Clinicians Should Not Adopt a Single Self-Reported Item as a Screener for Suicide

To the Editor: In their recent article, Green and associates state that item 9 of the Beck Depression Inventory, an item that pertains to suicide ideas and plans, should be used as “a brief, efficient screen for suicide risk in routine clinical care”1(p1683) and that “clinicians would then conduct a comprehensive suicide risk assessment in response to a positive screen.”2(p1683) They imply that psychiatric outpatients and patients seen in the emergency department after a suicide attempt who do not self-report suicide ideas (with a score of 0 on item 9) do not need a “suicide risk assessment and corresponding risk management plan.” While we acknowledge that item 9 might distinguish between high- and low-risk groups for suicide in a statistical sense, we believe the authors have overstated the case for its use as a routine screening tool in these populations.

The World Health Organization (WHO) has very well-established guidelines outlining when screening is worthwhile.2,3 WHO suggests that a specific diagnostic test should be available to follow a sensitive but nonspecific screening procedure like item 9.2,3 However, there are no tests for future suicide that are specific enough to usefully divide patients into those at high or low likelihood of future suicide.4,5 Further, according to WHO, a useful intervention should be available to justify screening.2,3 However, there are no highly effective treatments that specifically prevent suicide or suicide attempts, and certainly none that have effectiveness over the very long period of follow-up described in the recent study. Finally, WHO recommends that screening should be shown to reduce overall morbidity or mortality.2,3 Despite over 50 years of suicide risk research, it has never been shown that allocating treatment resources on the basis of suicide risk assessment results in fewer suicides.

The thoroughness of a psychiatric assessment in these populations should never be determined by the simple presence or absence of self-reported suicidality. Every psychiatric outpatient and every patient seen in an emergency department after a suicide attempt should be thoroughly, sympathetically, and personally assessed by a mental health professional who should then be in a position to offer treatment in line with the patient’s needs and wishes.6 Unfortunately, there are no shortcuts in this realm of clinical practice.

REFERENCES

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Prevention and is also a component of the Zero Suicide approach, which has been found to reduce suicide deaths within health systems by up to 80%. Finally, Large and Ryan’s claim that no efficacious interventions exist for the prevention of suicide and suicide attempts is incorrect. Follow-up interventions (eg, caring letters) have been found to prevent both suicide and suicide attempts following discharge for periods of up to 2 years. Several efficacious outpatient psychotherapy interventions have also been shown to prevent suicide attempts with follow-up periods of up to 2 years, including but not limited to dialectical behavior therapy, cognitive therapy for suicide prevention, and brief cognitive behavioral therapy. For a more thorough review and discussion of effective interventions for suicide prevention, we encourage readers to refer to our recent reviews.

**REFERENCES**


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