**Recommendations on Living Systematic Review/Active Literature Surveillance (SPRINT Evidence Review Workgroup 2020)**

In 2020, the Workgroup reviewed current evidence-based clinical practice guidelines1, prior evidence synthesis reports and publications2, and active research and evaluation projects in suicide prevention3 to identify areas in the suicide prevention field which may be ready for the development of a *living systematic review (LSR) or ongoing active literature surveillance*. The evaluation was based on the following criteria for the appropriateness of establishing an LSR4:

* The topic is of sufficient importance to decision-making
* Certainty in existing evidence is low or very low; *new information is likely to change understanding of the evidence base*
* There is likely to be new evidence; the topic area is moving relatively quickly, and new evidence is emerging

Summary Considerations: Non-pharmacological, clinical interventions (e.g., psychotherapy), especially among acute-risk individuals, have had considerable attention in the empirical literature and there are several related studies underway. Clinical guideline recommendations conflict with one another on use of modalities such as cognitive behavioral therapy or dialectical behavioral therapy for prevention of suicide. While the 2019 VA-DoD clinical practice guidelines report a “strong for” recommendation for these modalities, our group did not feel that the current strength of evidence supports a strong recommendation, although this could change in the near future. Ongoing studies of other modalities, such as CAMS and brief psychotherapies, may also produce new, important evidence in the short term.

The evidence for use of pharmacological interventions in the clinical setting, especially Ketamine and Lithium, is similarly poised to shift over the short term. Evidence-based practice guidelines conflict in their recommendations for use of these medications for reducing suicide risk, yet there are several ongoing trials that are expected to produce relevant findings in the coming few years. VA-DoD guidelines currently state a “weak” recommendation for use of these medications, while other guidelines provide stronger recommendations for their use. Antidepressants, especially when used alone, remain controversial with respect to influencing suicide outcomes in nearly all guidelines.

Non-pharmacological, non-clinical, individual-level interventions (e.g., caring contacts, educational modalities) as well as technology-assisted/enhanced psychotherapy are also important areas to monitor, though may not be yet ready for an LSR. Non-pharmacological, non-clinical, individual-level interventions are not well studied. Caring contact interventions are by themselves a promising area with several studies underway, but this alone may not be enough to warrant the resources of an LSR. Technology-assisted/enhanced psychotherapy is emerging as a well-studied area but has been methodologically difficult and additional work is needed to create consensus around definitions and approaches in this area.

Finally, as much of the currently ongoing research is focusing on high- or acute-risk patients, we believe that if a living systematic review were to be developed in the near-term, it should be focused on this patient population.

1. **Proposed Key Questions for a suicide prevention LSR/active literature surveillance, in order of priority**:

a. What is the efficacy/effectiveness and harms of non-pharmacological clinical interventions for acute-risk patients?  
b. What is the efficacy/effectiveness and harms of pharmacological interventions for acute-risk patients?  
c. What is the efficacy/effectiveness and harms of non-clinical, non-pharmacological individual-level interventions for acute-risk patients?

2. **Recommended target populations, in order of priority**: Acute-risk patients (patients with a recent psychiatric hospitalization, recent suicide attempt, or active suicidal ideation with plan); moderate risk patients seen in emergency department or crisis line settings (suicidal ideation)

3. **Recommended outcomes, in order of priority**: Fatal or non-fatal suicidal self-directed violence; Suicidal ideation severity

4. **Recommended frequency of searching all sources for new evidence**: Quarterly

**Follow-Up**: In discussions of these considerations with leadership in ORD, the Office of Mental Health and Suicide Prevention (OMHSP), and VA Evidence-based Synthesis Program, we determined that the field is not yet in need of a living systematic review. Several non-pharmacological clinical interventions are in use or being implemented now and newly emerging evidence is unlikely to change policy or practice in the near term. Evidence for pharmacological interventions, such as Ketamine and Lithium, may shift over the coming years, but the shift is unlikely to happen at a pace requiring a living review; periodic reviews may suffice. Finally, there remains significant heterogeneity in other individual-level, non-clinical interventions that suggests a living review is not warranted at this time.

Surveillance of these areas is ongoing by the OMHSP Suicide Prevention Program and others, and we will re-evaluate the need for a living review as the field changes or new evidence suggests one might be needed.