Supporting Suicide Prevention Efforts in Clinical Settings

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Prioritizing and increasing access to effective suicide prevention efforts in clinical care is imperative to reducing the number of American lives lost each year to suicide. The need for more effective suicide prevention efforts is critically urgent and must be thoroughly examined, researched, and implemented. A comprehensive approach to suicide prevention in the clinical realm will require a systematic understanding of the barriers that hinder suicide prevention, how to identify those at risk, and effective intervention strategies for suicidal patients. Although research has sought to identify evidence-based interventions for suicide prevention, there still remains little cohesion and standardization in the medical field for producing and sustaining reductions in suicide. Due to the interconnectedness between healthcare providers, effective mental health treatment, and ultimately, potential suicide preventions, there is an essential responsibility that exists for healthcare leaders to improve current practices. A methodical literature review was conducted through an analysis of public health recommendations, surveys, studies, and quantitative data reports. The findings will show the staggering suicide statistics in the United States, which emphasizes the need for immediate action, as well as the disparity that exists between detectable and treatable conditions and successful suicide prevention. The literature will reveal that supporting suicide prevention in clinical settings is a multifaceted and complex initiative but can be achieved through the collective implementation of evidence-based practices, greater comprehensive training for providers, and continued research that addresses contributing factors and treatments for suicidality.

Introduction

Suicide is a serious public health concern that is among the leading causes of death in the United States. In 2020, there were 45,979 deaths by suicide, which is approximately one death every 11 minutes (CDC, 2022). In the same year, there were nearly two and a half times as many suicides in the United States as there were homicides (US DHHS, 2022). The number of people who think about or attempt suicide is even higher, with 0.5% of adults 18 and older in the United States reporting they attempted suicide in the past year and 4.9% having serious thoughts of suicide (US DHHS, 2022). And this

troubling phenomenon is increasingly worse for American teenagers and young adults as suicide is the second-leading cause of death among people age 15 to 24 in the U.S., with nearly 20% of high school students report serious thoughts of suicide and 9% have made an attempt to take their lives (National Alliance on Mental Illness, n.d.).

Suicide is a complicated and devastating loss that ripples through the lives of those left behind, leaving behind a profound sense of grief and compassion that is hard to describe. The impact of suicide is not just emotional, but it can also take a toll on the financial and social well-being of families and loved ones. It's a loss that nobody should have to experience, and unfortunately, it's rare to find someone in today's world who has not been touched by suicide in some way. Despite suicide often producing fatally permanence impacts, there are many risk factors and warning signs that increase one's susceptibility to suicide and can often be preventable through proper identification and care. The interconnectedness of suicide and diverse biopsychosocial factors calls for leaders and policymakers better understand trends, patterns, and relationships in the data that lead to effective and sustainable programs. Many suicide deaths are a result of pre-existing mental health conditions and are common among people who have recently been seen or under care in clinical settings; leaders in healthcare have a unique responsibility to implement effective systems that support suicide prevention (Hogan et al., 2016). Medical professionals play a central and critical role in improving access and delivery of quality health care that prevents premature death and disability (World Health Organization, n.d.). Furthermore, in the event of a suicidal crisis, many who seek help assume they can rely on medical professionals to connect them with proper support. While better outcomes and survival rates have increased for various physical conditions, there have long been fragments and barriers in the medical community that reduce access to proper and potentially life-saving mental health care. In order to promote suicide prevention in the clinical realm, healthcare leaders and managers must recognize and address factors that contribute to risk, effectively treat existing mental health conditions, and implement evidence-based interventions for those susceptible to and experiencing a suicide-related crisis. Research findings will enable leaders to adopt suicide prevention care that will ultimately increase access to psychological treatment and reduce deaths by suicide. A thorough review of literature from accredited web sources and peer-reviewed journals will offer statistical data and evidence-

based interventions that provide leaders with specific and sustainable implementations to support suicide prevention.

The Problem

The aim of this article is to answer the question: How can healthcare organizations increase access to effective treatment that supports suicide prevention? The urgency to implement more effective treatment options is apparent, as suicide now accounts for more years of life lost than any cause of death except cancer and heart disease (U.S. Department of Defense, n.d.). Before suicide prevention can be discussed we must recognize the many intrapersonal, interpersonal, community, occupational, environmental, and societal factors that correlate with risk or provide protection from suicide ideation, attempts, and deaths (APHA, 2021).

Suicide Risk Factors

As a complex and multifaceted phenomenon, it is essential to identifying and addressing the risks associated with suicide. Suicide risk factors can include intrapersonal, interpersonal, community, occupational, environmental, and societal factors, characteristics, or conditions that increase the chance a person may try to take their life (APHA, 2021). The more risk factors that are present, the higher the risk is for suicide, so it is imperative to outline and identify these risks when pursuing suicide prevention. Furthermore, risk factors must be continually assessed as society faces new and unique challenges, such as the COVID-19 pandemic.

Mental Illness

Among the contributing factors, mental illness and substance abuse are some of the strongest individual risk factors for suicide. While the majority of people struggling with mental illness do not take their own life, research has revealed that at least nine out of ten people who die from suicide are struggling with mental illness or substance abuse (Goldsmith, 2017). In a U.S. study, Brown and colleagues (Brown et al., 2000) found that mood disorder, major depressive disorder, and bipolar disorder were associated with a three- to tenfold increased risk of suicide mortality.

Substance Abuse

Substance abuse is closely linked with mental illness and has a substantial effect on suicide risk, with one in three people who die by suicide being under the influence of alcohol or drugs at the time of death (Goldsmith, 2017). The Substance Abuse and Mental Health Service Administration reported connections between substance abuse and suicide that include suicide being the leading cause of death among people

with substance abuse. People treated for alcohol abuse are ten times more likely to commit suicide than the general population and there is an even greater level of increased risk that exists when substance abuse and a mental illness are combined (Goldsmith, 2017).

Age

In addition to psychological and cognitive factors, the prevalence of suicide varies by other individual considerations such as age, gender, family dynamics and history, sexuality, and having a previous suicide attempt (Goldsmith, 2017). Suicide currently accounting for 6% of deaths in young people worldwide and for every teen who dies by suicide, at least twenty-five teens attempt (Goldsmith, 2017). Adolescents often struggle with a variety of stressors that can put them at risk for suicide; to address these challenges and successfully cope with these emotions, young people must have access to significant supporting resources such as a stable living situation, intimate friendships, a structural framework, and economic resources (Bilsen, 2018). While suicide attempts are more frequent in young adults, the highest suicide rate is found in people forty-five to sixty-four years old and the second highest among those eighty-five and older (Goldsmith, 2017). Strong risk factors for death by suicide in these age groups include stress, death of a spouse, isolation, and mental disorders (Davidson et al., 2018).

Gender

Although suicide rates have steadily increased for both males and females, gender differences do exist. While women are more likely to attempt suicide, suicide is four times higher among males than among females and men account for nearly 70% of all suicides in America (Davidson et al., 2018). Many studies have sought to explain the gender imbalance in suicide rates, attributing factors such as unemployment or retirement status, the access to and use of firearms, mental health stigma, or societal roles and pressures that deter help seeking behaviors to explain the gender paradox of suicidal behaviour (Freeman et al., 2017). Some theorists have suggested the gender gap in suicides is associated with one's level of intent, an individual desire to bring about one's own death, which is seen stronger in men more frequently and is unsurprisingly associated with an elevated risk of completed suicide (Freeman et al., 2017). While the reason for gender differences in suicide rates is multiplex, research should continue to assess explanations for this gap in order to standardised measurement for suicide intent and risk and effectively manage the treatment of patients at risk of suicide (Freeman et al., 2017).

Ethnicity, Sexuality, and Social Considerations

Other risk factors for suicide that are beyond a person's control and significant enough to mention include ethnic, sexual/gender identity, family structure. In terms of ethnicity, the highest rates of suicide in the United States are among American Indians and Alaska Natives, followed by Caucasians (Goldsmith, 2017). Lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) are at an increased risk for suicide when compared to individuals identifying as straight (Goldsmith, 2017). Gay men are six times more likely to attempt suicide and lesbians are twice as likely when compared to heterosexual men and females (Goldsmith, 2017). The National Transgender Discrimination Survey of 2014 found that 41 percent of transgender individuals reported attempting suicide at some point in their lives (Goldsmith, 2017). It is estimated that in 50 percent of youth suicide cases, family factors are involved (Bilsen, 2018). A history of mental disorders among direct family members themselves, especially depression and substance abuse, poor communication within the family, and violence at home often seems to be found in the background history of young suicide cases (Bilsen, 2018). Furthermore, more than a quarter of all women who attempt suicide have experienced domestic violence (Goldsmith, 2017).

Biological Considerations

Genetic links to increased risk for suicide have only begun to be explored in recent years, with results presenting some evidence for genes contributing to mental illness and suicidal behavior. Zachary Kaminsky, Ph.D. assistant professor of psychiatry at John Hopkins, and colleagues published a study in 2014 in which they claim to have discovered an alteration in a single human gene linked to stress reactions.

Increasing attention has been drawn to the SKA2 gene, which is expressed in the prefrontal cortex of the brain and affects the ability to inhibit negative thoughts and control impulsive behavior (Johns Hopkins Medicine, 2014). Additionally, SKA2 is specifically responsible for enabling the body to adapt and respond to stress, so when there isn't enough SKA2, or it is altered in some way, cells are unable to suppress the release of primary stress hormones such as cortisol (Johns Hopkins Medicine, 2014). Previous research has shown that such cortisol release is abnormal in people who attempt or die by suicide. The researchers from this groundbreaking study looked at brain samples from mentally ill and healthy people, paying special attention to biological differences in those whom had died by suicide, and they found that of the people who had died by suicide, the levels of SKA2 was significantly reduced (Johns Hopkins Medicine, 2014). This was a result of a mutation

to the SKA2 gene, which ultimately affected the body's ability to regulate stress and cause an abnormal production of cortisol (Johns Hopkins Medicine, 2014). The results suggest that gene identification and possible blood monitoring that detects this mutation may be able to identify those at risk of suicide and provide a point of intervention and hormone regulation (Johns Hopkins Medicine, 2014). This offers an intriguing new sector of research to explore ways of identifying and treating people genetically at risk for suicide.

Means and Desire for Suicide

After identifying specific risk factors that increase one's susceptibility to suicide, the question still remains as to *why* people die by suicide. There are many people who experience commonly difficult situations but never go on to become suicidal. Developing an answer to this question is essential to understanding and intersecting the space between suicidal ideation and suicide attempts, and ultimately achieving effective suicide prevention strategies. Research by psychologist Thomas E. Joiner Jr offers a theory as to what leads to suicidal action being taken. The Interpersonal-Psychological Theory of Suicidal Behavior (2007) proposes that an individual will not die by suicide unless they have both the desire to die by suicide and the ability to do so. Joiner illustrates his theory through a Venn diagram (Figure 1) showing overlapping conditions that result in different levels of suicidal activity.

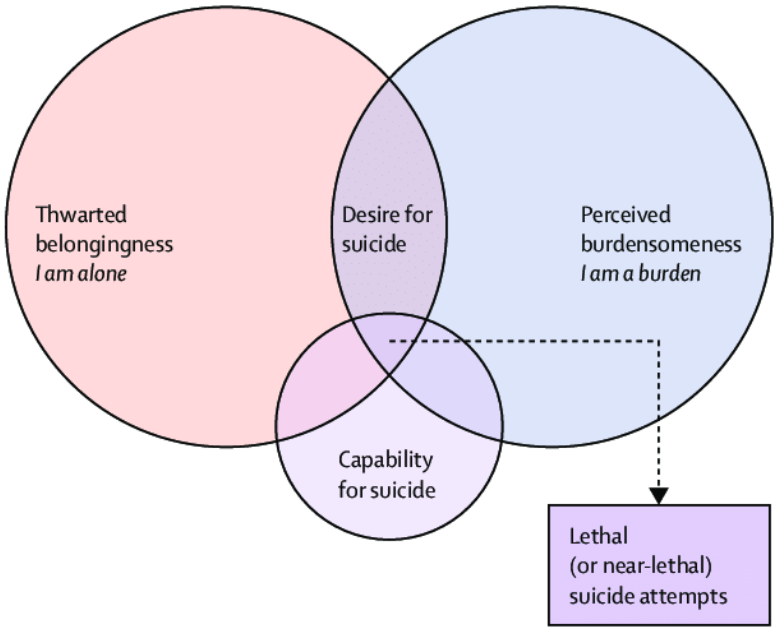


Fig. 1. The interpersonal psychological theory of suicidal behaviour (Van Orden et al., 2010).

Joiner theorizes the most dangerous form of suicidal desire is caused by the simultaneous presence of two interpersonal constructs—thwarted belongingness (*I am alone*) and perceived burdensomeness (*I am a burden*)—and further, that the capability to engage in suicidal behavior is separate from the desire to engage in suicidal behavior (Van Orden et al., 2010). When someone feels both thwarted belongingness (Figure 2) and perceived burdensomeness (Figure 3), they may have a desire for suicide with no means for acting upon it, but when combined with the additional condition of having the capacity and means (Figure 4) to do so, suicidal

attempts are likely a result.

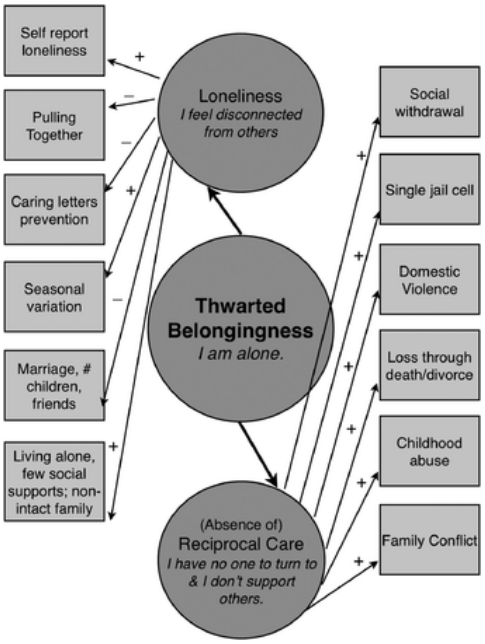
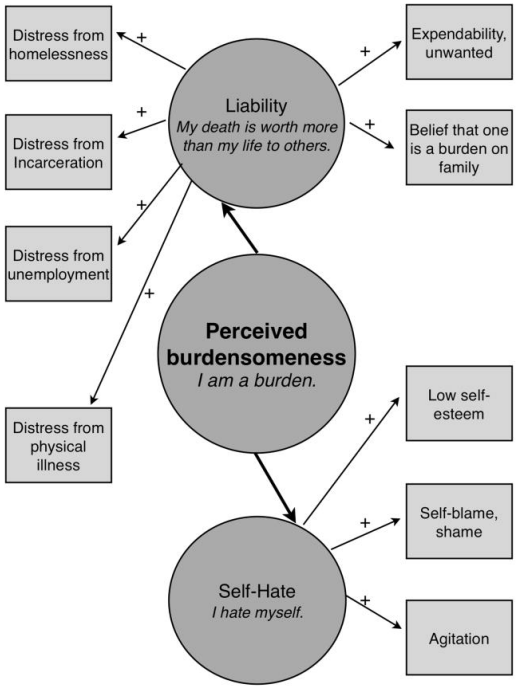


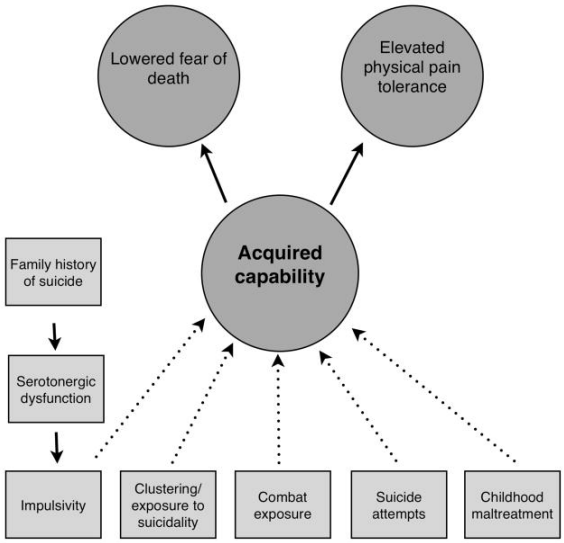
Fig. 2. Perceived burdensomeness from the interpersonal psychological theory (Van Orden et al., 2010)

Fig. 3. Thwarted belongingness from the interpersonal psychological theory (Van Orden et al., 2010)



According to the theory, capability for suicide is composed of both increased

Fig. 4. Acquired capacity from the interpersonal psychological theory (Van Orden et al., 2010)



physical pain tolerance and reduced fear of death, through habituation and activation of opponent processes, in response to repeated exposure to physically painful and/or fear-inducing experiences (Van Orden et al., 2010). By understanding the interpersonal theory of suicide and the factors that contribute to suicidal behavior, leaders can develop interventions and prevention strategies that target these underlying issues and help reduce the risk of suicide.

Risk-Factors Conclusion

With sufficient data identifying factors that increase the risk of suicide, one can begin to explore current barriers, protective factors, and evidence-based suicide prevention strategies to promote suicide prevention in clinical settings and beyond. A comprehensive public health approach to suicide prevention begins with improving national, state, and local infrastructure

that targets contextual factors that contribute to risk and increase protection (APHA, 2021). Such efforts may include teaching coping and problem-solving skills to help people manage challenges, expanding options for temporary assistance for those in need, and connecting people at-risk to effective and coordinated mental and physical health care (Parekh, 2018). While the remainder of the article will focus specifically on clinical applications, the data is not limited to healthcare settings alone andshould be utilized to inform suicide prevention across diverse settings and communities.

Suicide Prevention in Clinical Settings

Call to Action

The United States Surgeon General's Call to Action recognizes that "suicide is a complex issue requiring comprehensive solutions and no single strategy alone will be enough to reduce suicide rates" and "all of us have a role to play in spreading kindness and compassion and supporting one another when we are struggling" (US DHHS, 2021). There is a critically urgent need to leverage "resources to identify best practices in suicide prevention" and for those at risk for suicide to be provided with "effective care that will support their recovery" (US DHHS, 2021). The Call to Action stresses that "we can and must do more to prevent these deaths and distress and to help all Americans lead healthy and fulfilling lives" and evidenced-based approaches must be implemented more widely (US DHHS, 2021). It is important to mention the social context in which Americans are facing new challenges given that "the coronavirus disease-2019 (COVID-19) pandemic is taking a tremendous toll on Americans' emotional and economic well-being" (US DHHS, 2021).

The Relationship Between Clinical Care and Suicide

After exploring data on suicide risk and theories explaining motivations for suicide, there still a remains a challege for American systems, leaders, and citizens. While suicide prevention requires a multisystems approach, the National Strategy for Suicide Prevention (2012) concluded that healthcare is one of the best places to prevent suicide (Ahmedani et al., 2019). The clinical context of suicide prevention is highly significant because of the close time frames between contact with health services and preceding suicide death. Previous studies have shown over one-fifth of individuals make an emergency room visit within two months prior to their death and 50–70 percent of those who complete suicide have contact with health services in the days to months before their death (Ahmedani et al., 2019; Goldsmith, p.5, 2002). To enhance targeted

healthcare efforts for suicide prevention, it is important to understand varying health service patterns in utilization and outcomes (Ahmedani et al., 2019).

Healthcare utilization

High rates of health care utilization among suicide decedents indicate a need to understand why people escape risk detection and improve suicide prevention stratagies across all health care systems (Braciszewski et al., 2022). The majority of those who died by suicide received health services in the year prior to death and half made a medical visit within 4 weeks prior, which includes outpatient medical specialty and primary care, inpatient hospitals, and emergency rooms visits (Brent et al., 2023). These findings highlight the gaps in maximizing prevention opportunities and improving targeted intervention for those with the greatest risk (Ahmedani et al., 2019). Achieving healthcare standards that address intervention shortcomes may start in the emergency rooms, as the last clinical contact for a substantial proportion of patients with suicide attempts and deaths is an emergency room visit (Brent et al., 2023). Over one-fifth of individuals who die by suicide make an emergency room visit within two months prior to their death and suicide decedents aged 10 to 24 years were nearly 7 times more likely to have visited an ED within 30 days prior to their death (Ahmedani et al., 2019; Brent et al., 2023). Moreover, there has been an increase in presentations to pediatric emergency rooms for adolescent suicidal behavior that has accelerated since the onset of the COVID-19 pandemic, likely because of rising mental health concerns (Brent et al., 2023). Emergency department personnel often do not directly document and assess suicide intent at all, despite national guidelines and policy initiatives recommending that psychosocial assessments must be undertaken after every self-harm presentation (Freeman et al., 2017). A significant effort to prevent suicide for all patients in the emergency room appears warranted, particularly since emergency room visits are generally longer in duration than outpatient visits, providing an opportunity for risk intensity identification and brief intervention before connection to specialized behavioral health care (Ahmedani et al., 2019). In addition to emergency rooms, improving detection and treatment is necessary across all healthcare settings and there must be increasing efforts to understand the factors continuing to low healthcare utilization, such as insurance coverage barriers or insufficient access to providers.

Current Healthcare Barriers and Challenges

The barriers to receiving effective mental health treatment are nothing short of daunting

(US DHHS, 1999). Identifying the barriers to treatment that exist in a clinical setting "is essential for design, development, and implementation of preventive interventions" and is warranted by several key findings (Goldsmith, 2002). Several central, but certainly not limited, clinical barriers to effective treatment and suicide prevention to be discussed include integration of mental health systems, underdetection of suicidal risk and intent, and under-treatment.

Integration of Mental Health Systems

The fragmented organization of mental health services has been repeatedly recognized as a serious barrier to obtaining treatment (US DHHS, 1999). Linkages between different clinical settings are critical for the detection and treatment of mental disorders and suicidality (Mechanic, 1997). This includes a cohesive connection between a range of clinical settings (primary care, emergency department care, substance abuse care) and mental health care. People with mental illness frequently report their frustrations and waiting times as they navigate through a maze of disorganized services (Sturm and Sherbourne, 2001). Services research has focused for decades on developing better models of care that bridge different sectors of care and deliver more integrated mental health care, but it must be implemented in a variety of populations and community settings (Goldsmith, 2002). Furthermore, barriers to accessing proper care such a health insurance should be addressed as numerous longitudinal and cross-sectional studies have reported health insurance as a variable significantly associated with suicide rate (Steelesmith, 2019). Improving mental health care integration and insurance coverage can support suicide preventions and reduce risks within a community and lower suicide rates (Steelesmith, 2019).

Underdetection of Suicidal Risk and Intent

Detecting suicidal risk and level of intent in healthcare settings presents immense barriers to prevention, influenced by a lack of professional guidelines for assessment, traditionally exclusive detection strategies, and poorly understood patterns and variations that point to risk intensity. As previously emphasized, there is a troubling pattern associated with the frequency of healthcare visits and subsequent suicide deaths and despite the greater likelihood of suicide associated with mental disorder diagnoses, such disorders were present among only 51% of suicide decedents, which begs the question as to why more disorders and heightened risk-levels are not detected (Braciszewski et al., 2022). Detecting suicidality and intervening before it is too late though requires targeted efforts that capture individuals presenting with clear risk but also expanding risk

detection to reach a wider range of individuals who consistently escape detection. Unfortunately, limited evidence base to inform suicide prevention has made it hard to design, implement, and target interventions for those at greatest risk (Ahmedani, 2014). Most American healthcare guidelines recognize the need to assess risk level, but less than 60% of professional guidelines offer standardized risk level categorizations (Hogan et al., 2016). The lack of acute predictors for suicide assessment creates a discrepancy in professional guidelines recommending routine screening of asymptomatic patients (Goldsmith, 2002). Furthermore, despite there being several measures to assess suicide intent, including Beck's Suicide Intent Scale, the Feuerlein Scale, the five-point ordinal scale developed by Dorpat and Boswell, and other assessment instruments, the is still a high degree in variability in the empirical measurement, nomenclature and analysis of suicide intent, and this lack of consistency and standardisation impedes future research related to the measurement of suicide risk and outcome (Freeman et al., 2017). For suicide prevention efforts to be effective, accurate identification of those at risk is required.

Undertreatment

Addressing the barrier of undertreatment is also key to supporting better suicide prevention strategies in clinical settings. As previously discussed, depression and substance abuse are substantial risk factors for suicide, yet studies have found that a large percentage of suicide victims with major depression were not receiving treatment or were receiving inadequate treatment (Goldsmith, 2002) and alcohol dependence is under-treated in the vast majority of patients both before and after a suicide attempt (Suominen et al., 1999). The reason for this may be related to healthcare professionals' level of training as mental health professionals often receive only minimal training in treating suicidality, despite mental health services being a pivotal practice setting where lives can be saved (Hogan et al., 2016). Considering training predicts practice, there must be sufficient training for staff who interact with patients to be aware of signs of suicidality and know the steps they should take. A national survey of psychiatry residency training directors indicated that while the majority of programs provided some degree of training in the assessment and management of suicidal patients, little was known about both whether trainees felt adequately prepared to work with individuals at elevated risk and what specific practices were being used (Bernert et al., 2014). Providing optimal suicide prevention treatment requires education and training for healthcare professionals

on an ongoing basis to ensure patients are being treated with the most effective approaches and interventions (US DHHS, 2021). This is especially important in suicide prevention, where early identification and intervention can mean the difference between life and death.

Although the barriers mentioned represent only a fraction of the challenges clinicians face, they must be accounted for when seeking to improve access and effectiveness of suicide prevention care.

Potential Clinical Interventions

After identifying several key barriers to suicide prevention in a clinical setting, there are ample evidence-based intervention strategies and recommendations that address these barriers and improve outcomes for suicidality. While research will show many additional effective intervention options, key practices to be addressed here include: (1) Improving risk and intent assessment; (2) Increasing training and implementation of evidence-based treatment interventions; and (3) emphasizing the establishment of empathic care of suicidal individuals.

Risk and Intent Assessment

Capstone to suicide prevention in clinical settings is the ability of providers to recognize risk, determine severity, and provide effective and culturally competent treatment and care. To address the suicide intent and risk limitations previously discussed, it is critical to recognize that training predicts practice and optimal suicide prevention care requires assessment and treatment training on evidence-based suicide care practices to be incorporated into medical education programs and behavioral health graduate programs, which should be included as criteria for professional licensure and license renewal (US DHHS, 2021). To improve intent and risk assessment and detection, certain methodologies can be utilized, like the usage of Joiner's Interpersonal Theory. When applying the Interpersonal Theory to risk assessment frameworks, the degree to which patients are currently experiencing thwarted belongingness and perceived burdensomeness should be explicitly assessed, as well as the degree to which they have acquired the capability for lethal self-harm (Van Orden et al., 2010). Risk assessment grounded in the Interpersonal Theory, if supported empirically, will allow for a more parsimonious and clinically useful conceptualization of the etiology of suicide because this conceptualization does not presume that assessing individuals' degree of risk for suicide requires measurement (or estimation of) a vast number of risk factors (Van Orden et al., 2010). In addition to risk assessment, measurement of suicide intent may be particularly useful in the

assessment of short-term suicide risk (Freeman et al., 2017). The concept of intent is a critical component in the clinical appraisal of suicide attempts, as it distinguishes between acts of deliberate and accidental self-harm (Freeman et al., 2017). Emergency department personnel often do not directly document and assess suicide intent at all, despite national guidelines and policy initiatives recommending that psychosocial assessments must be undertaken after every self-harm presentation (Freeman et al., 2017). To further promote suicide prevention, it is necessary that a standardised measurement for suicide intent is implemented in clinical settings in order to develop and effectively manage the treatment of patients at risk of suicide (Freeman et al., 2017).

Evidence-Based Treatment Interventions

When treating suicidality, research suggests the use of evidence-based interventions like cognitive behavior therapy for suicide prevention, dialectical behavior therapy, and collaborative assessment and management of suicidality, which are more effective than traditional therapies that seek to treat mental disorders but do not focus explicitly on reducing suicidality (Hogan, 2016). In addition to psychotherapeutic approaches, providing training and implementing the use of safety planning can serve as an effective intervention strategy for patients at risk for suicide. Safety planning involves a brief intervention following a suicide-risk assessment that has been shown to help reduce suicidal thoughts and actions (US DHHS, 2022). The provider works with the patient to discuss a plan for recognizing suicidal thoughts and coping with them safely. This could include limiting access to lethal means and making a list of people and resources to contact during a crisis. Safety planning with lethal means of safety should be embedded in the suicide care protocols and electronic medical record systems used in all health care settings (US DHHS, 2021). Research has shown that when at-risk patients create a safety plan followed by a series of supportive phone calls, their risk for suicide goes down (US DHHS, 2022).

Empathic Care

Even with proper protocols in place, suicide cannot always be prevented and there likely remains a level of deeply personal pain and suffering present for those at serious risk. Examining evidence-based care requires an understanding of specific drivers for suicidal desire and exploring what a life worth living would look like to patients (U.S. Department of Veteran Affairs). While other strategies may be effective for decreasing suicidal risk, treatment of suicidal patients also requires their pain to be validated

through empathy offered by the provider. The main sources of psychological pain — shame, guilt, rage, loneliness, hopelessness, and so forth — stem from frustrated or thwarted psychological needs (U.S. Department of Veteran Affairs).

Because feeling understood may help a suicidal person's recovery, providers should demonstrate deeper empathetic insight by exploring metaphors, analogies, and imagery to enable the expression of painful or distressing feelings (U.S. Department of Veteran Affairs). Key aspects of The Guidelines for Clinicians developed by The Aeschi Working Group of suicidologists emphasized the significance of the therapeutic alliance between the clinician and patient, highlighted the importance of offering empathy and of being non-judgmental, and placed the patient's story as a priority over clinical expertise (Stephany, 2017). Specifically, in hopeless patients, increased hope is instilled if they feel understood and cared for by their physician or nurse (Stephany, 2017). Strategies to practice being an empathic provider for those in crisis include establishing a connection, fostering a therapeutic alliance, offering unconditional positive regard, heartfelt listening, and presenting compassion (Stephany, 2017). Empathic providers have the power to promote suicide prevention by offering a feeling of validation and support for those in distress.

Clinical Practice and Research Implications

Suicide prevention is a complex and multifaceted initiative but must be thoroughly examined and improved in the United States to support individual's well-being and reduce the number of lives lost. Although significant strides have been made in suicide prevention measures in recent decades, there is still considerable room for improvement in implementing clinically relevant practices on a wider scale. A comprehensive approach to suicide prevention will require cooperative efforts from leaders in healthcare to reduce fragmentation of efforts and which mirrors the preventive approaches used for conditions such as heart disease or diabetes (APHA, 2021). In order to support suicide prevention efforts, it is essential to clearly outline risk factors that shed light on the key influences of suicidality. Identifying risk factors in a clinical setting is particularly significant given the interrelation between diagnosable and treatable conditions and suicide victims. Professionals across the board recognize the need for individuals at risk to have access to coordinated and effective care which supports recovery, but there are still significant challenges to achieving this goal. Improving diagnostic measures and access to evidence-based treatment in healthcare must start by examining

current barriers that hinder these efforts such as a lack of mental health services integration, poorly standardized detection measures of suicide, and underdiagnosis of mental health conditions. Additionally, there are still widespread shortages of behavioral health clinicians who are trained in evidence-based, culturally sensitive suicide treatment so immediate emphasis should be placed on improving education for clinicians (APHA, 2021). While there are many evidence-based interventions to be further considered, collective efforts to address this problem should involve a commitment to detect, assess, empathetically manage, and effectively treat suicide risk and intent.

Conclusion

Suicide is a rapidly growing and urgent tragedy to be addressed in America, which is the collective responsibility of leaders in all sectors of public health. We must recognize that suicide is not just an individual issue, but a societal one. It's a reflection of the challenges and struggles that our communities are facing, and it requires a collective effort to address. Policy makers, educators, and leaders in public health have a crucial role to play in suicide prevention, including practice standardization, research, advocating for change, and promoting awareness, and ensuring patients receive ethical and effective care for suicidality. Because of the complexity suicide presents, leadership must create a culture marked both by a commitment to safety and by support for staff members who do the difficult work of caring for suicidal individuals (Hogan, 2016). An effective leader will review clinically relevant research to set goals, take action toward goals, and emphasize suicide prevention as a critical patient safety issue (Hogan, 2016). There is no single way to increase access to effective treatment, so leaders should be aware of the variety of models to be integrated that meet the needs of diverse individuals. Suicide prevention efforts to be implemented in healthcare will require a substantial continuation of research that explores advancements and adapts to societal changes.

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