October 17, 2022

Carol M. Mangione, MD, MSPH
Chair, U.S. Preventive Services Task Force
5600 Fishers Lane
Mail Stop 06E53A
Rockville, MD 20857

Re: Draft Recommendation Statement on Screening for Depression and Suicide Risk in Adults

Dear Dr. Mangione and Members of the USPS Task Force:

On behalf of the American Association of Psychiatric Pharmacists (AAPP), we appreciate the opportunity to provide feedback on the Draft Recommendation Statement on Screening for Depression and Suicide Risk in Adults, released by the U.S. Preventive Services Task Force (USPSTF) on September 20, 2022.

AAPP is a professional association of nearly 3,000 members who envision a world where all individuals living with mental illness, including those with substance use disorders (SUD), receive safe, appropriate, and effective treatment. Members are pharmacists who specialize in psychiatry, substance use disorders (SUDs), and psychopharmacology. Psychiatric pharmacists are an important member of the healthcare team working in collaboration with the patient and other health care providers including psychiatrists, other physicians, therapists, social workers, and nurses. They provide expert, evidence based Comprehensive Medication Management (CMM) services for the most complex patients with mental health and/or substance use disorders.

The World Health Organization has been focusing on suicide prevention since 2014.[1] It's widely accepted that suicide is usually caused by an interplay of complex and dynamic risk factors and therefore prevention will require a multi-pronged approach.[2] Psychiatric pharmacists are well-positioned to be part of suicide prevention efforts as front-line healthcare providers who can screen for and potentially prevent suicidal thoughts and behaviors. Doctoral level education, post-graduate residency training, and board certifications prepare pharmacists to practice in direct patient care roles and many pharmacy school's curricula include specific training on suicide screening. Specific to mental health, there are over 1,400 Board Certified Psychiatric Pharmacists[3] practicing in advanced roles and improving access to care. Along the continuum of health care, pharmacists are accessible and well-trained providers that can play a role in universal suicide screening efforts.

Concerning Suicide Trends and Request for Routine Suicide Screening for Adults in Primary Care

Given the 36% increase in the national rate of suicide from 1999 to 2018, followed by two years of decreased rates (by 5%),[4] and with new provisional data just released on September 29 by CDC showing a 4% increase in 2021,[5] AAPP is concerned that the overall trend remains in an upward trajectory for suicide in our nation. In 2021, 15–24-year-old males were found to have the largest increase in suicide

8055 O Street, Ste S113 ■ Lincoln, NE 68510
www.aapp.org ■ info@aapp.org
402-476-1677 (phone)

rate, an increase of 8% year over year. Additionally, underrepresented populations including American Indian and Black youth,[6] Hispanic males, multi-racial females, and LGBTQ people, especially those with intersecting identities, are experiencing disproportionate increases in suicide risk.[7] AAPP has concerns about the decision related to suicide screening given these concerning trends in a leading cause of death, and one that is considered generally and potentially preventable. **AAPP strongly urge the USPSTF to revisit existing research on suicide screening in adults with attention to peer-reviewed literature highlighted in this response.** Specifically, we request that the task force consider adding a recommendation for routine suicide screening for adults in primary care settings. Screening is the first step in the process of identifying individuals with suicidal risk, which then affords clinicians and health systems to employ suicide risk reducing steps that have been implemented and studied in outpatient primary care settings. These next steps include further assessment of risk, brief interventions that reduce risk, provision of crisis resources when appropriate, referral for treatment and follow-up as recommended by the National Action Alliance for Suicide Prevention.[8] We strongly recommend this process that has been shown to reduce suicide rates in large health systems (Henry Ford, Parkland). [8, 9, 10]

There is consensus amongst the leading suicide prevention organizations for the importance of moving forward with routine or indicated screening based[11] on 1) the magnitude of missed opportunities in primary care settings for detecting adults at risk for suicide, 2) demonstrated effectiveness of screening and risk assessment, 3) the feasibility of screening and appropriate care steps for primary care, and 4) the acceptability of screening and suicide preventive care among health professionals and by health systems. The details outlined below provide rationale supporting suicide risk screening as a timely and important step for reducing suicide risk for patients in primary care settings.

Data on Suicide and Healthcare Contacts

Data from the United States indicates suicide risk is largely undetected in primary care settings, which constitutes missed opportunities to reduce risk and save lives – essentially a major gap in a public health approach to suicide prevention. Studies find that 45% of those who die by suicide saw a primary care physician in the year preceding their death compared to only 20% who saw a mental health professional in that same time frame.[12,13] A more recent systematic review of studies from over a dozen countries found that 80% of those who died by suicide had contact with primary care in the year preceding their death, and 44% had contact within the previous month.[14] Moreover, 60% of mental health care delivery occurs in the primary care setting.[15] Together, these data suggest that primary care visits present a key intervention point wherein universal screening with follow-up guidance can potentially save lives.[16] More specifically, in a longitudinal study of eight geographically diverse healthcare systems across the U.S., researchers found that among nearly 6,000 patients who died by suicide between 2000 and 2010, 45% saw a primary care provider within a month of dying by suicide, 20% saw a mental health provider within a month, and 39% were seen in an emergency department in the year prior to dying by suicide.[17] Similarly, in a case-control study examining the health records of eight geographically diverse healthcare systems across the U.S., researchers found that among over 2,500 patients who died by suicide between 2000 and 2013, nearly 30% of people had a healthcare visit in the seven days before suicide (6.5% in EDs, 16.3% in outpatient clinics, and 9.5% in primary care). An additional 54.3% had a healthcare visit within the 30 days preceding suicide death, and more than 90% had a healthcare visit in the prior year.[7]

Effectiveness of Screening and Follow-up

Suicide risk screening instruments have demonstrated validity and reliability among adults across both inpatient and outpatient medical settings.[18, 19] The Joint Commission has published a list of evidence-based assessments on its website. These tools include the Ask Suicide-Screening Questions (ASQ),[20] the Columbia-Suicide Severity Rating Scale,[21] the Patient Health Questionnaire-9 (PHQ-9),[17,22,23] and the Suicide Behavior Questionnaire-Revised (SBQ-R).[24,25,26] A recent review summarizes the validity of these instruments, and together, they demonstrate effectiveness across urban, rural, and specialized population settings.[27] Screening embedded in a suicide prevention plan of further assessment, referral to care and follow-up, has been shown to be effective for reducing suicide rates in many settings such as large health systems, VA settings and emergency departments.[8,9,28]

Perception and Feasibility

Recent studies have found that implementing suicide risk screening in primary care settings is both feasible and effective at identifying patients at risk for suicide.[29,30] In fact, in one study of a rural primary care clinic, researchers found a 99% completion rate for the ASQ instrument and 100% completion rate for the brief suicide safety assessment (BSSA) instrument. Moreover, 94% of participants agreed that providers in primary care should screen for suicide, and screening rates increased from 5.8% to 61% between baseline and intervention phases.[14] The Parkland Hospital System in Texas[8] and the Veterans Administration[31] have also demonstrated the feasibility of universal screening, illustrating its utility and feasibility across urban, rural, and specialized settings. In the former, the authors found that "the burden to the system from universal screening was not overwhelming and was managed effectively through thoughtful allocation of clinical resources."[8]

Clinical Pathway for Implementation

Despite its effectiveness and feasibility, it is worth noting that the integration of universal suicide risk screening for adults in primary care presents challenges for implementation, similar to many new protocols for addressing other complex health issues. In a recent special article in the *Journal of the Academy of Consultation-Liaison Psychiatry*, Ayer and colleagues describe a clinical pathway for integrating suicide risk screening in adult primary care settings, including a pathway diagram and implementation guidance.[32] Together, these materials describe the importance of a three-step clinical pathway that includes a brief screen for suicidal ideation and behavior, a brief suicide risk and safety assessment, and disposition and planning.

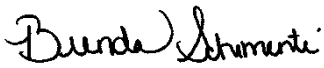
Some primary care settings have implemented protocols for suicide risk screening when indicated rather than universally. We believe this can be an important step for health systems in making progress and gaining sophistication in their system-approach to suicide prevention. These steps can include training of all staff in suicide prevention as appropriate to their role on the healthcare team, developing new workflows and protocol which incorporate use of health records, surveillance and tracking of suicide-related outcomes, and incorporating evidence-based or evidence-informed care steps including Safety Planning, lethal means safety counseling, bridging gaps in care, providing follow-up caring communications, and providing education and resources to patients and families.

There has never been a more urgent time for implementing effective suicide prevention initiatives in primary care, and leading health policy initiatives are responding. Screening for possible suicide risk is the first step in taking further supportive steps that have evidence for reducing suicide risk. These

include brief "interventions" that can be feasibly done in a primary care setting: lethal means counseling, safety planning, education of patients and families, and supportive ongoing follow up communication in addition to crisis resources and referrals for further assessment of risk and effective intervention.

AAPP urges the Task Force to expand the recommendations to provide appropriate considerations for the critical role of primary care clinicians and outpatient primary care settings in addressing a national crisis related to suicide and mental health. Thank you again for the opportunity to comment.

Sincerely,



Brenda K. Schimenti
Executive Director

---

[1] Centers for Disease Control and Prevention. World Health Organization's (WHO) Report on Preventing Suicide. https://www.cdc.gov/violenceprevention/suicide/WHO-report.html

[2] Centers for Disease Control and Prevention. Risk and Protective Factors. https://www.cdc.gov/suicide/factors/index.html

[3] Board of Pharmacy Specialties. Annual Report 2021. http://books.bpsweb.org/books/ocro/#p=31

[4] Ehlman DC, Yard E, Stone DM, et al. Changes in Suicide Rates - United States, 2019 and 2020. MMWR Morb Mortal Wkly Rep. 2022 Feb 25;71(8):306-312. doi: 10.15585/mmwr.mm7108a5. PMID: 35202357.

[5] Curtin SC, Garnett MF, Ahmad FB. Provisional numbers and rates of suicide by month and demographic characteristics: United States, 2021.Vital Statistics Rapid Release; no 24. September 2022. DOI: https://dx.doi.org/10.15620/cdc:120830.

[6] Sheftall AH, Vakil F, Ruch DA, et al. Black Youth Suicide: Investigation of Current Trends and Precipitating Circumstances. J Am Acad Child Adolesc Psychiatry. 2022 May;61(5):662-675. doi: 10.1016/j.jaac.2021.08.021. Epub 2021 Sep 9. PMID: 34509592; PMCID: PMC8904650.

[7] Ramchand R, Gordon JA, Pearson JL. Trends in Suicide Rates by Race and Ethnicity in the United States. JAMA Netw Open. 2021;4(5):e2111563. doi:10.1001/jamanetworkopen.2021.11563

[8] Roaten K, Johnson C, Genzel R, et al. Development and Implementation of a Universal Suicide Risk Screening Program in a Safety-Net Hospital System. Jt Comm J Qual Patient Saf. 2018 Jan;44(1):4-11. doi: 10.1016/j.jcjq.2017.07.006. Epub 2017 Nov 22. PMID: 29290245.

[9] Coffey MJ, Coffey CE, Ahmedani BK. Suicide in a health maintenance organization population. JAMA Psychiatry. 2015 Mar;72(3):294-6. doi: 10.1001/jamapsychiatry.2014.2440. PMID: 25607598.

[10] Richards JE, Simon GE, Boggs JM, et al. An implementation evaluation of "Zero Suicide" using normalization process theory to support high-quality care for patients at risk of suicide. Implement Res Pract. 2021 Jan 1;2:10.1177/26334895211011769. doi: 10.1177/26334895211011769. Epub 2021 May 24. PMID: 34447940; PMCID: PMC8384258.

[11] National Action Alliance for Suicide Prevention. Transforming Health Systems Initiative Work Group. (2018). Recommended standard care for people with suicide risk: Making health care suicide safe. Washington, DC: Education Development Center, Inc. https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf

[12] Bono V, Amendola CL. Primary care assessment of patients at risk for suicide. JAAPA. 2015 Dec;28(12):35-9. doi: 10.1097/01.JAA.0000473360.07845.66. PMID: 26556217.

[13] Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry. 2002 Jun;159(6):909-16. doi: 10.1176/appi.ajp.159.6.909. PMID: 12042175; PMCID: PMC5072576.
[14] Stene-Larsen K, Reneflot A. Contact with primary and mental health care prior to suicide: A systematic review of the literature from 2000 to 2017. Scand J Public Health. 2019 Feb;47(1):9-17. doi: 10.1177/1403494817746274. Epub 2017 Dec 5. PMID: 29207932.
[15] Frank RG, Huskamp HA, Pincus HA. Aligning incentives in the treatment of depression in primary care with evidence-based practice. Psychiatr Serv. 2003 May;54(5):682-7. doi: 10.1176/appi.ps.54.5.682. PMID: 12719498.
[16] Horowitz LM, Roaten K, Pao M, et al. Suicide prevention in medical settings: The case for universal screening. Gen Hosp Psychiatry. 2020 Mar-Apr;63:7-8. doi: 10.1016/j.genhosppsych.2018.11.009. Epub 2018 Dec 1. PMID: 30686522.
[17] Ahmedani BK, Simon GE, Stewart C, et al. Health care contacts in the year before suicide death. J Gen Intern Med. 2014 Jun;29(6):870-7. doi: 10.1007/s11606-014-2767-3. Epub 2014 Feb 25. PMID: 24567199; PMCID: PMC4026491.
[18] Simon GE, Rutter CM, Peterson D, et al. Does response on the PHQ-9 Depression Questionnaire predict subsequent suicide attempt or suicide death? Psychiatr Serv. 2013 Dec 1;64(12):1195-202. doi: 10.1176/appi.ps.201200587. PMID: 24036589; PMCID: PMC4086215.
[19] Horowitz LM, Snyder DJ, Boudreaux ED, et al. Validation of the Ask Suicide-Screening Questions for Adult Medical Inpatients: A Brief Tool for All Ages. Psychosomatics. 2020 Nov - Dec;61(6):713-722. DOI: 10.1016/j.psym.2020.04.008. PMID: 32487323.
[20] Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med. 2012 Dec;166(12):1170-6. doi:
[21] Posner K, Brown GK, Stanley B, et al. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. Am J Psychiatry. 2011 Dec;168(12):1266-77. doi: 10.1176/appi.ajp.2011.10111704. PMID: 22193671; PMCID: PMC3893686.
[22] Louzon SA, Bossarte R, McCarthy JF, et al. Does Suicidal Ideation as Measured by the PHQ-9 Predict Suicide Among VA Patients? Psychiatr Serv. 2016 May 1;67(5):517-22. doi: 10.1176/appi.ps.201500149. Epub 2016 Jan 14. PMID: 26766757.
[23] Rossom RC, Coleman KJ, Ahmedani BK, et al. Suicidal ideation reported on the PHQ9 and risk of suicidal behavior across age groups. J Affect Disord. 2017 Jun;215:77-84. doi: 10.1016/j.jad.2017.03.037. Epub 2017 Mar 16. PMID: 28319695; PMCID: PMC5412508.
[24] Brown G. (2003). A review of suicide assessment measures for intervention research with adults and older adults. Bethesda, MD: National Institute of Mental Health. https://go.edc.org/Brown2003
[25] Kreuze E, Lamis DA. (2018). A Review of Psychometrically Tested Instruments Assessing Suicide Risk in Adults. OMEGA - *Journal of Death and Dying, 77*(1), 36–90. https://doi.org/10.1177/0030222816688151
[26] Osman A, Bagge CL, Gutierrez PM, Konick LC, Kopper BA, Barrios FX. The Suicidal Behaviors Questionnaire-Revised (SBQ-R): validation with clinical and nonclinical samples. Assessment. 2001 Dec;8(4):443-54. doi: 10.1177/107319110100800409. PMID: 11785588.
[27] Thom R, Hogan C, Hazen E. Suicide Risk Screening in the Hospital Setting: A Review of Brief Validated Tools. Psychosomatics. 2020 Jan-Feb;61(1):1-7. doi: 10.1016/j.psym.2019.08.009. Epub 2019 Sep 12. PMID: 31629482.
[28] Bahraini N, Reis DJ, Matarazzo BB, et al. Mental health follow-up and treatment engagement following suicide risk screening in the Veterans Health Administration. PLoS One. 2022 Mar 17;17(3):e0265474. doi: 10.1371/journal.pone.0265474. PMID: 35298536; PMCID: PMC8929551.
[29] Horowitz LM, Boudreaux ED, Schoenbaum M, et al. Universal Suicide Risk Screening in the Hospital Setting: Still a Pandora's Box? Jt Comm J Qual Patient Saf. 2018 Jan;44(1):1-3. doi: 10.1016/j.jcjq.2017.11.001. Epub 2017 Dec 1. PMID: 29290241; PMCID: PMC6675409.

[30] LeCloux MA, Weimer M, Culp SL, et al. The Feasibility and Impact of a Suicide Risk Screening Program in Rural Adult Primary Care: A Pilot Test of the Ask Suicide-Screening Questions Toolkit. Psychosomatics. 2020 Nov-Dec;61(6):698-706. doi: 10.1016/j.psym.2020.05.002. Epub 2020 May 15. PMID: 32646611.

[31] Bahraini N, Reis DJ, Matarazzo BB, et al. Mental health follow-up and treatment engagement following suicide risk screening in the Veterans Health Administration. PLoS One. 2022 Mar 17;17(3):e0265474. doi: 10.1371/journal.pone.0265474. PMID: 35298536; PMCID: PMC8929551.

[32] Ayer L, Horowitz LM, Colpe L, et al. Clinical Pathway for Suicide Risk Screening in Adult Primary Care Settings: Special Recommendations. J Acad Consult Liaison Psychiatry. 2022 Sep-Oct;63(5):497-510. doi: 10.1016/j.jaclp.2022.05.003. Epub 2022 May 23. PMID: 35618222; PMCID: PMC9489622.