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In Reply: We agree with Dr. Wintersteen regarding the importance of universal depression screening in the community setting, consistent with the U.S. Preventive Services Task Force (USPSTF) guidelines, when appropriate systems are in place to provide accurate diagnosis, effective treatment, and follow-up. Given the lack of incentives for provision of mental health screenings (1), the intent of our research effort was not to discourage depression screening but rather to document and highlight the additional time demands of important, recommended screening practices and raise awareness among key stakeholders. Our findings also highlight the need for more definitive screening intervals in the USPSTF guidelines to assist with the interpretation of the observed occurrence of depression screening at 3.4% of patient visits. Although we attempted to reduce potential bias by excluding visits in which the patient saw a midlevel practitioner (that is, a physician assistant or nurse practitioner), the study data did not allow for exclusion of cases in which a nurse administered the screening instrument before physician evaluation. As noted in our article, the effect of screening by nurses may have resulted in a slight underestimate in the overall probability of depression screening.

Given the high prevalence (2) and related morbidity of depression (3), it is unfortunate that the potential of longer patient visits may discourage some physicians from using depression screening tools. Therefore, we believe that the findings of our study should motivate health care payers, providers, and policy makers to develop mechanisms that increase the efficiency of universal depression screening practices.

In our recently published study of variations in the probability of depression screening (4), we found a significant increase in the odds of documented depression screening for visits by patients who had a current or prior diagnosis of depression. This finding is consistent with Dr. Wintersteen's assertion that primary care providers may be using targeted screening for patients at higher risk. In practice settings that routinely screen patients for depression, this process may be very efficient. However, settings that do not routinely perform depression screening may have suboptimal implementation, which may lengthen patient visits. Although we have found depression screening to be associated with increased visit duration, it is also likely that additional time burden is incurred after the act of screening itself (for example, investigating the results of a positive finding or attempting to explain a negative finding).

Our belief is that expanded use of technology and alternative health care providers, working in collaboration with physicians, will facilitate greater provision of depression screening services in the community given appropriate financial incentives. A paradigm shift is needed in the way that the health care system values depression screening efforts. Thus, although our findings may discourage some physicians from screening for depression, our greater hope is that information from our research will be used to justify the need for systems change to expand depression screening to all patients.

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Donald L. Harrison, Ph.D.

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Societal Stigma and Suicide Prevention

To the Editor: Although we fully agree with Dr. Caine's commentary (1) in the December 2010 issue that it is hard to prevent suicide, we would like to note that societal prevention is an important option. In our opinion, such an approach is the only way to reduce suicides. Dr. Caine rightly notes that most people who commit suicide do not have a history of psychiatric treatment, "despite the high frequency of psychopathological findings revealed by using postmortem psychological autopsy methods." And most people do not seek professional help for their suicidal intentions.

Dr. Caine believes that when we have programs that deal with adverse factors, such as "family turmoil, early-life abuse," and so forth, suicide will become less common. This may be true; however, this focus addresses only risk factors, which is not enough. What needs to be done, and Dr. Caine hints at this, is lifting the stigma on suicide and suicidal ideation. This task can be undertaken in two ways. First, we can take practical measures, such as constructing physical barriers in places that are known to attract suicidal persons. Such barriers have been erected at many so-called suicide bridges, and they may influence impulsive suicidal behavior. Telephones with a direct connection to crisis teams have also been installed at several of these places.

More important, however, is prevention in the public domain, analogous to the prevention of smoking. Initially, it did not have much effect to tell smokers that smoking is bad for one's health. However, large-scale prevention programs eventually reduced the number of smokers signifi-

cantly. Of course, it may be argued that suicidal thoughts and behavior differ from lighting a cigarette, but this does not mean that such an approach cannot be taken. Efforts to improve knowledge, attitudes, and help-seeking behavior are being made in middle and high schools, and they seem to have yielded results as far as knowledge and attitudes are concerned (2). It is too early to conclude that such efforts prevent suicide, but we should not forget that it took some time before antismoking campaigns produced an effect. In our view, campaigns to prevent suicide need a much wider audience than adolescents in schoolrooms. Antisuicide messages should receive wide exposure in the media, such as television and radio.

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In Reply: I very much appreciate the thoughtful comments of Drs. Hovens and van der Ploeg, which echo and reaffirm a point of view expressed by my colleagues and me (1) and place suicide prevention in a public health framework involving community-driven activities that promote mental health while also seeking to mitigate or prevent risks. I also agree that controlling the means of suicide—as exemplified by erecting bridge barriers, changing the composition of cooking gas, and limiting access to lethal pesticides—can be a robust method for preventing suicide (2). And reducing stigma must be a central component to building effective prevention and mental health promotion efforts, as advocated by the President's New Freedom Commission.

At the same time, it is all too apparent that reducing the nation's suicide rate has been a challenge that has defied sustained efforts and substantial commitments of resources during the past decade (3). Increases in suicide rates during the middle years of life far outweigh the declines among youths and young adults (≤24 years) and among elders. Comprehensive approaches to suicide prevention, such as those used by the U.S. Air Force (4), have been shown to reduce suicide in a meaningful way when applied in a consistent, sustained, and comprehensive fashion. No single intervention aimed at one element of the population alone is sufficient to have a major impact.

What should we do now? On the basis of the epidemiological burden that we see in the United States, I would argue that it is long overdue to focus on men and women in the middle years of life in addition to youths and elders (5). Suicide often is the final punctuation of a long story of distress and disturbed relationships; in the middle years this story typically involves many others—spouses and partners, children, parents sometimes, and employers frequently. There is a heavy toll of alcohol and drug use, recurrent mood disturbances, family violence, and years (if not decades) of decline, and many opportunities for prevention and early intervention and for socially and environmentally focused mental health promotion (strength building in the face of challenges and adversities). Whether a smoking or a heart disease analogy is employed, which we have used previously, seeking to change life trajectories must begin decades before the immediate life-ending event.

Such efforts, together with the suggestions of Drs. Hovens and van der Ploeg, may provide a path toward effectively lowering suicide rates and greatly lessening the impacts of the life-disrupting events and distress that precede them, as well as their long-lasting after-effects.

Eric D. Caine, M.D.

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Race, Mental Illness, and Premature Mortality: Double Jeopardy?

To the Editor: Racial-ethnic disparities in mortality have been extensively noted in the literature (1). A number of studies have also established that a diagnosis of a mental disorder increases a person's risk of premature death (2). However, research has not focused on the issue of "double jeopardy," as postulated by Dowd and Bengtson (3). If race-ethnicity and a mental illness diagnosis lead to a double disadvantage in regard to health, then racial-ethnic health disparities should be greater among persons with mental illness than among those who do not have mental illness.

To address this issue, I compared racial-ethnic differences in premature mortality among decedents with severe mental illness and decedents in the general population without mental illness. Death records for the City of Akron, Ohio, were matched with clinical case management files from Community Support Services (CSS), a community mental health center in Akron. The sample consisted of 16,164 individuals who died between January 1998 and December 2004; 647 of these individuals also had CSS records and 15, 517 did not. The mean±SD age of decedents in