Reviewer's report

Title: Detecting Suicidality at Adolescent Outpatients: Evaluation of Trained Clinicians’ Suicidality Assessment against a Structured Diagnostic Assessment Made by Trained Raters

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Reviewer: Berit Groholt

Reviewer's report:

This paper compares two different ways of assessing suicidality in adolescents. The conclusion is that structured scales perform best, and that suicidality and self-harm need to be better assessed by clinicians.

The topic is of interest for people working with suicidal adolescents. However, there are some methodological problems which need to be underlined and explained better in the manuscript.

General comments:

1. The list of references seems to be relatively old. Except papers by the authors, there is one paper from 2004 and a few from 2003. None are from 2005-2008. The authors might consider finding newer references, which exist.

2. The relationship between suicide attempt and self-harm with no suicidal intention represents a problem. In one of the two assessment methods (Clinical assessment), the questions quoted do not address non-suicidal deliberate self-harm, as do the questions in the other method (Kiddie-SADS). This might account for much of the difference between the results. Could the authors explain more carefully in which way the clinicians addresses this topic (they were asked to note self-harm, one way or the other)? Could they analyze suicide attempt and non-suicidal self-harm separately, so the reader could see how much of the difference that was related to non-suicidal self-harm?

3. There is also a difference in the measurement of suicidal ideation. The authors conclude that clinicians over-report this. Was the clinician asked to consider if the ideation was significant? If not, the difference could be explained by different inclusion criteria. As far as I understand, the authors are not able to judge which way of reporting was most valid as they have no follow-up. This should be commented more clearly as a possible limitation. The difference related to thought of death seems to be well explained in the paper.

4. Further, both assessment methods are related to the last two weeks. In some cases the periods measured were not the same for both methods. This must be of importance. The authors should inform the reader if correlation between the two methods were influenced by time between assessments. It is well known that suicidality may fluctuate, and a suicide attempt / self-harm is not necessarily repeated.
Thus, a lot of the difference found could be explained by different things being measured due to different periods and different thresholds for suicidal acts and ideation, thus make it impossible to compare methods, as the authors do. I would like the authors to have this in mind when they discuss their results.

Specific comments

5. Methods It is surprising that almost all the adolescents with a BDI score 10 or above had a clinical diagnosis of depression (218 out of 221). Generally the correlation between a clinical diagnosis and a self-rated score is much lower. Have I misunderstood anything, or was this really the case?

6. The inter-rater reliability is reported for the diagnosis of mood disorder, and not for the suicidality questions. Did all 9 raters rate the 15 videotapes in order to get a measurement of Kappa? What is the relevance of this rating, for the questions addressed in this paper?

7. With Kiddie-SADS the life-time versions was used. Did you also use life-time measurements for the clinical assessments? Is the life-time measures included in the comparisons between the methods?

8. Results You write: “---After including recurrent thoughts of death ----was present at 52 subjects.” Was that including all types of suicidal ideation (not only this form of suicidality)? Look closely at the English in this paragraph.

9. I do not understand Table 2. The heading says it includes 66 subjects. I do not find 66 subjects in the table.

10. Discussion You state that structured interviews (still face-to-face interviews), leads to more openness and less fear about confidentiality, than clinical interviews. Is this your suggestion or do you know studies that supporting this notion. In that case, quote them.

11. I do not understand a statement, starting with: “The assessment of intention--- and so on---as they may not perceive correctly the lethality of their attempt.” What is the relationship between intention and lethality?

12. I find your comments about KIDDIE SADS and suicidality interesting.

13. I believe that seeing out-patients (or no in-patients) is a real clinical situation. Thus, I do not understand your statement about seeing suicidal ideation too narrow.

14. I think your conclusion that assessment of suicidal behavior needs to be better, is important. It seems as if structured questions about self-harm, independent of suicidality, is needed.

The English is close to adequate as far as I can judge, but some improvements should be done (for instance may some of my “not understanding” be related to the language).

The statistics is simple and straight forward.
I see no competing interests between myself and the authors.
I think this report may be published, but that the authors should dwell more with the possible weaknesses in the study.

**Quality of written English:** Needs some language corrections before being published

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests