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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."[1(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

1. Green KL, Brown GK, Jager-Hyman S, et al. The predictive validity of the Beck Depression Inventory suicide item. *J Clin Psychiatry.* 2015;76(12):1683–1686.
2. Wilson JMG, Jungner G. *Principles and Practice of Screening for Disease.* Geneva, Switzerland: WHO; 1968.
3. Andermann A, Blancquaert I, Beauchamp S, et al. *Revisiting Wilson and Jungner in the Genomic Age: A Review of Screening Criteria Over the Past 40 Years*. Geneva, Switzerland: WHO; 2008.
4. Pisani AR, Murrie DC, Silverman MM. Reformulating suicide risk formulation: from prediction to prevention. *Acad Psychiatry.* 2015.
5. Large M, Ryan C. Suicide risk assessment: myth and reality. *Int J Clin Pract.* 2014;68(6):679–681.
6. Ryan CJ, Large M, Gribble R, et al. Assessing and managing suicidal patients in the emergency department. *Australas Psychiatry.* 2015;23(5):513–516.

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Dr Green and Colleagues Reply

To the Editor: We appreciate the response from Large and Ryan to our article "The Predictive Validity of the Beck Depression Inventory Suicide Item."[1] First, Large and Ryan assert that we suggest patients who score 0 on the suicide item "do not need 'a suicide risk assessment and corresponding risk management plan.'" We did not intend to imply that a score of 0 should preclude risk assessment and management. Rather, we stated in our article that the item "should not be relied upon as the sole determination of risk in a suicide risk assessment or to make risk management decisions."[1(p1684)] Given the space limitations of our article, we did not unpack this statement further, so we will elaborate here. Although we suggest that a score of 1 or above should alert clinicians of the need to further assess suicide risk during the encounter, there are cases in which patients scoring a 0 warrant further assessment (such as assessing for a history of a suicide attempt). Thus, clinicians should take all available data into account when making clinical decisions.

Second, we strongly disagree with Large and Ryan's assertion that it is not worthwhile to implement routine suicide risk screening. Identification of at-risk individuals is a necessary first step to preventing suicide. Indeed, recent research indicates that routine suicide risk screening improves detection of at-risk individuals[2] and also changes clinician behavior for the better, resulting in increased rates of further risk assessment.[3] Troubling data indicating that up to 40% of psychiatric patients who die by suicide are not assessed for suicide risk by mental health providers at their last visit prior to death[4] suggest that inappropriate shortcuts occur during clinical practice. Screening is not a shortcut. Rather, it is a tool that provides guidance for conducting suicide risk assessments during each visit, which, in turn, prompts clinicians to use evidence-based interventions to reduce suicide risk. It is for this reason that suicide risk screening is included in the National Strategy for Suicide

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Prevention[5] and is also a component of the Zero Suicide approach,[6] which has been found to reduce suicide deaths within health systems by up to 80%.[7,8]

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.[9] 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,[10] cognitive therapy for suicide prevention,[11] and brief cognitive behavioral therapy.[12] For a more thorough review and discussion of effective interventions for suicide prevention, we encourage readers to refer to our recent reviews.[9,13]

References

1. Green KL, Brown GK, Jager-Hyman S, et al. The predictive validity of the Beck Depression Inventory suicide item. *J Clin Psychiatry*. 2015;76(12):1683–1686.
2. Boudreaux ED, Camargo CA Jr, Arias SA, et al. Improving suicide risk screening and detection in the emergency department. *Am J Prev Med*. 2016;50(4):445–453.
3. Betz ME, Arias SA, Miller M, et al. Change in emergency department providers' beliefs and practices after use of new protocols for suicidal patients. *Psychiatr Serv*. 2015;66(6):625–631.
4. Smith EG, Kim HM, Ganoczy D, et al. Suicide risk assessment received prior to suicide death by Veterans Health Administration patients with a history of depression. *J Clin Psychiatry*. 2013;74(3):226–232.
5. The 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. US Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention Web site. http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf. Updated 2012.
6. About Zero Suicide. ZeroSuicide Web site. http://zerosuicide.sprc.org/about. Accessed February 2, 2016.
7. Coffey CE. Pursuing perfect depression care. *Psychiatr Serv*. 2006;57(10):1524–1526.
8. Coffey CE, Coffey MJ, Ahmedani BK. An update on perfect depression care. *Psychiatr Serv*. 2013;64(4):396.
9. Brown GK, Green KL. A review of evidence-based follow-up care for suicide prevention: where do we go from here? *Am J Prev Med*. 2014;47(suppl 2):S209–S215.
10. Linehan MM, Comtois KA, Murray AM, et al. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Arch Gen Psychiatry*. 2006;63(7):757–766.
11. Brown GK, Ten Have T, Henriques GR, et al. Cognitive therapy for the prevention of suicide attempts: a randomized controlled trial. *JAMA*. 2005;294(5):563–570.
12. Rudd MD, Bryan CJ, Wertenberger EG, et al. Brief cognitive-behavioral therapy effects on post-treatment suicide attempts in a military sample: results of a randomized clinical trial with 2-year follow-up. *Am J Psychiatry*. 2015;172(5):441–449.
13. Brown GK, Jager-Hyman S. Evidence-based psychotherapies for suicide prevention: future directions. *Am J Prev Med*. 2014;47(suppl 2):S186–S194.

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