I have the privilege of co-chairing with Dr. Regina Benjamin, our nation’s Surgeon General, the Action Alliance for Suicide Prevention task force on revising the U.S. National Strategy for Suicide Prevention (NSSP). The rationale for creation of the task force is that the field has evolved since 2001, and our national strategy should be revised to reflect these advances as well as to advance future efforts. Working with a great team of experts, we hope to complete our work in the summer of 2012. As many of you know, the national strategy was first published in 2001 and, in the eleven years since the document was published, much has changed—or has it?

Our knowledge of suicide prevention has increased, public awareness surrounding suicide has risen, more and more individuals and organizations are dedicated to advancing suicide prevention, and public and private funding for suicide prevention efforts has been applied. We can and should celebrate the advances made in the last eleven years. We now have Garrett Lee Smith grants helping fund state, tribal and campus suicide prevention efforts. There is also:

- a strong response from our Departments of Veterans Affairs and Defense
- a national lifeline that links crisis centers throughout the country
- a national Suicide Prevention Resource Center
- a public/private partnership charged with championing, catalyzing and cultivating suicide prevention activity
- the longstanding important work of many nonprofits and local and community organizations dedicated to advancing suicide prevention efforts

While such effort, advancement and investment is encouraging, we must challenge ourselves to apply our increased understanding of the problem of suicide on a much broader scale. The facts are that suicide numbers and rates are increasing, at least for some groups. Since the initial NSSP was released, between 2001 and 2009 we have lost, on average, over 33,000 fellow citizens to suicide each year. Over this period there have been slight declines in the rate of suicide among youth and older adults, while for other populations, particularly middle-aged men and, more recently, women, rates continue to increase.
If we want to reach the 8.7 million adults in the United States who seriously considered suicide in 2010, or the 14 percent of high school students who seriously considered suicide in the past 12 months, it is time for an honest and open reassessment of the issue at hand. The complex solutions needed must combine all that we have learned in the years since the NSSP was originally released.

We may be disheartened by the rising numbers and rates and wonder why we have not seen more reductions. On the other hand, I wonder what we might be experiencing if we did not have this infrastructure in place and had not made the investments we have made. We often do not hear the stories of lives saved. And, we must not forget we are seeing reductions in behavioral health budgets across the nation; we have not fully engaged a nation in understanding that suicide is preventable; our nation has been at war; and the economy has presented a challenge for many in terms of work, housing and financial stability. We also know that dramatic reductions in rates don’t happen overnight and many of our more recent initiatives will take time to yield the results intended. But now is the time to move ahead, apply what we know works in more integrated ways than ever before, and commit to a goal of eliminating the tragic experience of suicide. This must be our message.

Solutions will not be simple or linear and our collective resolve must challenge each of us to think and act differently. As our 2012 NSSP task force met over the last year, we worked hard to strike a balance between all of the approaches to suicide prevention that are needed in a national strategy:

- How do we truly integrate a public health and mental health approach?
- How do we promote a new dialogue about hope and resilience and not compromise on the important message about the severity of suicide?
- How do we treat the individual at significant suicidal risk and at the same time move upstream and prevent the onset of suicidal behavior in the first place?
- Even further upstream, how do we make the promotion of a healthy lifestyle—physical, mental, spiritual and emotional—a priority of our health policy and practice?
- How do we shift our thinking from a focus solely on the individual in crisis and move more intently to efforts to examine the communities where people live and work and the systems they visit to receive care?

I think the answers lie in accepting from the outset that the solutions to suicide are complex. The application of one evidence-based practice, or the activity of one organization, or the dissemination of one research study is not enough. It is time for genuine and intentional cross-sector, cross-discipline, and cross-funded approaches that will act synergistically to bring the best that we know to the complex problem of suicide.

What are your thoughts? I hope you will take a moment to share your comments for the benefit of everyone.

Planning and Implementing: Overview of Suicide Prevention
