May 9, 2022

Carol M. Mangione, M.D., M.S.P.H.
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 Children and Adolescents

Dear Chair Dr. Mangione:

The American Psychological Association, the nation’s largest scientific and professional organization representing the discipline and profession of psychology with more than 133,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in the field of psychology, is writing to respectfully urge that the draft Recommendations Statement released by the U.S. Preventive Services Task Force (USPSTF) on screening for depression and suicide risk in children and adolescents be revised. We support the recommendation to screen for major depressive disorder (MDD) in asymptomatic adolescents. We understand why the Task Force did not issue a recommendation to screen for MDD in asymptomatic younger children or to screen for suicide risk in asymptomatic children and adolescents, but we urge the Task Force to modify their report to include more of the content of the evidence review in light of the current national emergency in children and youth mental health.

Between April and October 2020, the proportion of children between the ages of 5 and 11 and adolescents ages 12 to 17 visiting an emergency room due to a mental health crisis increased by 24% and 31%, respectively.1 In recent months, children’s hospitals have reported their highest number of children “boarding” in hospital emergency departments awaiting treatment.2 During the first three quarters of 2021, children’s hospitals reported a 14% increase in mental health-related emergencies and a 42% increase in cases of self-injury and suicide, compared to the same time period in 2019.3 And concerning suicide mortality, youth suicide rates have been rising steadily since 2013. While 2020 saw a

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hopeful decrease in the overall national suicide rate, this was not the case for youth and young adults, for whom suicide rates increased over the previous year.

Faced with such data, in December 2021, the U.S. Surgeon General issued an advisory calling for a unified national response to the mental health challenges young people are facing.4 Considering the rarity of such advisories, this further underscores the need for action to help stem the long-term impacts of the pandemic on the mental health and well-being of children and adolescents.

While the Task Force determined there was insufficient research that met inclusion or quality criteria to be able to make a recommendation statement, the APA believes there is significant concern about youth suicide and a body of evidence to encourage such screenings.

Routine screening in primary care pediatric settings and emergency department settings detects suicidal ideation and behavior in meaningful ways that can lead to potentially lifesaving actions in these clinical settings. Further, studies have found screening to be feasible in medical settings. One body of evidence even finds that patients, parents, and clinicians support the use of suicide screening in medical settings. It has also been demonstrated that screening for depression alone can miss suicidal ideation and behavior risk in as much as 30-50% of cases.

Given this growing body of evidence that supports the validity, feasibility, and patient/parent/clinician acceptability of suicide screening, along with the grave youth mental health and suicide crisis, we urge the Task Force to expand the Practice Considerations section of the current recommendation statement, and in particular the Suggestions for Practice Regarding the I Statement section. We recommend including stronger language in this section to acknowledge the need to prevent youth suicide and the potential benefit of screening as a method to identify at-risk youth whose risk would otherwise go undetected. We also recommend adding language acknowledging universal screening as an avenue toward equity, since Black and Hispanic youth show concerning trends in suicidal behavior and mortality, and implicit bias still deters clinicians from recognizing mental health distress in minoritized populations. Additionally, including language that emphasizes whenever clinicians have concerns regarding the patient, screening is an appropriate course of action given the existence of effective, validated screening instruments, the lack of harms associated with screenings, and the importance of evidence-informed care steps that are patient centered and culturally sensitive.

Also, the evidence review that led to these recommendations statements notes important risk factors for youth suicide. These should be highlighted in the Task Force report to guide primary care practitioners when meeting with asymptomatic youth. For instance, as noted in the report, adverse childhood experiences and mental health disorders are the “most substantial” risk factors for youth suicide. Clinicians should understand that screening youth for mental disorders and adverse childhood experiences is an important component of routine care and positive screening should lead to more detailed screening regarding suicide risk. The evidence report also notes other risk factors including “physical and sexual abuse, bullying, social isolation and loneliness, impulsivity, very high or very low engagement in health behaviors, low concentrations of serotonin metabolism; and variations in genes related to serotonin synthesis, transport, signaling, and catabolism.” Mechanisms to identify and flag

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these risk factors in clinical records are imperative so that clinicians are more adept at recognizing asymptomatic youth at higher risk and proceeding with routine screening.

We also encourage the Task Force to use stronger language in the Research Needs and Gaps section to highlight the urgent need for further research, especially as it pertains to suicide screening and care for minoritized youth populations. We applaud the Task Force’s inclusion of these areas in the 2020 10th Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services and urge the Task Force to consider these areas for inclusion in the 2022 Report to Congress as well.

There has never been a more urgent time for implementing effective suicide prevention initiatives, and leading health policy initiatives are responding. For example, Bright Futures revised their recommendations in January of this year to encourage pediatricians to routinely perform suicide screening for patients ages 12 and up. Similarly, the new Blueprint for Youth Suicide Prevention released by the American Academy of Pediatrics and the American Foundation for Suicide Prevention in March 2022 recommends the same universal pediatric suicide screening starting at age 12, and outlines evidence-informed care steps to take for youth who screen positive. These include brief "interventions" that can be feasibly done in a primary care setting: lethal means counseling, safety planning, education of parents and youth, and supportive ongoing follow up communication in addition to crisis resources and referrals.

We urge the Task Force to underscore in this report the current mental health crisis faced by youth and expand the report to provide appropriate considerations for primary care clinicians at this time. Many researchers, mental health consumer organizations, and clinicians recognize the critical importance of screening for major depressive disorder and for suicide risk to aid our nation’s children and youth and primary care clinicians will turn to this report to better understand what they can do in practice. The Blueprint should be added to the “Additional Tools and Resources” section but more importantly, greater direction and urging of practitioners to identify youth in need is warranted.

Sincerely,

Arthur C. Evans Jr., PhD
Chief Executive Officer

cc: USPSTF Members