

May 9, 2022

Carol M. Mangione, M.D., M.S.P.H.

Chair

U.S. Preventive Services Task Force
5600 Fishers Lane
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Rockville, MD 20857

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

Dear Chair Dr. Mangione:

The Kennedy Forum is grateful for the opportunity to share comments on 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. The Kennedy Forum supports the recommendation to screen for major depressive disorder (MDD) in asymptomatic adolescents. While 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, we have concerns about the decision related to suicide screening and encourage the USPSTF to further review the available research, detailed below, and consider adding a recommendation for suicide screening for youth ages 12 and older.

The [US Surgeon General](https://www.hhs.gov/about/news/2021/12/07/us-surgeon-general-issues-advisory-on-youth-mental-health-crisis-further-exposed-by-covid-19-pandemic.html) and [other groups](https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/) recently declared a state of emergency related to youth mental health. Suicide is the second leading cause of death among youth 10-17 years of age in the United States (and in many places globally), with significant disparities by race, ethnicity, gender, and sexual identity. Suicide and suicidal behavior among youth– are a major public health crisis. While the overall U.S. suicide rate decreased in 2020 for the second consecutive year, the decline was not experienced by all demographic groups; youth, young adults, Black and Hispanic males and multi-racial females all showed concerning increases in suicide rates during the early phase of the pandemic. Our children should grow, thrive and live long, healthy lives. Yet over a quarter of youth deaths in the U.S. are from suicide, which could potentially be prevented. Preventing youth suicide depends on several strategies from the public health model, but chief among them is identifying those at risk so that supportive strategies can be employed.

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]](#footnote-1) In recent months, children’s hospitals have reported their highest number of children “boarding” in hospital emergency departments awaiting treatment.[[2]](#footnote-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]](#footnote-3)

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]](#footnote-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.

Our organization supports universal screening for suicide risk in youth ages 12 and older. This screening recommendation is included in the AAP/AFSP [*Blueprint for Youth Suicide Prevention.*](http://www.aap.org/suicideprevention) In addition, the 2022 update to the AAP/Bright Futures Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) recommends screening for suicide risk for all youth ages 12 and older. The Task Force determined there was insufficient research that met inclusion or quality criteria to be able to make a recommendation statement, however our organization is aware of the substantial and growing body of evidence that support the implementation of such screenings. Moreover, many suicidal youth presenting to primary care do not have overt signs of distress or mental illness.

We respectfully encourage the USPSTF to review the attached research and to consider changing the “I” recommendation for screening for suicide risk in asymptomatic children and adolescents.

Given the growing body of evidence that supports the validity, feasibility, acceptability of suicide screening that can be paired with evidence-based support, along with the grave youth mental health and suicide crisis, we respectfully urge the Task Force to review the evidence further and consider aligning with Bright Futures and the AAP Blueprint for Youth Suicide Prevention in recommending routine suicide screening starting at age 12.

We also encourage 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 potentially critical benefit of universal 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, when clinicians have concerns regarding the patient, language should be included that emphasizes 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.

It has been well established by research that asking about suicidal thoughts does not cause harm.[[5]](#footnote-5),[[6]](#footnote-6)  We also know that screening for depression misses approximately 30% of youth who are experiencing thoughts of suicide or have made a suicide attempt, largely because depression isn’t the only risk factor for suicide, and the single suicide-related item in the most commonly used depression screening instrument (item #9 of the PHQ-9) often fails to identify individuals whose suicide risk is elevated. Suicide is dynamic and complex, and stems from the combined effect of factors including mental and behavioral health conditions such as depression, anxiety, ADHD, psychosis, eating disorders, substance use, as well as current life stressors such as interpersonal conflict in the home, bullying, and trauma, among others.

There has never been a more urgent time for implementing effective suicide prevention initiatives, and leading health policy initiatives are responding. Screening for suicide risk among youth 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 parents and youth, and supportive ongoing follow up communication in addition to crisis resources and referrals.

We urge the Task Force to expand the report to provide appropriate considerations for primary care clinicians at this time of national crisis related to youth suicide and mental health. Thank you for your consideration.

Sincerely,



Amy Kennedy

Education Director

The Kennedy Forum

cc: USPSTF Members

**Research for Consideration**

There are validated approaches to assessing suicide risk in pediatric patients, including in primary care outpatient settings

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There are evidence-based suicide prevention treatments for pediatric patients

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