



## Complete Summary

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### GUIDELINE TITLE

Screening for suicide risk: recommendation statement.

### BIBLIOGRAPHIC SOURCE(S)

Screening for suicide risk: recommendation and rationale. Ann Intern Med 2004 May 18;140(10):820-1. [4 references] [PubMed](#)

### GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 50, Screening for suicide risk. p. 547-54.

## COMPLETE SUMMARY CONTENT

SCOPE  
METHODOLOGY - including Rating Scheme and Cost Analysis  
RECOMMENDATIONS  
EVIDENCE SUPPORTING THE RECOMMENDATIONS  
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS  
QUALIFYING STATEMENTS  
IMPLEMENTATION OF THE GUIDELINE  
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES  
IDENTIFYING INFORMATION AND AVAILABILITY  
DISCLAIMER

## SCOPE

### DISEASE/CONDITION(S)

Mood disorders or other mental disorders, comorbid substance abuse disorders, history of deliberate self-harm, a history of suicide attempts, and other conditions associated with a higher than average risk of suicide

### GUIDELINE CATEGORY

Prevention  
Screening

### CLINICAL SPECIALTY

Family Practice  
Internal Medicine  
Preventive Medicine

## **INTENDED USERS**

Advanced Practice Nurses  
Allied Health Personnel  
Nurses  
Physician Assistants  
Physicians

## **GUIDELINE OBJECTIVE(S)**

- To summarize the current U.S. Preventive Services Task Force (USPSTF) recommendations on screening for suicide risk and the supporting scientific evidence
- To update the 1996 recommendations contained in the *Guide to Clinical Preventive Services*, Second Edition: Periodic Update

## **TARGET POPULATION**

Patients seen in primary care settings

## **INTERVENTIONS AND PRACTICES CONSIDERED**

Screening for suicide risk using established risk factors (e.g., mood disorders or other mental disorders, comorbid substance abuse disorders, history of deliberate self-harm, and a history of suicide attempts) and screening instruments (e.g., Scale for Suicide Ideation; Scale for Suicidal Ideation-Worst; Suicidal Ideation Screening Questionnaire; and the Symptom-Driven Diagnostic System for Primary Care)

**Note:** Treatment interventions including problem-solving therapy, dialectical behavior therapy, interpersonal psychotherapy, and group therapy are considered but not recommended.

## **MAJOR OUTCOMES CONSIDERED**

- **Key Question No. 1:** Does screening for suicide risk in primary care settings result in decreased attempts and/or decreased mortality?
- **Key Question No. 2:** Can a screening test reliably detect suicide risk in primary care populations?
- **Key Question No. 3:** Main outcome: For those identified as being at risk, does treatment result in decreased suicide attempts and/or decreased mortality from suicide?
- **Key Question No. 4:** Intermediate outcome: For those identified as being at risk, does treatment result in decreased suicidal ideation, decreased depressive severity, decreased hopelessness, or improved level of functioning?
- **Key Question No. 5:** What are the harms of screening?
- **Key Question No. 6:** What are the costs of screening?
- **Key Question No. 7:** What are the harms of treatment?

- **Key Question No. 8:** What are the costs of treatment?

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

**Note from the National Guideline Clearinghouse (NGC):** A systematic evidence review was prepared by the Research Triangle Institute (RTI) International-University of North Carolina Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

#### Search Strategy

Using methods established by the USPSTF, EPC staff developed an analytic framework and key questions to guide the literature search. The population of interest was primary care patients with unidentified suicide risk.

To identify relevant articles, EPC staff searched the MEDLINE® database from 1966 to October 17, 2002, beginning with the terms *suicide* or *suicide, attempted*. They supplemented these sources by using the same search terms in PsycINFO, searching the Cochrane Collaboration Library, and hand searching the bibliographies of systematic reviews, relevant original articles, and the 1996 edition of the *Guide to Clinical Preventive Services*. They additionally reran searches using *deliberate self-harm* as a search term and identified no further articles.

#### Inclusion and Exclusion Criteria

Two EPC staff members independently reviewed all titles and abstracts. If either reviewer determined that the study met inclusion criteria, the full paper was retrieved for further evaluation. The studies were subsequently reviewed by both staff members to determine final inclusion. Disagreements were adjudicated by consensus discussion.

### NUMBER OF SOURCE DOCUMENTS

Not stated

### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

## **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

The U.S. Preventive Services Task Force (USPSTF) grades the **quality of the overall evidence** for a service on a 3-point scale (good, fair, poor):

### **Good**

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

### **Fair**

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

### **Poor**

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

## **METHODS USED TO ANALYZE THE EVIDENCE**

Systematic Review with Evidence Tables

## **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

**Note from the National Guideline Clearinghouse (NGC):** A systematic evidence review was prepared by the Research Triangle Institute (RTI) International-University of North Carolina Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

### **Synthesis of the Literature**

Two standardized data abstraction forms were developed, one for studies that addressed screening for suicide risk and the other for those addressing treatment. The forms were pretested by the three authors and modifications were made based on the findings of the pretest. For the studies that met the inclusion criteria, a primary reviewer abstracted relevant information onto the appropriate abstraction form. Another member of the EPC staff entered the information from the abstraction forms into the evidence tables. The primary reviewer for each study checked the accuracy of the evidence table entries, and the two other authors checked the clarity of the information.

To characterize the quality of the included studies, the internal and external validity was rated for each article using criteria developed by the U.S. Preventive Services Task Force Methods Work Group. In addition to these criteria, validity

was further assessed as follows: Internal validity considered the proportion of eligible patients who consented to participate as a key factor. External validity focused on the study population's relevance to our population of interest: primary care patients with unidentified suicide risk. For all treatment studies, several quality factors were assessed, such as whether inclusion criteria were used and whether attrition between groups was similar; for randomized controlled trials, in particular, the reviewers further evaluated the adequacy of randomization and allocation concealment and whether an intention to treat analysis was conducted. For each study, the primary reviewer rated internal and external validity per the above criteria initially. Subsequently, these ratings were reviewed by the EPC staff to reach consensus agreement. Finally, the first author reviewed all quality ratings to ensure consistency in the ratings.

Apart from grading individual study quality, the reviewers also assessed the aggregate internal and external validity and coherence (agreement of the results of the individual studies) for each of the key questions in the analytic framework.

## **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Balance Sheets  
Expert Consensus

## **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to "balance sheets") are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive service affect benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a "close-call," then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):21-35.

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

The USPSTF grades its **recommendations** according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

### **A**

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

### **B**

The USPSTF recommends that clinicians provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

### **C**

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve

health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

## **D**

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

## **I**

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

Comparison with Guidelines from Other Groups  
External Peer Review  
Internal Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center (EPC) and the Agency for Healthcare Research and Quality (AHRQ) send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations, and federal agencies. These comments are discussed before the whole U.S. Preventive Services Task Force before final recommendations are confirmed.

Recommendations of Others. Recommendations regarding screening for suicide risk were considered from the following groups: the Canadian Task Force on Preventive Health Care, the American Academy of Pediatrics; the American Academy of Child and Adolescent Psychiatry and the American Medical Association.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening by primary care clinicians to detect suicide risk in the general population. **I recommendation.**

*The USPSTF found no evidence that screening for suicide risk reduces suicide attempts or mortality. There is limited evidence on the accuracy of screening tools to identify suicide risk in the primary care setting, including tools to identify those at high risk (see Clinical Considerations). The USPSTF found insufficient evidence that treatment of those at high risk reduces suicide attempts or mortality. The USPSTF found no studies that directly address the harms of screening and treatment for suicide risk. As a result, the USPSTF could not determine the balance of benefits and harms of screening for suicide risk in the primary care setting.*

### Clinical Considerations

- The strongest risk factors for attempted suicide include mood disorders or other mental disorders, comorbid substance abuse disorders, history of deliberate self-harm (DSH), and a history of suicide attempts. Deliberate self-harm refers to intentionally initiated acts of self-harm with a non-fatal outcome (including self-poisoning and self-injury). Suicide risk is assessed along a continuum ranging from suicidal ideation alone (relatively less severe) to suicidal ideation with a plan (more severe). Suicidal ideation with a specific plan of action is associated with a significant risk for attempted suicide.
- Screening instruments are commonly used in specialty clinics and mental health settings. The test characteristics of most commonly-used screening instruments (Scale for Suicide Ideation [SSI], Scale for Suicide Ideation – Worst [SSI-W], and the Suicidal Ideation Questionnaire [SIQ]) have not been validated to assess suicide risk in primary care settings. There has been limited testing of the Symptom-Driven Diagnostic System for Primary Care (SDDS-PC) screening instrument in a primary care setting.

### Definitions:

### Strength of Recommendations

The USPSTF grades its **recommendations** according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

### **A**

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The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

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## **I**

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective, is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

### **Strength of Evidence**

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#### **Poor**

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### **CLINICAL ALGORITHM(S)**

None provided

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The type of evidence supporting the recommendations is identified in the "Major Recommendations" field.

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

- Decreased suicide attempts
- Decreased mortality from suicide

### **POTENTIAL HARMS**

Not stated

## **QUALIFYING STATEMENTS**

### **QUALIFYING STATEMENTS**

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

## **IMPLEMENTATION OF THE GUIDELINE**

### **DESCRIPTION OF IMPLEMENTATION STRATEGY**

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and

feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its [Web site](#). The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

## **IMPLEMENTATION TOOLS**

Foreign Language Translations  
Patient Resources  
Personal Digital Assistant (PDA) Downloads  
Pocket Guide/Reference Cards

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## **INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES**

### **IOM CARE NEED**

Staying Healthy

**IOM DOMAIN**

Effectiveness  
Patient-centeredness

**IDENTIFYING INFORMATION AND AVAILABILITY**

**BIBLIOGRAPHIC SOURCE(S)**

Screening for suicide risk: recommendation and rationale. Ann Intern Med 2004 May 18;140(10):820-1. [4 references] [PubMed](#)

**ADAPTATION**

Not applicable: The guideline was not adapted from another source.

**DATE RELEASED**

1996 (revised 2004 Apr)

**GUIDELINE DEVELOPER(S)**

United States Preventive Services Task Force - Independent Expert Panel

**GUIDELINE DEVELOPER COMMENT**

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

**SOURCE(S) OF FUNDING**

United States Government

**GUIDELINE COMMITTEE**

U.S. Preventive Services Task Force (USPSTF)

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*\*Members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to [www.ahrq.gov/clinic/uspstfab.htm](http://www.ahrq.gov/clinic/uspstfab.htm).*

## **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. *Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med* 2001 Apr;20(3S):21-35.

## **GUIDELINE STATUS**

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. *Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 50, Screening for suicide risk. p. 547-54.*

## **GUIDELINE AVAILABILITY**

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#). Also available from [Annals of Internal Medicine Online](#) and the [National Library of Medicine's Health Services/Technology Assessment Text \(HSTAT\) Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

## AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Gaynes BN, West SL, Ford CA, Frame P, Klein J, Lohr KN. Screening for suicide risk in adults: a summary of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med* 2004 May 18;140(10):822-35.

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#). Also available from [Annals of Internal Medicine Online](#).

- Screening for suicide risk: systematic evidence review for the U.S. Preventive Services Task Force. Rockville (MD); Agency for Healthcare Research and Quality; 2004 May (Systematic Evidence Review No. 32).

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt JS. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):36-43.

Electronic copies: Available from [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

The following are also available:

- The guide to clinical preventive services, 2006. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2006. 228 p. Electronic copies available from the [AHRQ Web site](#).
- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2002 May. 189 p. Electronic copies available from the [AHRQ Web](#)

[site](#). See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

The [Electronic Preventive Services Selector \(ePSS\)](#), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors.

## **PATIENT RESOURCES**

The following is available:

- The pocket guide to good health for adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#). Copies also available in Spanish from the [USPSTF Web site](#). See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

- Screening to identify primary care patients who are at risk for suicide: recommendations from the U.S. Preventive Services Task Force. *Ann Intern Med* 2004 May 18;140(10):I-49.

Electronic copies: Available from the [Annals of Internal Medicine Online Web site](#).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## **NGC STATUS**

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This summary was updated by ECRI on May 18, 2004. The information was verified by the guideline developer on May 20, 2004.

## **COPYRIGHT STATEMENT**

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## **DISCLAIMER**

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