse (male)	1 if divorced, separated or single
S- Sickness	1 if medical or physical illness present especially if chronic, debilitating, severe
S - Stated intent	2 if stated intent, ambivalent about attempt, or determined

IS PATH WARM? Method

I - Ideation
S - Substance Abuse
P - Purposelessness
A - Anxiety
T - Trapped
H - Hopelessness
W - Withdrawal
A - Anger
R - Recklessness
M - Mood Changes

Suicide Intervention Plans

Suicide intervention plans tend to be simple and include the following components:

- Steps I will follow
- Contact persons
- Other resources

Steps I will follow

As suicidal ideation increases, the client and therapist will have a predetermined, clear action plan of steps to take. Examples include, reducing access to means, coping strategies, sobriety, reducing social isolation and engaging one's social network.

Contact Persons

No therapist is available 24 hours a day 7 days a week. Hotlines, community resources, friends and family members can also be included on a contact list.

Other Resources

Other resources can include: support groups, such as AA; hotlines; activities that support coping strategies; etc.

Suicide Prevention Contracts

Contracts that are time limited, specific, include alternative action, and are signed. An example of a sample contract is included in the handouts.

Suicide and Aging

The elderly make up 12.5% of the population and they account for 15.7% of all suicides. The greatest risk of all age-gender-race groups is a white male over 85 years of age. The suicide rate for this group is 2.5 times as great as the suicide rate for men of all ages.

84.4% of elderly suicides are male. The rate of suicide for women is highest in middle age, 45-49, and declines slightly after 60.

Firearms are the most common means used for completing suicide.

SLAP Method – Lethality and proximity

Lethality - Firearms are a highly lethal means of suicide. Firearms are used in 71.9% of elderly suicides.

Proximity – Socially isolated seniors living alone are unlikely to be found in time to prevent death after an attempt.

The leading cause of suicide among the elderly is considered to be depression, often undiagnosed and/or untreated. The risk of depression increases with other illnesses and when ability to function becomes limited. Depression is not a normal part of aging.

Studies routinely find that between two-thirds and three-fourth of elder suicides had visited their primary care physician in the month before their death. An estimate half visit their physician the week of their death.

Medicare recipients pay 50% of mental health service charges versus a 20% co-pay on medical visits.

Common risk factors include:

- The recent death of a loved one
- Physical illness, uncontrollable pain or fear of a prolonged illness
- Perceived poor health
- Social isolation and loneliness
- Major changes in social roles (e.g. retirement)

Conclusions

While there are correlates with suicide, there are no predictors. Understanding the risk factors and warning signs, facilitates determining suicide potential, but does not assure safety.

The warning signs are an opportunity to begin a dialogue. There are a number of suicide assessment tools available. They all provide a framework for discussing suicide ideation and potential.

As with the crisis intervention, resolving suicidal ideation is an opportunity to develop new coping skills, increase internal capacity and build social supports.