LETTERS

SUICIDE PREVENTION IS A WINNABLE BATTLE

At the heart of the challenge posed by suicide, attempted suicide, and their antecedent risks (e.g., trauma, interpersonal violence, drinking and drug use, family turmoil, work-related difficulties, depression) is the question of whether suicide really is preventable. This is especially true now for veterans and active duty personnel, for whom the nation has been challenged as never before, to support service personnel returning from combat with new or more intense problems not routinely encountered in the past.

Here are 10 reasons why suicide prevention is possible:

1. SUICIDE IS UNAVOIDABLE AS A PUBLIC HEALTH CHALLENGE

Suicide continues to increase in the United States to the point that it has become unavoidable as a public health challenge—it is now the tenth leading cause of death. It is associated with greater mortality and morbidity than other recognized priorities for injury prevention. The need is great, and a necessary national urgency is emerging. In September 2010, Health and Human Services Secretary Kathleen Sebelius and Department of Defense Secretary Robert M. Gates commissioned the National Action Alliance for Suicide Prevention, a public–private partnership now co-chaired by the Secretary of the Army John McHugh and former Senator Gordon Smith. This points directly to the nation's building commitment and deepening resolution to frankly address the challenge.

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US Army veteran Manny Arredondo and his wife Josie take part in a "financial peace" workshop session at a Project Sanctuary retreat on November 11, 2011, near Granby, CO. Arredondo was severely injured during a mortar attack in Iraq in 2007 and still suffers from posttraumatic stress. Photograph by John Moore. Printed with permission of Getty Images.

2. SUICIDE PREVENTION EFFORTS CAN SUCCEED

Suicide prevention efforts can succeed: we know how to make a difference by providing the vision, the will, and the support.

The systematic implementation of national strategies for suicide prevention has been associated with robust reductions in suicide—e.g., World Health Organization (WHO) data showed decreases of more than 20% in the United Kingdom and more than 30% in Finland during the past two decades.[1] Suicide in Denmark declined from 1600 to 600 individuals per year (M. Nordentoft, personal communication, September 2011), which was associated with robust means control efforts (i.e., elimination of barbiturates from the country's pharmacopeia, substitution of less toxic second generation antidepressants for first generation compounds, use of catalytic converters in automobiles, and removal of carbon monoxide from domestic cooking gas) and enhanced clinical follow-up services of individuals who survived their "index" suicide attempt or were deemed clinically unstable and "at risk." Each national program involved multilayered initiatives that were inclusive of broader universal and selective efforts (e.g., changing laws about alcohol intoxication and clarifying and enforcing policies regarding the safe design of psychiatric inpatient services) and indicated interventions such as post–emergency room (ER) or inpatient aftercare.

The US Air Force suicide prevention program, a multilayered array of initiatives, demonstrated that a public health approach saved lives involving multiple forms of violent death—suicide, homicide, and accidental death—as it targeted antecedent morbidity (e.g., family violence, alcohol use, financially related tensions) using a "common risk" strategy.[2,3] Of note, this program did not focus on means restriction; by necessity, service personnel have access to many weapons and a culture of safety is deeply ingrained.

US health care systems that defined "boundaried" populations showed that it was

possible to deploy multipronged approaches that altered outcomes, including suicide and attempted suicide—when the entire system is committed to implementing and sustaining the changes.[4,5]

The WHO Suicide Prevention of Suicidal Behaviors—Multisite Intervention Study (SUPRE-MISS) randomized controlled trial reported that post-ER interventions with attempters reduced subsequent suicides (although not all subsequent attempts reported were in its published data).[6]

The Taiwan National Suicide Surveillance System demonstrated that a public health surveillance program, including mandatory registration of attempts followed by widely applied aftercare, was associated with reduced attempts and deaths (Lee MB et al., unpublished data, 2011).

3. SOCIETY MEMBERS ARE OWED THE BEST INTERVENTIONS

A society owes its members the best interventions that current knowledge can support, especially when applied in a cost-effective fashion. Where there is sufficient political will power, action to save lives is feasible even when all causes are not known, especially when using public health approaches to prevention and early intervention. The nation has had significant success with HIV/AIDS; it can muster the same commitment to reducing suicide by focusing on socially important "presuicidal" conditions and behaviors that have public health significance.

4. SUICIDE IS ONE OF SEVERAL OVERLAPPING RISKS

Suicide and attempted suicide reflect one of several sets of adverse outcomes arising from overlapping or common risks, including, among others, interpersonal violence and homicide, and accidental death because of motor vehicle accidents or drug ingestion ("overdose"). There are many survivor groups, community organizations, and governmental agencies that separately deal with such risks, largely in isolation from each another.[7] Acting together, they would have the potential to profoundly influence social priorities that could prevent a broad swath of mortality and morbidity.

5. THERE ARE OPPORTUNITIES FOR FUTURE EFFECTIVE ACTION

A fair accounting of the burdens of suicide in the Unites States—and a candid appraisal of the shortcomings of past and recent efforts—reveals many opportunities for future effective action. From a public health perspective, these can be applied at broader, intermediate, and individual levels in a developmental framework—as part of a well-conceived mosaic of preventive and therapeutic interventions that share a public health philosophy. These interventions involve contextual social and community initiatives to complement indicated clinical activities for individuals, the latter largely being built on mental health perspectives.

6. SUICIDE CAN BE PREVENTED

At the individual level, suicide can be prevented readily—*if* there is the ability to intervene in a timely fashion before someone reaches the "edge of the cliff." As a multidetermined outcome, there are frequent opportunities to change individuals' life trajectories before they become acutely or severely distressed and "suicidal." Distal interventions are relevant to individuals as well as broader communities and segments of society.

7. STIGMA SURROUNDING SUICIDE IS STILL A BARRIER

Although the stigma associated with frankly discussing suicide, self-harming behaviors, and interpersonal victimization has diminished greatly over the past two decades, allowing more open consideration of complex and potentially embarrassing problems, it continues as a powerful force. Suicide remains a frightening and devastating way to end life; at an individual and family level, it may be a forbidden topic. Yet discussions of suicide prevention now serve to mobilize broad concern and cooperative efforts to build essential "action coalitions." It is now possible to candidly consider centrally important issues—firearm safety, suicide among populations that have fewer advocates, and the weighing and balancing of population and individual perspectives—when such discussions were too sensitive or "off limits" only a few years ago. Such discussions will be essential for building a foundation for future prevention initiatives.

8. IMPROVED SURVEILLANCE CAN REDUCE SUICIDE MORTALITY

Taken together, research indicates that improved surveillance, when linked to action, can reduce the mortality and morbidity of suicide and attempted suicide. Put succinctly: suicides and suicide attempts can be counted—repeated measurement can drive accountability and quality improvement.

9. PREVENTION AND SUPPORT EFFORTS ARE GROWING STRONGER

Many individuals and agencies are committed to preventing suicide, attempted suicide, and their antecedent risk factors; they now are in a position to actively and creatively respond to galvanizing leadership, knowledge, guidance, and technical support.

10. THE TIME TO ACT IS NOW

The timing is right! The next generation of the National Strategy for Suicide Prevention (NSSP 2.0) is now being developed.

It is notable that the Department of Veterans Affairs and Department of Defense have embarked on a variety of initiatives to lessen suicide among those whom they serve. Each organization faces distinct challenges. The experiences of others—in bounded systems akin to the Veterans Health Administration and each of the military services, or more open systems such as countries—have much to teach us. However, one thing is certain: this is a winnable battle! ■

Eric D. Caine, MD

About the Author

Eric D. Caine is with the Department of Psychiatry, Center for the Study and Prevention of Suicide, University of Rochester Medical Center, Rochester, NY, and the VA Center of Excellence for Suicide Prevention, Canandaigua, NY.

Correspondence should be sent to Eric D. Caine, MD, University of Rochester Medical Center, 300 Crittenden Blvd., Rochester, NY 14642-8409 (e-mail: eric_caine@urmc.rochester.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints/Eprints" link.

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LOCAL BOARD OF HEALTH AUTHORITY TO ADDRESS OBESITY

We read with interest the article by Pomeranz[1] on the authority for state and local health departments to address obesity. We agree that "states and locales are often innovators in creating and implementing public health policy,"[1(p1192)] and we support that regardless of a health department's size, structure, and authority, they all have a responsibility to protect the public's health and ensure health in all policies.[1] However, the statement that the health department has the authority to adopt obesity prevention policies is misleading and an inaccurate depiction of how policies are enacted in today's public health system.

Although the terms "health department" and "board of health" are often used synonymously, it is important to clearly differentiate between the 2 because they do operate in different capacities. According to state statutes, the role of local boards of health is to serve as a policymaker for the health jurisdiction, provide an advisory role, complete rulemaking, and operate in a managerial or supervisory role over local health department or other entities.[2] This is in contrast to the role of the health department. Local health departments are defined as those that "exist for the common good and are responsible for demonstrating strong leadership in the promotion of physical, behavioral, environmental, social, and economic conditions that improve health and well-being; prevent illness, disease, injury, and premature death; and eliminate health disparities."[3] Therefore, the board of health is often the entity legally responsible for developing and adopting public health policies, whereas the health department and health officer are responsible for instituting programs and services to support those policies.

This differentiation is further exemplified by data from our 2011 Local Board of Health National Profile. Primary analysis of the Profile's imbedded random sample shows that local boards of health have the authority to adopt (80.0%), review (93.5%), and revise (82.5%) public health regulations. Additionally, local boards of health have the authority to recommend (88.8%) and establish (81.2%) public health policies.[4] It is these local boards of health with rule-making authority, as compared with the health department, that "can use this power to address obesity-related concerns."[1(p1195)] Boards of health are the link between the health department and community. This link, together with policies, will drive the citizen engagement needed to improve public health outcomes. It is vital for the public health field to continue engaging and utilizing boards of health, in addition to health departments, to address obesity. ■

Ed Schneider, OD
Marie M. Fallon, EdD
Tricia Valasek, MPH

About the Authors

Ed Schneider was the 2011 President of the National Association of Local Boards of Health, Bowling Green, OH. Marie M. Fallon and Tricia Valasek are with the National Association of Local Boards of Health, Bowling Green.

Correspondence should be sent to Tricia Valasek, MPH, National Association of Local Boards of Health, 1840 East Gypsy Lane Road, Bowling Green, OH 43402 (e-mail: tricia@nalboh.org).

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POMERANZ RESPONDS

I appreciate the letter from Schneider et al., from the National Association of Local Boards of Health, as it enriches the discussion of the roles and responsibilities of boards of health and health departments throughout the country. After working through the rigors of the peer review process, I regret that I did not catch any errors in terminology prior to publication.

Schneider et al. raise a nice opportunity to highlight the important role state and local boards of health and health departments play in supporting and improving public health. I urge both state and local governments to work on improved food environments and address obesity to the extent they are authorized. Obesity continues to threaten America's future,[1] and it is vital that government[2] is empowered to devote the time and resources necessary to address this public health issue. ■

Jennifer L. Pomeranz, JD, MPH

About the Author

The author is the with the Rudd Center for Food Policy & Obesity, Yale University, New Haven, CT.

Correspondence should be sent to Jennifer L. Pomeranz, Rudd Center for Food Policy and Obesity, PO Box 208369, Yale University, New Haven, CT 06520-8369 (e-mail: jennifer.pomeranz@yale.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints/Eprints" link.

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