Suicidality Screening Guidelines Highlight the Need for Intervention Studies

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The revised US Preventive Services Task Force (USPSTF) guidelines advise screening for major depressive symptoms in primary care (B statement), as in past iterations. The evidence base on this point is compelling. Major depressive disorder itself contributes massively to morbidity and mortality worldwide, and for almost every other illness, the presence of depression can make the management of that illness more difficult. The depression screening instruments have repeatedly been shown to have good sensitivity for identifying depressive episodes. Depression treatments, whether pharmacologic or psychosocial, have repeatedly demonstrated efficacy compared with placebo treatment. The effect sizes of such treatments may be smaller than we might hope, but notwithstanding some popular misconceptions to the contrary, their effect sizes are clinically significant.

But while physicians are advised to screen for depression, the guidelines explicitly do not advise for or against screening for the most feared complication of depression, suicide risk (I statement). In general, guidelines in other disorders would advise for screening for the disorder as well as its major complications. What accounts for this apparent inconsistency?

The lack of a recommendation is not attributable to a lack of potential impact: suicide represents a leading cause of death in the US. The screening measures themselves are valid, insofar as they estimate future risk, although as the USPSTF report notes, the positive predictive value is very low. But the USPSTF conclusions rest primarily on a paucity of evidence that interventions to prevent suicide are efficacious—primarily drawn from studies of self-harm in borderline personality disorder. The report emphasizes that, absent sufficient data, it cannot advise for or against screening for suicidality.

But if there are effective treatments for depression, and depression is a risk factor for suicide, it should follow that treating depression reduces suicide risk. This association has been profoundly difficult to demonstrate. The notable exception is among adults aged 65 years and older, for whom an analysis of clinical trials data by the US Food and Drug Administration (FDA) found that antidepressants were associated with a significant diminution in risk of suicidal thoughts and behaviors compared with placebo.

There are a multitude of reasons that diagnosis and treatment of depression is important, many outlined in the USPSTF report. Unfortunately, there remains a lack of clinical trials demonstrating antisuicide efficacy for most antidepressant interventions. Notably, emerging short-term studies do support benefit for acute interventions, such as ketamine infusion, but these interventions remain inaccessible to most patients, as public and private insurance generally will not yet pay for them.

In fact, perhaps the most important impact of the USPSTF guidelines is to underscore the mismatch between the amount of discussion of suicidality and the amount of data. In light of the indisputable public health impact, it is worth considering why we lack such studies.

The differential diagnosis here is broad. These studies are challenging to conduct, human research ethics committees make them even harder, and funding organizations that support trials do not invest sufficiently in them. They are challenging to conduct because the outcome itself is rare and existing interventions may not have large effects, even if they are clinically meaningful, necessitating large studies and potentially yielding underpowered studies. This challenge can be mitigated somewhat by enriching trials for individuals who are more severely ill or who are at higher risk, but here well-intentioned human research ethics committees make it extraordinarily difficult to study this population, precisely because it is considered vulnerable. Witness the proliferation of...
studies using the Patient Health Questionnaire 8-item but omitting the suicide item to avoid having to respond to a positive response on this item. There is great irony in considering a group of patients too sick to study.

Funding agencies also contribute. Clinical trials are costly. Federal funding for randomized trials in high-risk populations remains sparse, despite emphasis on studying other aspects of suicide. For the pharmaceutical companies themselves, there is little to gain and much to lose by investing in high-risk studies that might tarnish their new medications just as they come to market for more traditional indications.

Filling this gap will require psychiatry, and medicine more broadly, to encourage and expand the cadre of researchers engaged in trying to study suicide. Top-down commitments to supporting this work from funders would help, as would FDA expressions of willingness to approve treatments specifically for suicidality. Human research ethics committees must recognize the pressing need for such studies and be open to new designs. And advocacy groups must recognize that, however well-intended the “zero suicide” drumbeat is, it is unrealistic at present: this statement inadvertently inhibits our ability to learn about suicide by diverting investigators from studying high-risk populations.

Ultimately, however, pressure on these groups will need to come from people with depression, from their families, and from the health care practitioners who care for them. The US Surgeon General’s speaking about suicide and the launch of the National Suicide Prevention Lifeline are important steps but not solutions. The call cannot just come from psychiatry; it must come from the very primary care physicians to whom the USPSTF is speaking. As physicians, advocating for our patients means advocating for the knowledge necessary to care for our patients. The USPSTF’s statement, far from directing us away from suicide prevention, should instead prompt a reevaluation of why we know so little, and how we fill that gap.

ARTICLE INFORMATION
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REFERENCES

