

Screening for Suicide Risk in Adolescents, Adults, and Older Adults in Primary Care: Recommendation Statement

This summary is one in a series excerpted from the Recommendation Statements released by the USPSTF. These statements address preventive health services for use in primary care clinical settings, including screening tests, counseling, and preventive medications.

The complete version of this statement, including supporting scientific evidence, evidence tables, grading system, members of the USPSTF at the time this recommendation was finalized, and references, is available on the USPSTF website at <http://www.uspreventiveservicestaskforce.org/>.

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A collection of USPSTF recommendation statements published in *AFP* is available at <http://www.aafp.org/afp/uspstf>.

Summary of Recommendation and Evidence

The U.S. Preventive Services Task Force (USPSTF) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in adolescents, adults, and older adults in primary care (*Table 1*). **I statement.**

Go to the Clinical Considerations section for suggestions for practice regarding the I statement.

Rationale

IMPORTANCE

Suicide was the 10th leading overall cause of death in the United States in 2010 and one of the five leading causes of death for children, adolescents, and adults 10 to 54 years of age. Rates of suicide attempts and deaths vary by sex, age, and race or ethnicity.¹ Psychiatric disorders and previous suicide attempts increase suicide risk.²

DETECTION

There is insufficient evidence to conclude that screening adolescents, adults, and older adults in primary care adequately identifies patients at risk of suicide who would not otherwise be identified on the basis of an existing mental health disorder, emotional distress, or previous suicide attempt.

BENEFITS OF DETECTION AND EARLY INTERVENTION OR TREATMENT

Evidence on the benefits of screening adolescents, adults, and older adults for suicide risk in primary care is inadequate.

Evidence is inadequate on whether interventions reduce suicide risk in patients identified through primary care screening or similar methods; most evidence for treatment effectiveness is in high-risk populations who were not discovered through

screening, such as persons who presented to an emergency department because of a suicide attempt.

HARMS OF DETECTION AND EARLY INTERVENTION OR TREATMENT

Evidence on the possible harms of screening adolescents, adults, and older adults for suicide risk is inadequate.

USPSTF ASSESSMENT

The USPSTF concludes that the evidence on screening for suicide risk in primary care is insufficient and that the balance of benefits and harms cannot be determined.

Clinical Considerations

PATIENT POPULATION

This recommendation applies to adolescents, adults, and older adults in the general U.S. population who do not have an identified psychiatric disorder.

SUGGESTIONS FOR PRACTICE REGARDING THE I STATEMENT

Potential Preventable Burden. In 2010, suicide accounted for more than 1.4 million years of potential life lost before 85 years of age, or 4.3% of total years of potential life lost in the United States.³ Past studies estimated that 38% of adults (50% to 70% of older adults) visited their primary care clinician within one month of dying by suicide.⁴ Nearly 90% of suicidal youths were seen in primary care during the previous 12 months.⁵

Given that most persons who die by suicide have a psychiatric disorder and many have been seen recently in primary care, primary care clinicians should be aware of psychiatric problems in their patients and should consider asking these patients about suicidal ideation and referring them for psychotherapy, pharmacotherapy, or case management.

Table 1. Screening for Suicide Risk in Adolescents, Adults, and Older Adults in Primary Care: Clinical Summary of the USPSTF Recommendation

Population	Adolescents, adults, and older adults in the general U.S. population who do not have an identified psychiatric disorder
Recommendation	No recommendation Grade: I statement
Risk assessment	Suicide risk varies by age, sex, and race/ethnicity. Risk factors for suicide attempt include presence of a mental health disorder; serious adverse childhood events; family history of suicide; prejudice or discrimination associated with being lesbian, gay, bisexual, or transgender; access to lethal means; and possibly a history of being bullied, sleep disturbances, and chronic medical conditions. In men, socioeconomic factors, such as low income, occupation, and unemployment, are also related to suicide risk. In older adults, additional risk factors, such as social isolation, spousal bereavement, neurosis, affective disorders, physical illness, and functional impairment, increase the risk of suicide. Risk factors of special importance to military veterans include traumatic brain injury, separation from service within the past 12 months, posttraumatic stress disorder, and other mental health conditions. Individual risk factors have only limited ability to predict suicide in an individual at any particular time. A large proportion of Americans have a risk factor for suicide; however, only a small proportion will attempt suicide, and even fewer will die from it.
Screening tests	Screening tests for suicide risk vary and have a wide range in accuracy. Data on screening tests are limited.
Treatment	Most effective treatments to reduce suicide risk include psychotherapy. The most commonly studied psychotherapy intervention is cognitive behavior therapy and related approaches, including dialectical behavior therapy, problem-solving therapy, and developmental group therapy.
Balance of benefits and harms	The evidence on screening for suicide risk in primary care is insufficient, and the balance of benefits and harms of screening cannot be determined.
Other relevant USPSTF recommendations	The USPSTF has made recommendations on screening for depression in adolescents and adults. These recommendations are available at http://www.uspreventiveservicestaskforce.org/ .

NOTE: For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, go to <http://www.uspreventiveservicestaskforce.org/>.

USPSTF = U.S. Preventive Services Task Force.

The USPSTF recommends that primary care clinicians screen adolescents and adults for depression when appropriate systems are in place to ensure adequate diagnosis, treatment, and follow-up. Primary care clinicians should also focus on patients during periods of high suicide risk, such as immediately after discharge from a psychiatric hospital or after an emergency department visit for deliberate self-harm.⁶ Recent evidence suggests that interventions during these high-risk periods are effective in reducing suicide deaths.

Potential Harms. Evidence on the potential harms of screening for suicide risk is insufficient.

Costs. The monetary cost of screening for suicide risk is minimal. Additional time would be needed in the primary care visit to accommodate screening.

Current Practice. In a study of U.S. primary care clinicians, suicide was discussed in 11% of encounters with patients who had (unbeknownst to their clinicians) screened positive for suicidal ideation.⁷ Similarly, 36%

of U.S. primary care physicians explored suicide in encounters with standardized patients presenting with major depression or adjustment disorder or those who sought antidepressants.⁸ Less than one-fourth of surveyed primary care pediatricians or family physicians in Maryland reported that they frequently or always screened adolescents for suicide risk factors.

RISK FACTORS FOR SUICIDE

Although evidence to determine whether the general asymptomatic population should be screened for suicide risk is inadequate, clinicians should consider identifying patients with risk factors or those who seem to have high levels of emotional distress and referring them for further evaluation.

Suicide risk varies by age, sex, and race or ethnicity. In men, the greatest increases in suicide rate were in those 50 to 54 years of age (49.4% [from 20.6 to 30.7 deaths per 100,000]) and those 55 to 59 years of age (47.8% [from 20.3 to 30.0 deaths per 100,000]). In women,

the suicide rate increased with age, and the largest percentage increase was in those 60 to 64 years of age (59.7% [from 4.4 to 7.0 deaths per 100,000]).⁹

American Indians and Alaska Natives 14 to 65 years of age and non-Hispanic white persons older than 18 years have higher-than-average rates of suicide death, and the risk among non-Hispanic white persons continues to increase after 75 years of age. The highest rates are seen in American Indians and Alaska Natives 19 to 24 years of age and non-Hispanic white persons older than 75 years. Among adolescents, Hispanic females are at especially high risk of attempting suicide.⁹

The greatest increases in suicide rate from 1999 to 2010 by racial or ethnic population in men and women overall were among American Indians and Alaska Natives (65.2%) and white persons (40.4%). Among American Indians and Alaska Natives, the suicide rate in women increased by 81.4% (from 5.7 to 10.3 deaths per 100,000), and the rate in men increased by 59.5% (from 17.0 to 27.2 deaths per 100,000). Among white persons, the rate in women increased by 41.9% (from 7.4 to 10.5 deaths per 100,000), and the rate in men increased by 39.6% (from 24.5 to 34.2 deaths per 100,000).⁹

Increased risk is also associated with the presence of a mental health disorder, such as depression, schizophrenia, posttraumatic stress disorder, and substance use disorders. About 87% of patients who die by suicide meet the criteria for one or more mental health disorders. A lifetime history of depression more than doubles the odds of a suicide attempt in U.S. adults, and depression is probably present in 50% to 79% of youths attempting suicide, although it may not always be recognized.²

Other important risk factors for suicide attempt include serious adverse childhood events; family history of suicide; prejudice or discrimination associated with being lesbian, gay, bisexual, or transgender; access to lethal means; and possibly a history of being bullied, sleep disturbances, and such chronic medical conditions as epilepsy and chronic pain. In males, socioeconomic factors, such as low income, occupation, and unemployment, are also related to suicide risk.²

In older adults, additional risk factors, such as social isolation, spousal bereavement, neurosis, affective disorders, physical illness, and functional impairment, increase the risk of suicide. Risk factors of special importance to military veterans include traumatic brain injury, separation from service within the past 12 months, posttraumatic stress disorder, and other mental health conditions.²

Individual risk factors have limited ability to predict suicide in an individual at a particular time. A large proportion of Americans have one of these risk factors; however, only a small proportion will attempt suicide, and even fewer will die from it.²

SCREENING TESTS

The reviewed studies used various screening tools. One example is the Suicide Risk Screen, a 20-item screening instrument embedded in a broader self-report questionnaire administered in high schools to youths at risk of dropping out of school. Another tool consists of three suicide-related items (“thoughts of death,” “wishing you were dead,” and “feeling suicidal” within the past month) targeting primary care patients 18 to 70 years of age with scheduled appointments.

Sensitivity and specificity of screening tools generally ranged from 52% to 100% and from 60% to 98%, respectively. The instruments showed a wide range in accuracy, but data were limited and no instruments were examined in more than one study.²

TREATMENT

Most effective treatments to reduce risk of suicide attempt include psychotherapy. The most commonly studied psychotherapy intervention was cognitive behavior therapy and related approaches, including dialectical behavior therapy, problem-solving therapy, and developmental group therapy. Other approaches included psychodynamic or interpersonal therapy. Although most of these treatments are not customarily administered by primary care clinicians in the office, patients can be referred to behavioral health professionals for them. The primary care clinician can play a continued role in the care of these patients by monitoring them during the process, providing follow-up, and coordinating with other care professionals.²

OTHER APPROACHES TO PREVENTION

In addition to approaching the problem of suicide from an individual level in primary care, approaches are being implemented at community, regional, and national levels. In the health care system, laws requiring coverage parity between mental and physical health disorders will give more persons the ability to access care for psychiatric problems associated with suicide, such as depression. Efforts to coordinate care among programs that address mental health, substance use, and physical health can also increase access to care. Activities that have been shown to be correlated with lower suicide rates in other countries include detoxification of domestic gas in the United Kingdom and discontinuation of the use of highly toxic pesticides in Sri Lanka. These actions were associated with 19% to 33% and 50% reductions in suicide, respectively, providing evidence that engineering controls can be effective. Such activities as installing barriers at common suicide jump spots may also be effective.^{10,11}

On an individual level, patients with a history of suicide attempt or suicidal ideation should not have easy access to means that may be used in suicide attempts, such as firearms or other weapons, household chemicals or poisons, or materials that can be used for hanging or suffocation.¹¹

USEFUL RESOURCES

The USPSTF recommends that physicians screen adolescents and adults for depression when appropriate systems are in place to ensure adequate diagnosis, treatment, and follow-up (available at <http://www.uspreventiveservicestaskforce.org>).

The Community Preventive Services Task Force has related recommendations on collaborative care approaches to managing depression, mental health parity policy, and home-based depression care for older adults (available at <http://www.thecommunityguide.org/mentalhealth/index.html>).

In 2012, the U.S. Surgeon General and the National Action Alliance for Suicide Prevention released the National Strategy for Suicide Prevention, which includes goals and objectives for action (available at <http://www.surgeongeneral.gov/library/reports/>

[national-strategy-suicide-prevention/full-report.pdf](http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf)).

The Suicide Prevention Resource Center, supported by the Substance Abuse and Mental Health Services Administration, offers various resources on suicide prevention (available at <http://www.sprc.org>).

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The "Other Considerations," "Discussion," "Update of Previous Recommendation," and "Recommendations of Others" sections of this recommendation statement are available at <http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/suicide-risk-in-adolescents-adults-and-older-adults-screening>.

The USPSTF recommendations are independent of the U.S. government. They do not represent the views of the Agency for Healthcare Research and Quality, the U.S. Department of Health and Human Services, or the U.S. Public Health Service.

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