APPENDIX A. SEARCH STRATEGIES

ELECTRONIC DATABASE SEARCHES

Databases Searched

· MEDLINE via PubMed
· PsycINFO via OVID
· Cochrane Central Register of Controlled Trials (CCRCT) via OVID
· SocINDEX* via EBSCOHost

Search Strategies

All searches were updated September 11, 2015.

MEDLINE via PubMed
Searched March 3, 2015*

Concept	Search Terms
Suicide	(("Suicide"[Mesh]) OR "Suicidal Ideation"[Mesh]) OR "Suicide, Attempted"[Mesh]
	OR (suicide[Title/Abstract] OR suicidal[Title/Abstract] OR suicidality[Title/Abstract] OR parasuicide[Title/Abstract] OR self-harm[Title/Abstract] OR "self-directed violence"[Title/Abstract] OR parasuicidal[Title/Abstract]) NOT "non-suicidal self injury"[Title/Abstract]
Prevention	"prevention and control" [Subheading] OR "Tertiary Prevention"[Mesh] OR "Secondary Prevention"[Mesh] OR "Primary Prevention"[Mesh]
	OR (prevent*[Title/Abstract] OR control[Title/Abstract])
Risk Prediction	(((((("Risk"[Mesh]) OR "Risk Reduction Behavior"[Mesh]) OR "Risk Assessment"[Mesh]) OR "Risk Factors"[Mesh]) OR "Mass Screening"[Mesh]) OR "Validation Studies" [Publication Type]
	OR (risk[Title] OR screening[Title] OR screen[Title] OR assessment[Title] OR assessments[Title] OR questionnaire[Title] OR questionnaires[Title] OR instrument[Title] OR instruments[Title] OR tool[Title] OR tools[Title] OR scale[Title] OR scales[Title] OR measure[Title] OR measures[Title] OR correlate*[Title] OR “risk-stratification”[Title] OR predict[Title] OR predicts[Title] OR predictor[Title] OR predictors[Title]) OR (((((((ReACT Self Harm Rule[Title/Abstract]) OR Suicidal Ideation Attributes Scale[Title/Abstract]) OR Suicide Trigger Scale[Title/Abstract]) OR Cultural Assessment of Risk for suicide[Title/Abstract]) OR Affective Intensity Rating Scale[Title/Abstract]) OR Columbia Suicide Severity Rating Scale[Title/Abstract]) OR Edinburgh Risk of Repetition Scale[Title/Abstract]) OR Manchester Self Harm tool[Title/Abstract]
Limits: Humans Adults English only Last 5 years Not letters, editorials	NOT ((("Letter" [Publication Type]) OR "Editorial" [Publication Type]) OR "Comment" [Publication Type]) Filters: published from January 2008 to Present; Humans; English; Adult: 19+ years **N=3411** **After de-duplication N=2913**

***Update search on September 11, 2015; 4 additional records retrieved.**

PsychINFO via OVID
Searched March 3, 2015*
Database: PsycINFO <1806 to February Week 4 2015>
Search Strategy:
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1 suicide/ or attempted suicide/ or suicidal ideation/ (29009)
2 (suicide or suicidal or suicidality or parasuicide or self-harm or "self-directed violence" or parasuicidal).mp. (49986)
3 1 or 2 (49986)
4 exp Suicide Prevention/ or prevention.mp. or exp Suicide Prevention Centers/ (98208)
5 exp Risk Assessment/ or risk.mp. or exp Risk Factors/ (249298)
6 (risk or screening or screen or assessment or assessments or questionnaire or questionnaires or instrument or instruments or tool or tools or scale or scales or measure or measures or correlate* or "risk stratification" or predict or predicts or predictor or predictors).mp. (1380001)
7 ReACT Self Harm Rule.mp. (3)
8 Suicidal Ideation Attributes Scale.mp. (2)
9 Suicide Trigger Scale.mp. (4)
10 Cultural Assessment of Risk for suicide.mp. (5)
11 Affective Intensity Rating Scale.mp. (2)
12 Columbia Suicide Severity Rating Scale.mp. (183)
13 Edinburgh Risk of Repetition Scale.mp. (2)
14 Manchester Self Harm tool.mp. (0)
15 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 (1380001)
16 4 or 15 (1420668)
17 3 and 16 (30393)
18 limit 17 to (peer reviewed journal and human and english language and treatment & prevention and adulthood <18+ years> and from January 2008 to Present) **(1445) after deduplication N= 946**
***Update search on September 11, 2015; 244 additional records retrieved.**

Cochrane Central Register of Controlled Trials (CCRCT) via OVID
Searched March 3, 2015*
Database: EBM Reviews - Cochrane Central Register of Controlled Trials <January 2015>
Search Strategy:
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1 suicide/ or attempted suicide/ or suicidal ideation/ (488)
2 (suicide or suicidal or suicidality or parasuicide or self-harm or "self-directed violence" or parasuicidal).mp. (1720)
3 1 or 2 (1720)
4 exp Suicide Prevention/ or prevention.mp. or exp Suicide Prevention Centers/ (41007)
5 exp Risk Assessment/ or risk.mp. or exp Risk Factors/ (83788)
6 (risk or screening or screen or assessment or assessments or questionnaire or questionnaires or instrument or instruments or tool or tools or scale or scales or measure or measures or correlate* or "risk stratification" or predict or predicts or predictor or predictors).mp. (272313)
7 ReACT Self Harm Rule.mp. (0)
8 Suicidal Ideation Attributes Scale.mp. (0)
9 Suicide Trigger Scale.mp. (0)
10 Cultural Assessment of Risk for suicide.mp. (0)
11 Affective Intensity Rating Scale.mp. (0)
12 Columbia Suicide Severity Rating Scale.mp. (11)
13 Edinburgh Risk of Repetition Scale.mp. (0)

14 Manchester Self Harm tool.mp. (0)
15 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 (272313)
16 4 or 15 (293030)
17 3 and 16 (1319)
18 limit 17 to (peer reviewed journal and human and english language and treatment & prevention and adulthood <18+ years> and from January 2008 to Present) [Limit not valid; records were retained] **(583) after deduplication 342**
***Update search on September 11, 2015; 202 additional records retrieved.**

SocINDEX* via EBSCOHost
Searched March 6, 2015
Search Strategy:

S1 TI suicide OR suicidal OR suicidality OR parasuicide OR self-harm OR "self directed violence" OR parasuicidal
S2 DE "HEALTH risk assessment" OR DE "SUICIDAL behavior -- Risk factors"
S3 DE "SUICIDE" OR DE "SUICIDAL behavior"
S4 DE "SUICIDE prevention" OR DE "PREVENTIVE medicine"
S5 TI prevent* OR control OR risk OR screen OR screen OR assessment OR assessments OR questionnaire OR questionnaires OR instrument OR instruments OR tool OR tools OR scale OR scales OR measure OR measures OR correlate* OR "risk-stratification" OR predict OR predicts OR predictor OR predictors
S6 S1 OR S3
S7 S2 OR S4 OR S5
S8 S6 AND S7
S9 S6 AND S7 Limiters - Date of Publication: 20100101-20151231
N= (317) 223 after deduplication
***Update search on September 11, 2015; 0 additional records retrieved.**

GREY LITERATURE SEARCHES

Search Strategies

All grey literature searches were completed on July 16, 2015.

Conferences and Organizations:	
American Association of Suicidology	http://www.suicidology.org/
DOD VA Suicide Prevention Conference	http://www.suicideoutreach.org
International Suicide Summit	http://www.suicide-research.org/
American Foundation of Suicide Prevention	https://www.afsp.org/
Military Suicide Research Consortium	https://msrc.fsu.edu/
The Mental Illness Research, Education and	http://www.mirecc.va.gov/

Clinical Centers (MIRECC)	
Suicide Prevention Resource Center	http://www.sprc.org
Other Sources:	
ClinicalTrials.gov	http://clinicaltrials.gov
NIH RePORTER	http://projectreporter.nih.gov/reporter.cfm
Journals Searched Individually:	
Depression and Anxiety	http://onlinelibrary.wiley.com/journal/10.1002/%28ISSN%291520-6394
JAMA Psychiatry	http://archpsyc.jamanetwork.com/Solr/advancedSearch.aspx
Injury Prevention	http://injuryprevention.bmj.com/search
Suicide and Life-threatening Behavior	http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%291943-278X
Journal of Affective Disorders	http://www.jad-journal.com/search/advanced?seriesIssn=0165-0327&searchType=advanced&journalCode=jad
Psychiatry : Interpersonal and Biological Processes	http://www.tandfonline.com/loi/upsy20#.VTEnqpPVr0w

APPENDIX B. STUDY SELECTION

Inclusion Criteria

Category	Include	Exclude
Population	Veterans; military personnel; non-Veteran/military individuals age ≥18 who are demographically similar from US, UK, Canada, New Zealand, or Australia.	Individuals dissimilar to the included population; patients with other serious psychiatric or medical co-morbidities (*eg*, cancer).
Intervention	Population-directed healthcare services (*eg*, hotlines, outreach programs); individual-directed healthcare services (*eg*, case management, follow-up); services that are clinically relevant to medical practice in the US.	Interventions other than those specifically described in the inclusion criteria, including: interventions that primarily treat co-existing conditions, including pharmacotherapy.
Comparator	Intervention versus non-intervention, usual care, or other intervention.	Comparison groups using interventions other than those specifically described in the inclusion criteria.
Outcomes	Suicidal self-directed violence including suicide attempt and suicide; suicide-specific mortality. Additional secondary outcomes will be collected as available from studies designed primarily to capture suicidal self-directed violence. For KQ2, studies need to report a measure of diagnostic accuracy.	Self-directed violence ideation and undetermined or non-suicidal self-directed violence; other outcomes not listed as included.
Timing	All included.	No limitations.
Setting	For risk assessment and intervention studies: Veteran or military inpatient or outpatient setting; or comparable non-Veteran/military setting.	Settings not applicable to US Veteran or military populations.
Study Design	**KQ1:** Studies reporting diagnostic accuracy for methods to identify at-risk individuals using best evidence approach. Methods include risk assessment instruments and checklists of clinical symptoms and warning signs, for example; comparisons between various settings and modes of delivery, targeting specific populations, and other approaches. **KQ2:** *Effectiveness:* randomized controlled trials (RCTs); observational studies with comparison groups, systematic reviews with these study designs. *Adverse effects:* RCTs, observational studies, systematic reviews, meta-analyses, and modeling studies; others considered. **KQ3:** New studies of risk assessment and interventions specific to Veterans/military personnel.	Case reports.
Language	English-language abstracts (includes English-language abstracts of non-English language papers) and papers.	Non English-language papers.
Data Sources	Ovid MEDLINE, PubMed, PsycINFO, SocINDEX, Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, grey literature sources.	Sources not listed as included.
Search Dates	Varies by key question; for questions addressed by prior systematic reviews, searches will include dates since the prior searches.	Studies published outside of the specified search dates.

Study Selection Process

Importing Citations into EndNote Library

Search results were imported into the EndNote library and search characteristics (database name, date of search) were entered into Custom 1.

Title/Abstract Review

All titles and abstracts were reviewed to eliminate obviously irrelevant publications. A single reviewer provided decision codes that were recorded in Custom 3 of the EndNote library.

Decision codes:

R = Retrieve for full-text review
E = Exclude (not eligible for inclusion)
B = Retrieve for Background only (not eligible for inclusion)

Full-text Review

Two reviewers independently assessed the eligibility of references coded for full-text review. Each reviewer recorded a decision code. All disagreements about inclusion were resolved using a consensus process and/or review by the Principal Investigator (HDN).

Exclusion Codes:

1 = Non-English language
2 = Ineligible country (*ie*, any country other than the US, UK, Canada, New Zealand, Australia)
3 = Ineligible population or setting (*eg*, children or adolescents, patients with serious comorbidities such as cancer, nursing home populations, institutionalized populations)
4 = Study does not involve diagnostic accuracy of suicide risk assessment (KQ 1) or a healthcare service intervention to prevent suicide (KQ2)
5 = Study does not have a comparison group
6 = Ineligible outcome
7 = Ineligible study design (*eg*, case reports, case series)
8 = Ineligible publication type (*eg*, letter, editorial, publication available only as abstract, protocol without results, non-systematic review or regulatory agency analysis)
9 = Ineligible systematic review (due to scope, inclusion criteria, or limitations in quality)

APPENDIX C. CRITERIA USED IN QUALITY ASSESSMENT

Risk of Bias Assessment for Randomized Controlled Trials (RCTs): The Cochrane Collaboration Risk of Bias tool[25]

Overview

Domain	Description	Review authors' judgment
Sequence generation	Describe the method used to generate the allocation sequence in sufficient detail to allow an assessment of whether it should produce comparable groups.	Was the allocation sequence adequately generated?
Allocation concealment	Describe the method used to conceal the allocation sequence in sufficient detail to determine whether intervention allocations could have been foreseen in advance of or during enrollment.	Was allocation adequately concealed?
Blinding of participants, personnel and outcome assessors *Assessments should be made for each main outcome (or class of outcomes).*	Describe all measures used, if any, to blind study participants and personnel from knowledge of which intervention a participant received. Provide any information relating to whether the intended blinding was effective.	Was knowledge of the allocated intervention adequately prevented during the study?
Incomplete outcome data *Assessments should be made for each main outcome (or class of outcomes).*	Describe the completeness of outcome data for each main outcome, including attrition and exclusions from the analysis. State whether attrition and exclusions were reported, the numbers in each intervention group (compared with total randomized participants), reasons for attrition/exclusions where reported, and any re-inclusions in analyses performed by the review authors.	Were incomplete outcome data adequately addressed?
Selective outcome reporting	State how the possibility of selective outcome reporting was examined by the review authors, and what was found.	Are reports of the study free of suggestion of selective outcome reporting?
Other sources of bias	State any important concerns about bias not addressed in the other domains in the tool. If particular questions/entries were pre-specified in the review's protocol, responses should be provided for each question/entry.	Was the study apparently free of other problems that could put it at a high risk of bias?

Specific Criteria Details for Judging Risk of Bias by Domain

SEQUENCE GENERATION **Was the allocation sequence adequately generated? [Short form: *Adequate sequence generation*?]**	
Criteria for a judgment of 'YES' (*ie*, low risk of bias)	The investigators describe a random component in the sequence generation process such as: § Referring to a random number table; using a computer random number generator; coin tossing; shuffling cards or envelopes; throwing dice; drawing of lots; minimization.* *Minimization may be implemented without a random element, and this is considered to be equivalent to being random.

Criteria for the judgment of 'NO' (*ie*, high risk of bias)	The investigators describe a non-random component in the sequence generation process. Usually, the description would involve some systematic, non-random approach, for example: § Sequence generated by odd or even date of birth; § Sequence generated by some rule based on date (or day) of admission; § Sequence generated by some rule based on hospital or clinic record number. Other non-random approaches happen much less frequently than the systematic approaches mentioned above and tend to be obvious. They usually involve judgment or some method of non-random categorization of participants, for example: § Allocation by judgment of the clinician; § Allocation by preference of the participant; § Allocation based on the results of a laboratory test or a series of tests; § Allocation by availability of the intervention.
Criteria for the judgment of 'UNCLEAR' (*ie*, uncertain risk of bias)	Insufficient information about the sequence generation process to permit judgment of 'Yes' or 'No'.
ALLOCATION CONCEALMENT **Was allocation adequately concealed? [Short form: *Allocation concealment*?]**	
Criteria for a judgment of 'YES' (*ie*, low risk of bias)	Participants and investigators enrolling participants could not foresee assignment because one of the following, or an equivalent method, was used to conceal allocation: § Central allocation (including telephone, web-based, and pharmacy-controlled randomization); § Sequentially numbered drug containers of identical appearance; § Sequentially numbered, opaque, sealed envelopes.
Criteria for the judgment of 'NO' (*ie*, high risk of bias)	Participants or investigators enrolling participants could possibly foresee assignments and thus introduce selection bias, such as allocation based on: § Using an open random allocation schedule (*eg*, a list of random numbers); § Assignment envelopes were used without appropriate safeguards (*eg*, if envelopes were unsealed or non-opaque or not sequentially numbered); § Alternation or rotation; § Date of birth; § Case record number; § Any other explicitly unconcealed procedure.
Criteria for the judgment of 'UNCLEAR' (*ie*, uncertain risk of bias)	Insufficient information to permit judgment of 'Yes' or 'No'. This is usually the case if the method of concealment is not described or not described in sufficient detail to allow a definite judgment; for example, if the use of assignment envelopes is described, but it remains unclear whether envelopes were sequentially numbered, opaque and sealed.
BLINDING OF PARTICIPANTS, PERSONNEL AND OUTCOME ASSESSORS **Was knowledge of the allocated interventions adequately prevented during the study? [Short form: *Blinding*?]**	
Criteria for a judgment of 'YES' (*ie*, low risk of bias)	Any one of the following: § No blinding, but the review authors judge that the outcome and the outcome measurement are not likely to be influenced by lack of blinding; § Blinding of participants and key study personnel ensured, and unlikely that the blinding could have been broken; § Either participants or some key study personnel were not blinded, but outcome assessment was blinded and the non-blinding of others unlikely to introduce bias.
Criteria for the judgment of 'NO' (*ie*, high risk of bias)	Any one of the following: § No blinding or incomplete blinding, and the outcome or outcome measurement is likely to be influenced by lack of blinding;

	§ Blinding of key study participants and personnel attempted, but likely that the blinding could have been broken; § Either participants or some key study personnel were not blinded, and the non-blinding of others likely to introduce bias.
Criteria for the judgment of 'UNCLEAR' (*ie*, uncertain risk of bias)	Any one of the following: § Insufficient information to permit judgment of 'Yes' or 'No'; § The study did not address this outcome.
INCOMPLETE OUTCOME DATA **Were incomplete outcome data adequately addressed? [Short form: *Incomplete outcome data addressed*?]**	
Criteria for a judgment of 'YES' (*ie*, low risk of bias)	Any one of the following: § No missing outcome data; § Reasons for missing outcome data unlikely to be related to true outcome (for survival data, censoring unlikely to be introducing bias); § Missing outcome data balanced in numbers across intervention groups, with similar reasons for missing data across groups; § For dichotomous outcome data, the proportion of missing outcomes compared with observed event risk not enough to have a clinically relevant impact on the intervention effect estimate; § For continuous outcome data, plausible effect size (difference in means or standardized difference in means) among missing outcomes not enough to have a clinically relevant impact on observed effect size; § Missing data have been imputed using appropriate methods.
Criteria for the judgment of 'NO' (*ie*, high risk of bias)	Any one of the following: § Reason for missing outcome data likely to be related to true outcome, with either imbalance in numbers or reasons for missing data across intervention groups; § For dichotomous outcome data, the proportion of missing outcomes compared with observed event risk enough to induce clinically relevant bias in intervention effect estimate; § For continuous outcome data, plausible effect size (difference in means or standardized difference in means) among missing outcomes enough to induce clinically relevant bias in observed effect size; § 'As-treated' analysis done with substantial departure of the intervention received from that assigned at randomization; § Potentially inappropriate application of simple imputation.
Criteria for the judgment of 'UNCLEAR' (*ie*, uncertain risk of bias)	Any one of the following: § Insufficient reporting of attrition/exclusions to permit judgment of 'Yes' or 'No' (*eg*, number randomized not stated, no reasons for missing data provided); § The study did not address this outcome.
SELECTIVE OUTCOME REPORTING **Are reports of the study free of suggestion of selective outcome reporting? [Short form: *Free of selective reporting*?]**	
Criteria for a judgment of 'YES' (*ie*, low risk of bias)	Any of the following: § The study protocol is available and all of the study's pre-specified (primary and secondary) outcomes that are of interest in the review have been reported in the pre-specified way; § The study protocol is not available but it is clear that the published reports include all expected outcomes, including those that were pre-specified (convincing text of this nature may be uncommon).

Criteria for the judgment of 'NO' (*ie*, high risk of bias)	Any one of the following: § Not all of the study's pre-specified primary outcomes have been reported; § One or more primary outcomes is reported using measurements, analysis methods or subsets of the data (*eg*, subscales) that were not pre-specified; § One or more reported primary outcomes were not pre-specified (unless clear justification for their reporting is provided, such as an unexpected adverse effect); § One or more outcomes of interest in the review are reported incompletely so that they cannot be entered in a meta-analysis; § The study report fails to include results for a key outcome that would be expected to have been reported for such a study.
Criteria for the judgment of 'UNCLEAR' (*ie*, uncertain risk of bias)	Insufficient information to permit judgment of 'Yes' or 'No'. It is likely that the majority of studies will fall into this category.
OTHER POTENTIAL THREATS TO VALIDITY **Was the study apparently free of other problems that could put it at a risk of bias? [Short form: *Free of other bias*?]**	
Criteria for a judgment of 'YES' (*ie*, low risk of bias)	The study appears to be free of other sources of bias.
Criteria for the judgment of 'NO' (*ie*, high risk of bias)	There is at least one important risk of bias. For example, the study: § Had a potential source of bias related to the specific study design used; or § Stopped early due to some data-dependent process (including a formal-stopping rule); or § Had extreme baseline imbalance; or § Has been claimed to have been fraudulent; or § Had some other problem.
Criteria for the judgment of 'UNCLEAR' (*ie*, uncertain risk of bias)	There may be a risk of bias, but there is either: § Insufficient information to assess whether an important risk of bias exists; or § Insufficient rationale or evidence that an identified problem will introduce bias.

Risk of Bias Assessment for Cohort Studies[26,27]

Criteria:

- Initial assembly of comparable groups**:** consideration of potential confounders with either restriction or measurement for adjustment in the analysis; consideration of inception cohorts
- Maintenance of comparable groups (includes attrition, crossovers, adherence, contamination)
- Important differential loss to follow-up or overall high loss to follow-up
- Measurements: equal, reliable, and valid (includes masking of outcome assessment)
- Clear definition of interventions
- Important outcomes considered
- Analysis: adjustment for potential confounders.

Definition of Ratings Based on Above Criteria:

Good: Meets all criteria: Comparable groups are assembled initially and maintained throughout the study (follow-up at least 80 percent); reliable and valid measurement instruments are used and applied equally to the groups; interventions are spelled out

clearly; important outcomes are considered; and appropriate attention to confounders in analysis. In addition, for RCTs, intention to treat analysis is used.

Fair: Studies will be graded "fair" if any or all of the following problems occur, without the fatal flaws noted in the "poor" category below: Generally comparable groups are assembled initially but some question remains whether some (although not major) differences occurred in follow-up; measurement instruments are acceptable (although not the best) and generally applied equally; some but not all important outcomes are considered; and some but not all potential confounders are accounted for. Intention to treat analysis is done for RCTs.

Poor: Studies will be graded "poor" if any of the following fatal flaws exists: Groups assembled initially are not close to being comparable or maintained throughout the study; unreliable or invalid measurement instruments are used or not applied at all equally among groups (including not masking outcome assessment); and key confounders are given little or no attention. For RCTs, intention to treat is lacking.

Risk of Bias Assessment for Diagnostic/Screening Accuracy Studies*

Domain	Description
Adequate description of population?	Study describes inclusion criteria for selecting patients, demographics (at least age), and setting (primary care versus hospital versus one other)
Non-biased selection?	Study either reports enrolling (or attempting to enroll) a consecutive series of patients meeting inclusion criteria, or a random sample.
Adequate sample size?	The study reports a sample size of 500 or more patients.
Low loss to follow-up/ missing data?	Was there important differential loss to follow-up or overall high loss to follow-up? Numbers should be given for each group.
Standardized method of risk factor assessment and scoring clearly described or referenced?	Standardized, reproducible methods of assessment and scoring must be reported or referenced.
Unbiased risk factor assessment by independent assessors?	Study describes unbiased risk factor assessment by independent assessors.
Adequate outcome measurement?	Study clearly describes standardized and reproducible methods to identify/define the events - suicide attempt or behavior - in the entire population of eligible participants regardless of initial risk assessment.
Unbiased outcome measurement by independent assessors?	Study clearly describes unbiased methods to identify/define the events - suicide attempt or behavior - by independent assessors.
Adequate accounting for potential confounders?	Potential confounders are accounted for by a comparable control group or statistical methods of adjustment.

*Modified from Hayden et al 2006 and Harris et al 2001.[26,28]

APPENDIX D. PEER REVIEW COMMENTS/AUTHOR RESPONSES

Reviewer Number	Comment	Response
Are the objectives, scope, and methods for this review clearly described?		
3	No - The key questions are very confusing - unclear why effectiveness vs. efficacy; key question 3 and search strategy particularly unclear.	· Key Questions 1 and 2 use the term "effectiveness" rather than "efficacy" to reflect broader study inclusion criteria relevant to studies conducted in clinical populations and studies evaluating population-level interventions. More narrowly inclusive efficacy studies would also be included in the review. The revision uses both terms in order to clarify this. · Key Question 3 addresses research gaps based on the synthesis of findings for Key Questions 1 and 2. The studies cited in this section were also identified from the searches conducted for KQ 1 and 2, but were selectively used to highlight areas for future research that address the research gaps. This information has been clarified in the revision. In addition, tables describing relevant ongoing studies identified from our grey literature search have been added to the revision.
4	Yes	Noted.
5	Yes	Noted.
6	Yes	Noted.
7	Yes	Noted.
8	Yes	Noted.
9	No - See narrative review in the section for "Additional suggestions or comments". My greatest concern is that the criteria for selecting studies and publication for inclusion is not specified in sufficient detail to allow another investigator to follow the procedures that are specified and wind up with similar evidence tables.	Search strategies and inclusion/exclusion criteria for selecting studies for the systematic review are described in the appendix according to a standard format for systematic reviews. See above clarification regarding the search for studies included for Key Question 3.
Are there any <u>published</u> or <u>unpublished</u> studies that we may have overlooked?		
3	Yes - Per page 11 unclear by interventions that included healthcare services....were not included. This is particularly odd as review is to focus on effectiveness.	The scope of this review included healthcare service interventions other than studies of interventions to primarily treat co-conditions, as well as studies of pharmacotherapy.
4	Yes - There are multiple relevant assessment studies and clinical trials currently underway funded by the Military Suicide Research Consortium, beyond VHB and WtoH, not referenced. Details are available at	Two tables of relevant ongoing studies were added to the revision including studies from the MSRC website.

Reviewer Number	Comment	Response
	www.msrc.fsu.edu.	
5	Yes - I recently reviewed a paper using PHQ9 depression questionnaire data to predict subsequent suicidal behavior in a VA sample. I believe that paper is now accepted. I'd be happy to contact the journal for more information.	This reviewer graciously provided this study and it was considered for inclusion; however, the study was not eligible because it is not yet published and does not report a measure of diagnostic accuracy.
6	No	Noted.
7	Yes - There are at least one or two studies funded by VA and recently completed that are either in the publishing pipeline or the 'null results' file cabinet---e.g., Stephen Dobscha's recent work in primary care. I realize it's often hard to find these, but were these considered?	These studies will be added to the revision if they are available and meet inclusion criteria.
8	Yes - These may have been reviewed and not included as citations in the general text (not as selected studies for review), but I wondered if they may help update citation #12, which seems a bit dated. 1. Denneson LM, Teo AR, Ganzini L, Helmer DA, Bair MJ, Dobscha SK. Military Veterans' Experiences with Suicidal Ideation: Implications for Intervention and Prevention. Suicide & Life-Threatening Behavior. 2015 Aug 1; 45(4):399-414. 2. Dobscha SK, Denneson LM, Kovas AE, Teo A, Forsberg CW, Kaplan MS, Bossarte R, McFarland BH. Correlates of suicide among veterans treated in primary care: case-control study of a nationally representative sample. Journal of general internal medicine. 2014 Dec 1; 29 Suppl 4:853-60.	These papers include authors who are investigators for the systematic review. The references were added to the revision as contextual information in the introduction section.
9	Yes - See narrative review in the section for "Additional suggestions or comments."	See responses below.
Is there any indication of bias in our synthesis of the evidence?		
3	No	Noted.
4	No	Noted.
5	No	Noted.
6	No	Noted.
7	No	Noted.
8	No	Noted.
9	No	Noted.
Additional suggestions or comments can be provided below. If applicable, please indicate the page and line numbers from the draft report.		
3	Key questions confusing - grouping of effectiveness and adverse events -- are adverse events actually the outcome of interest (suicide). Few efficacy studies have been completed so again it is unclear why we would be moving	See above related responses.

Reviewer Number	Comment	Response
	to effectiveness. Number of studies in progress not identified - (e.g., lithium, blister packaging) which leads to even greater confusion are how data was identified for Key Question #3	
4	Overall this is a well written review summarizing relevant studies concisely. There are places where additional detail is needed, terminology could be clarified, or presentations of study findings are not as clear as one would like. These points are summarized below in order of appearance in the manuscript.	Noted.
	Executive Summary, page 1 line 19, suicide rates went up among all of the services, not just the Army. While Army rates increased the most, and the overall numbers of soldier suicides were larger than any other service due to the Army being the largest of the services, the impact on Sailors, Airmen, and Marines should not be overlooked. Page 3, line 16, the term "commit suicide" is not consistent with current nomenclature. "Died by suicide" or simply "suicide" are the preferred terms. If this was the term used in the referenced study and there is a reason the authors believe it should be maintained in the review then please place it in quotes.	Executive Summary: The point that suicide rates increased among all of the services, not just the Army, has been added to the revision. The term "commit suicide" has been changed throughout the report.
	Background, page 7 line 40, see previous comment regarding suicide rates in the other services. Line 42, I see the point being made but the wording is somewhat awkward and one could misinterpret the statistics to mean that Veteran rates increased from 20% of the U.S. population to 60%. Starting line 48, although STARRS includes "Army" in the title many people don't realize that it is a study focusing just on soldiers and not members of the other services. I suggest making that point clear and at other places in the manuscript where the study is discussed. One possible explanation for differences in STARRS results, particularly around the impact of deployments on suicide risk, is that the population sampled differs from the other large military cohort studies that have been recently published. It would be important to make that point in the review.	Background: The "20% to 60%" rise in suicide rate phrase was deleted in the revision to avoid misinterpretation. Additional information was added to the sentence describing the Army STARRS study to make it clear that it is specifically about Army soldiers, not members of the other services. The additional point about differences in STARRS results would require discussion of the risk factors described in other large military cohort studies, which is outside the scope of the background section of this report.
	Current practices, page 8 beginning line 30, there is no reference to the Zero Suicide initiative results from the Henry Ford Healthcare System in Detroit. They have published results indicating dramatic decreases in suicide deaths among their patients being treated for depression. Granted, this work was not in primary care, but it was still conducted throughout a large healthcare system treating approximately 200,000 individuals and seems relevant to cite here. I'm further confused by the lack of mention of that study here, since it is included on page 35 beginning line 52.	The Henry Ford Healthcare System Initiative is not described in the background because it was included as a study in the systematic review. Therefore, it is described in the results section.

Reviewer Number	Comment	Response
	Topic Development, page 9 line 22, again STARRS only includes data from Army soldiers. Results will likely generalize to other services and be applicable to Veterans, but those are empirical questions and it should not be assumed a priori that is the case.	Methods: Additional information was added to the sentence describing the Army STARRS study to make it clear that it is specifically about Army soldiers.
	In the description of the first individual level RCT to reduce suicide-specific outcomes on page 39 line 18 the intervention is referred to as "the cognitive behavioral therapy group", but it is individual psychotherapy. Perhaps the authors meant "condition" rather than group, but since they referred to TAU as including group therapy in the previous line this reference to the treatment condition is confusing and should be clarified.	Results: In the results section, the term "group" usually refers to comparison groups (treatment versus usual care); however, this could be confusing because treatment often included group therapy. The term "group" is now explicitly referred to as the "comparison group" when used in this context.
	The points made on page 47, beginning line 52 regarding the effectiveness of the Air Force Suicide Prevention Program are valid in general. But it seems somewhat disingenuous to criticize evaluations of the that program for not having comparison data to concurrent groups not receiving the intervention since it was a population-level intervention implemented in the entire Air Force. I suppose someone could have tried to create a demographically comparable sample from one of the other services that did not implement their own prevention program during the same time period, and compared results to that group, but the absence of such data should not be considered a limitation of the Air Force program evaluations.	The point about concurrent comparison data for the Air Force Suicide Prevention Program is intended to indicate evidence gaps and potential future research which is the purpose of Key Question 3.
	Use of the term "commit suicide" appears again on page 50, line 34. See previous comment regarding this issue for suggestions on how to address it.	See previous response regarding edits to statements that use the term "commit suicide."
	I leave it to the authors to determine the most appropriate place to add a discussion of balancing sensitivity and specificity in suicide risk assessment research. The authors define the terms and report the values for all studies which provided the statistics, but do not provide adequate context for readers to evaluate the presented data. This is a vital question for clinicians wishing to select specific measures to use in their practices, or more importantly for VA to consider in broad policy recommendations. This systematic review poses a good opportunity to address this issue in ways that can actually inform clinical practice.	Summary and Discussion: Since the primary goal of risk assessment is to identify individuals at risk for suicide, sensitivity measures were prioritized in the report. This statement and a new figure summarizing the sensitivity results for each study have been added to the revision.
5	General comment – The review is thorough, balanced, and clearly presented. I have no significant concerns regarding the methods, selection of evidence, or interpretation.	Noted.
	Specific comments/suggestions: 1) I think the presentation would be clearer if the authors adhered to the traditional classification of prevention programs: primary or universal	Regarding whether studies are primary, secondary, or tertiary prevention: There are too few studies to create additional sub-sections of this material in the report, however, details of the study participants are

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	prevention for the entire population, secondary or selective prevention for those at increased risk and tertiary or indicated prevention for those already affected. The author's current scheme appears (to me) to lump together secondary and tertiary prevention interventions. I believe that health systems should (and usually do) distinguish between these two needs. And the evidence in these two areas is quite distinct (much clearer evidence for effectiveness of tertiary prevention to prevent repeat suicide attempt than secondary prevention to prevent attempt in those at increased risk).	described in the text and table.
	2) When presenting data regarding screening or case-finding tools, I would emphasize sensitivity and PPV (and de-emphasize specificity). Specificity is markedly dependent on prevalence, and therefore much less generalizable across settings. PPV is also much more relevant to health system decision-makers (What proportion of the people we would identify would be true cases?).	See above related response.
	3) The discussion of screening or case-finding methods should probably distinguish between studies using some independent (and, ideally, prospective) ascertainment of suicidal behavior vs. those assessing risk factors and retrospectively assessing outcomes in the same cross-sectional interview. The latter method seems (at least to me) much more subject to bias.	The methods related to identifying at-risk individuals are described in more detail in the table. Additional points about methods have been added to the text as well.
	4) Even if the authors choose not to use the primary/secondary/tertiary scheme, the discussion of "individual-directed" interventions should certainly distinguish between those for at-risk populations (e.g. first-episode psychosis) and those for people with recent suicide attempts or suicidal behavior.	The participants included in each study are detailed in the text and tables.
6	Exec Summary – This section is so important and we know many read this over any other level of detail. Is it possibility to include references for the percentages cited page 1? Considering the high level scrutiny of the topic, etc.	According to the style template, references are not included in the Executive Summary.
	Page 2 – data abstraction and quality assessment, "pre-piloted" database not clear what that was referencing or is it important for exec summary? Same paragraph – suggest last sentence: … resolved through consensus – add process including all reviewers (as consensus process alone does not provide method for actual resolution).	Edits to the data abstraction and quality assessment section have been made accordingly.
	Page 3 – Line 22 included in the previous review – Previous review was not defined as far as I read in the exec summary exactly – are you referring to first sentence which includes three reviews (plural) or a specific?	The statement on page 3 refers to one of the previous reviews. To improve clarity, "a VA ESP review" was added to the statement.

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	Page 3 – Last paragraph line 58. No studies evaluated adverse effects. How is that possible if they were RCTs?	The statement about adverse effects was modified to, "No studies specifically evaluated adverse effects of the interventions."
	Page 5 – Discussion – Would you like to define "fair" predictive accuracy.	Fair diagnostic accuracy is described in a table in the Methods section (ROC AUC =0.70 to 0.79). This description was moved to the Executive Summary in order to support the discussion point.
	Page 6 – Conclusions – does it make sense to also acknowledge the inherent challenges in the work? This is just a conceptual discussion; I think agencies are working towards improvements (STARRS, the suicide prevention database, CSP trial of lithium).	This point about inherent challenges in the work has been added to the conclusions.
	Page 7 – Background – is there an opportunity end of first paragraph to also speak about risk from recent healthcare encounters/timing issues; may be appropriate in Page 8 Current Practices section instead/also. I really appreciate the Current Practices section.	The point about suicide in relationship to recent healthcare encounters has been added to the Current Practices section.
	Page 10 – Why is the alpha D, E, F used under Q1 and C, D under Q2?	The lettering for sub-questions was incorrect in the draft because of an auto formatting issue. This has been corrected in the current version.
	Page 45 – I like the discussion about the risk assessment issues. Somewhat related is an effort undertaken by NIH with VA and DoD to define common data elements for suicide prevention research http://www.research.va.gov/resources/suicide_prevention.cfm - describes the request; elements have been published in the PhenX toolkit and we are at least encouraging their use. This doesn't answer the need for more psychometric, but supports the idea of cde's for the topic going forward. Maybe this could be noted in the discussion?	The point about common data elements has been added to the discussion.
7	No comments.	Noted.
8	Page 10. It seems odd that the structure of Key Questions 1 and 2 are not the same, as they ask about very similar things. For KQ1, there is a sub-question on effectiveness of methods and a separate sub-question on adverse effects; but for KQ2, both effectiveness and adverse effects are addressed in a single sub-question. The way studies on effectiveness and adverse effects are laid out in the text are similar across both Key Questions, so it is not clear why the Key Questions are set up differently. If given a choice, I would prefer the 2 separate questions, as in KQ1, since this seems to fit slightly better with the layout of the text.	To improve consistency and efficiency, "adverse effects" was combined with "effectiveness" for both Key Questions.
	Also, under these questions on page 10, the lettering of the sub-questions seems to be out of order --where are A) and B)?	The lettering for sub-questions was incorrect in the draft due to an auto formatting issue. This has been corrected in the current version.
	In the paragraph starting on page 10, line 36, it says that adverse effects	For the purposes of study selection for the systematic review, non-

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	include any outcomes "that are not beneficial to the patients" suggesting that something with a neutral outcome -- one that does not help or hurt the patient -- would be considered adverse. Is this correct?	beneficial outcomes would be evaluated for adverse effects, but the clinical relevance of a specific outcome would need to be considered as well. Some outcomes may have a neutral effect on some patients and an adverse effect on others.
	On page 11, line 19, it seems there is either a word missing or an extra word inserted -- not sure which it is, and the sentence is unclear.	The sentence on page 11 was clarified in the revision.
	On page 12, line 21: What is it about these studies made them too heterogeneous for inclusion in a meta-analysis? The sample? The instruments? The outcome measures? The risk of bias?	Several factors made the studies too heterogeneous for meta-analysis; these factors have been added to the sentence in the revision (participants, interventions, measures, outcomes).
	On page 12, figure 2: under the box 'Excluded = 438 references', what are the ineligible systematic reviews? The criteria for judging the eligibility of systematic reviews for inclusion were not mentioned previously.	Inclusion criteria for systematic reviews have been added to the methods section in the revision.
	It is not clear why the literature reviews for both Key Questions were split into subsections based on whether the studies cited were used in the previous reviews or not; What was the justification for this? (apologies if I missed it in the text.) If it is being used to highlight changes in the literature over time, I think that focus needs to be made more explicit; maybe in a short summary section for each of the Key Questions.	Since this report is an update of parts of 3 earlier VA ESP systematic reviews, the results for each Key Question begin with a brief summary of relevant previous findings. Details of the studies are also included in tables. The revision provides a more explicit rationale for presenting the results this way, which is to consolidate the evidence.
	Page 16, line 57: Should 'analysis' be 'analyses' since it is referring to work across studies?	Here, “regression analysis” refers to the methodological approach, not necessarily each study’s analysis.
	Page 25, Table 1.3: If you are generating a table that lists the various measures of risk for SDV or suicide found in the selected studies, is there a need for the main citation for each measure to be included in the table as well, so a reader could know where to check on the key characteristics (i.e., reliability and validity) of specific measures? This basically adds another column to the table.	Additional citations for the risk instruments have been added to the Table as described by the reviewer.
	Page 50, line 6: Sentence does not seem complete.	The sentence on page 50 directs readers to tables.
	Could there be a summary paragraph at the end that highlights the advances made since the time of the previous reports, particularly with respect to the gaps that were previously identified?	Although the suggestion for a summary is helpful, few studies from the previous reviews addressed the Key Questions of this review, and these are briefly described at the beginning of each of the results sections.
9	There must be concerns about the specification of the criteria for inclusion of studies in the review as specified on page 11, rows 7-17. The text indicates “eligible studies included populations of … non-demographically comparable non-Veteran/military adults aged 18 and older ….” The statement about studies that “included … demographically	The inclusion criteria, “demographically comparable non-Veteran/military adults...” are intended to be inclusive. The exclusion criteria are more explicit and indicate that highly selective samples that would not be representative of military/Veteran populations would be excluded, including patients with other serious co-morbidities such as

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	comparable non-Veterans military adults" is vague. Does it mean that it included studies with any demographically comparable individuals or does it mean study that included only these individuals? What dimensions were included in the comparison? Without this information, it would be impossible for anyone to replicate the search and selection processes in a reliable way, or for anyone to evaluate the sensitivity of the process. If it does not specify methods that could allow replication, the article is of limited value as a systematic review. In a similar way, the text indicates that "(s)tudies enrolling participants from dissimilar populations were not included because they are less applicable to the target population of this review (eg, children and adolescents; individuals with serious psychiatric or medical comorbidities such as schizophrenia or cancer, and institutionalized populations). Alas, service members and Veterans can get serious psychiatric or medical illnesses such as schizophrenia and cancer, and they can get institutionalized. A substantial proportion of suicides among Veterans occurs among those with one serious psychiatric comorbidity, depression, and another large proportion occurs in those with schizophrenia or bipolar disorder or PTSD. Excluding these populations limits the potential utility of the review. In fact, it is unlikely that there is any study of suicide prevention that did not include individuals with "serious psychiatric …illnesses." The exclusion should be reconsidered or, at least, the text should be modified to indicate exactly what conditions were exclusionary. Most of the concerns discussed here are related to the sensitive of the methods used for identifying studies for inclusion. However, there may also be concerns about the specificity. One study (Galfavy HC, Oquendo MA, Mann JJ. Act Psychiatrica Scand 117: 244-252, 2008) discussed in detail on pages 17 and 18 included only patients with a major depressive episode and a diagnosis of major depressive disorder or bipolar disorder. All of the patients in this study had "serious psychiatric illnesses". Why was this paper, but not others, included? The text states that eligible studies included populations from the US, UK, Canada, New Zealand, and Australia. Again, does this mean that for inclusion, the studies included any individuals from these countries, or that they included only individuals from these countries. The stated rationale for including these countries was that they were "chosen because of their	advanced cancer, etc. Even though military/Veterans also experience serious illness, this report focuses on prevention in a broader population. Since depressive disorders, including many undiagnosed cases, are fairly common, studies conducted among depressed participants were included. It would be unmanageable to list all possible other exclusions. The criteria are described in the Appendix and more details have been added to the revision to address additional questions of the reviewer. The inclusion of studies performed in the selected countries is consistent with the previous reviews for which this report serves as an update. The use of the term "diagnostic accuracy study" is a category of study design that applies to studies for Key Question 1. While this may not be the best description for these studies, it is the appropriate term for the type of study. The revision minimizes its use to reduce confusion.

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	similarities to the US in terms of healthcare services as well as their involvement in the Operation Enduring Freedom/ Operation Iraqi Freedom (OEF/OIF) conflicts." The extent to which healthcare services in the UK, Canada, New Zealand, and Australia are similar to those in the US could be a matter of debate. Moreover, the selection of these countries appears arbitrary. There has been a substantial body of research on suicide prevention in other countries that participated in OEF/OIF including Germany, Italy, and the Scandinavian countries. It is not clear why the authors excluded them. Moreover, the restriction to the specified countries excluded information that is clearly relevant to military populations, e.g., findings from Israeli experience about soldier's access to firearms when they were not on duty (Lubin G, Webeloff N, Halperin D, et al, Suicide and Life Threatening Behavior 40: 421-424, 2010). The text included the statement, "For Key Question 1, included studies evaluated the diagnostic accuracy of methods …." It is not clear if including the word "diagnostic" is appropriate. This issue recurs elsewhere (e.g., page 5, line 23).	
	There are a number of studies that appear salient but are not included in the systematic review. This is of concern for two reasons. First, the findings are not included in the information presented to the readers. Second, and more important, their absence raises questions about the sensitivity and reliability of the processes used for identifying relevant studies. Two publications ([1]Kessler RC , Warner CH, Ivany C, et al. JAMA Psychiatry 72:49-57; and [2]Simon GE, Rutter CM, Peterson D, et al, Psychiatric Services 64: 1195-1202, 2013) are included in the references (Numbers 74 and 76 on page 61, respectively) and cited on page 46 in the discussion for key question #3. However, they are not included in the evidence tables or the discussion related to key question #1. This is a significant omission, not only because the findings from these studies are important, but because their absence suggests that the evidence tables may be incomplete. Findings from one VA study ([3]Ganzini L, Denneson LM, Press N, et al, Journal of General Internal Medicine 28, 1215-1221, 2013) are highly important for inclusion in the evidence base for key question #1, and for framing the discussion. Why wasn't this study included?	Although the studies identified by the reviewer are relevant to this review, studies that did not meet inclusion criteria for Key Questions 1 and 2 were not included in the evidence tables. Since Key Question 3 focuses on future research to address evidence gaps, inclusion criteria are broader, and some of these studies are described under the KQ3 section. The inclusion criteria state that studies of interventions to primarily treat co-existing conditions, as well as studies of pharmacotherapy, were not included (page 11). The scope of the review was determined by the sponsor and technical expert panel members. The review includes studies of interventions that reported suicide and other suicidal self-directed violence as outcomes; studies reporting other outcomes were excluded. Regarding specific studies mentioned by the reviewer: 1. Kessler RC, Warner CH, Ivany C, et al. Predicting suicides after psychiatric hospitalization in US Army soldiers: the Army Study To Assess Risk and rEsilience in Servicemembers (Army STARRS).

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	After reading the manuscript, I identified three studies that, from my perspective, should have been included in the evidence table and discussion related to key question #2 ([4]Beautrais AL, Gibb SJ, Faulkner A, et al. British Journal of Psychiatry. 197:55-60, 2010; [5]Currier GW, Fisher SG, Caine ED. Academic Emergency Medicine. 17:36-43, 2010; [6]Alexopoulos GS, Reynolds CF 3rd, Bruce ML, et al American Journal of Psychiatry. 166:882-90, 2009). Why weren't these studies included? Does their absence suggest that the search strategy and/or the inclusion/exclusion criteria for reviewing publications should be revised? Without explicitly stating that it does so, and without specifying relevant inclusion/exclusion criteria, the review appears to have excluded somatic treatments from the evidence table and discussion. Some of these publications (e.g., [7]Price RB, Iosifescu DV, Murrough JW, et al Depression & Anxiety. 31:335-43, 2014; [8]Cipriani A, Hawton K, Stockton S, et al BMJ. 346:f3646, 2013; [9]Khan A, Khan SR;,Hobus J, et al Journal of Psychiatric Research. 45:1489-96, 2011; [1]Oquendo MA, Galfalvy HC, Currier D, et al American Journal of Psychiatry. 168:1050-6, 2011; [11]Grunebaum MF, Keilp JG, Ellis SP, et al Journal of Clinical Psychiatry. 74(9):872-9, 2013; [12]Zisook S, Kasckow JW, Lanouette NM, et al Journal of Clinical Psychiatry. 71:915-22, 2010) may have been excluded because they focus on treatment of patients with specific mental disorders; this exclusion reinforces concerns about whether the exclusion of studies based in populations characterized by mental disorders limits the value of the review. However, a publication from VA investigators focused on somatic treatment of suicidality, rather than specific mental health conditions, albeit in patients with mental disorders or TBI ([13]George MS, Raman R, Benedek DM, et al Brain Stimulation. 7:421-31, 2013). It is not clear why this paper was excluded. Perhaps, related to this issue, the section related to key question #2 uses the term "Healthcare Services Intervention". What is a "healthcare services intervention"? Does the definition exclude somatic treatments?	JAMA Psychiatry. 2015 Jan;72(1):49-57. · This study was published after the initial literature search and has been included under Key Question 1 in the revision. 2. Simon GE, Rutter CM, Peterson D, et al. Does response on the PHQ-9 Depression Questionnaire predict subsequent suicide attempt or suicide death? Psychiatr Serv. 2013 Dec 1;64(12):1195-202. · This study does not meet inclusion criteria for Key Question 1 because it does not report measures of accuracy (*ie*, sensitivity and specificity) and these measures cannot be calculated from the reported data. Since it is a relevant study and future research to determine its sensitivity and specificity would be useful, the study is described in Key Question 3. 3. Ganzini L, Denneson LM, Press N, et al. Trust is the basis for effective suicide risk screening and assessment in Veterans. J Gen Intern Med. 2013 Sep;28(9):1215-21. · This study does not meet inclusion criteria. 4. Beautrais AL, Gibb SJ, Faulkner A, Fergusson DM, Mulder RT. Postcard intervention for repeat self-harm: randomised controlled trial. Br J Psychiatry. 2010 Jul;197(1):55-60. · The outcome of this study is self-harm, but the study did not differentiate suicidal or non-suicidal self-harm and it was not included in this review. 5. Currier GW, Fisher SG, Caine ED. Mobile crisis team intervention to enhance linkage of discharged suicidal emergency department patients to outpatient psychiatric services: a randomized controlled trial. Acad Emerg Med. 2010 Jan;17(1):36-43. · The outcome of this study is improved clinical contact after discharge, not suicidal self-directed violence. Therefore, it was not included in this review. 6. Alexopoulos GS, Reynolds CF 3rd, Bruce ML, Katz IR, Raue PJ, Mulsant BH, Oslin DW, Ten Have T; PROSPECT Group. Reducing suicidal ideation and depression in older primary care patients: 24-month outcomes of the PROSPECT study. Am J Psychiatry. 2009 Aug;166(8):882-90. · Results of this trial (PROSPECT) were reported in a separate publication in the previous systematic review. In the revision, this reference was added under the same trial in the table with

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		the other reference (Gallo). References 7-12 concern therapies that are not included in this systematic review (see Appendix B for inclusion/exclusion criteria): 7. Price RB, Iosifescu DV, Murrough JW, et al. Effects of ketamine on explicit and implicit suicidal cognition: a randomized controlled trial in treatment-resistant depression. Depress Anxiety. 2014 Apr;31(4):335-43. · Study of ketamine using the Implicit Associations Test as an outcome measure. 8. Cipriani A, Hawton K, Stockton S, Geddes JR. Lithium in the prevention of suicide in mood disorders: updated systematic review and meta-analysis. BMJ. 2013 Jun 27;346:f3646. · A systematic review of lithium for suicide prevention in people with mood disorders. 9. Khan A, Khan SR, Hobus J, et al. Differential pattern of response in mood symptoms and suicide risk measures in severely ill depressed patients assigned to citalopram with placebo or citalopram combined with lithium: role of lithium levels. J Psychiatr Res. 2011 Nov;45(11):1489-96. · A study of lithium. 10. Oquendo MA, Galfalvy HC, Currier D, et al. Treatment of suicide attempters with bipolar disorder: a randomized clinical trial comparing lithium and valproate in the prevention of suicidal behavior. Am J Psychiatry. 2011 Oct;168(10):1050-6. · A study of lithium. 11. Grunebaum MF, Keilp JG, Ellis SP, et al. SSRI versus bupropion effects on symptom clusters in suicidal depression: post hoc analysis of a randomized clinical trial. J Clin Psychiatry. 2013 Sep;74(9):872-9. · A study of SSRI vs. bupropion. 12. Zisook S, Kasckow JW, Lanouette NM, et al. Augmentation with citalopram for suicidal ideation in middle-aged and older outpatients with schizophrenia and schizoaffective disorder who have subthreshold depressive symptoms: a randomized controlled trial. J Clin Psychiatry. 2010 Jul;71(7):915-22. · A study of citalopram. 13. George MS, Raman R, Benedek DM, et al. A two-site pilot

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		randomized 3 day trial of high dose left prefrontal repetitive transcranial magnetic stimulation (rTMS) for suicidal inpatients. Brain Stimul. 2014 May-Jun;7(3):421-31. · Outcome measure is suicidal thinking, not suicidal self-directed violence.
	3. The manuscript includes a table of previous systematic reviews of interventions for suicide prevention. However, it appears incomplete. The authors should consider adding other recently published systematic reviews focusing on specific aspects of suicide prevention. ([1]Milner AJ, Carter G, Pirkis J. et al. Br J Psychiatry. 206:184-90, 2015; [2]Cuijpers P, de Beurs DP, van Spijker BA, et al J Affect Disord.144:183-90, 2013; [3]Lapierre S, Erlangsen A, Waern M, et al. Crisis. 32:88-98, 2011; [4]Brown GK, Green KL. American Journal of Preventive Medicine S209-S215, 2014; [5]van der Feltz-Correlis CM, Sachiapone M, Postuvan V, et al. Crisis 22:319-33, 2011.)	The systematic reviews cited by the reviewer include the following: 1. Milner AJ, Carter G, Pirkis J, Robinson J, Spittal MJ. Letters, green cards, telephone calls and postcards: systematic and meta-analytic review of brief contact interventions for reducing self-harm, suicide attempts and suicide. Br J Psychiatry. 2015 Mar;206(3):184-90. · This systematic review does not meet inclusion criteria. 2. Cuijpers P, de Beurs DP, van Spijker BA, Berking M, Andersson G, Kerkhof AJ. The effects of psychotherapy for adult depression on suicidality and hopelessness: a systematic review and meta-analysis. J Affect Disord. 2013 Jan 25;144(3):183-90. · This systematic review does not include any studies with suicidal self-directed violence as outcomes. 3. Lapierre S, Erlangsen A, Waern M, et al. A systematic review of elderly suicide prevention programs. Crisis. 2011;32(2):88-98. · This systematic review does not meet inclusion criteria. 4. Brown GK, Green KL. A review of evidence-based follow-up care for suicide prevention: where do we go from here? Am J Prev Med. 2014 Sep;47(3 Suppl 2):S209-15. · This paper is not a systematic review, but describes key papers from previously published systematic reviews. This publication was used to help identify additional studies that the literature search may not have captured. 5. van der Feltz-Cornelis CM, Sarchiapone M, Postuvan V, et al. Best practice elements of multilevel suicide prevention strategies: a review of systematic reviews. Crisis. 2011;32(6):319-33. · This paper is not a systematic review, but describes key papers from previously published systematic reviews. This publication was used to help identify additional studies that the literature search may not have captured.
	4. The literature on treatments such as transcranial magnetic stimulation and ketamine raise questions about whether suicidality, regardless of the underlying diagnosis of a mental health condition, can be a target for somatic	Somatic treatment is outside the scope of this review.

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	treatment. This issue should be discussed, either by including relevant studies in the evidence table for key question #2 or including it in the discussion for key question #3.	
	5. The discussion of Cognitive Behavioral Therapy (CBT) should distinguish between CBT directed toward suicidality as an indication (e.g., Rudd MD, Bryan CJ, Wertenberger EG, et al. American Journal of Psychiatry 172: 4441-449, 2015; Brown GK, Ten Have T, Henriques GR, et al, JAMA 294, 563-570, 2005) versus the large majority of other studies that evaluated CBT targeting an underlying mental health condition. It might acknowledge that the impact on suicide-related behaviors of CBT directed toward specific conditions has been variable, but the impact of the specific intervention Cognitive Therapy for Suicide Prevention has, thus far, been consistent.	This systematic review did not evaluate CBT for other indications and is unable to draw this conclusion.
	6. On page 4, the review includes the statement, "few studies have evaluated the effectiveness of preventive interventions in individuals at earlier stages of the suicide pathway." The review would have been strengthened by a discussion of rates of suicide-related behaviors across population, estimates of effect sizes for different types of interventions, the sample sizes that would be necessary to achieve adequate statistical power in an intervention study, and the anticipated costs of the research that would be needed.	This information would be interesting and relevant, but is outside the scope of this review.
	7. In discussing trends in suicide rates for Veterans and service members, it would be useful to include information about Veterans receiving health care services from VA and other Veterans, as well as the differences between the two groups.	Statistics regarding suicide trends among Veterans within and outside VA healthcare are provided as available from published sources.
	8. Page 7 line 43: Consider changing "Female Veterans are at especially high risk …" to "Female Veterans are at especially high risk relative to other women …"	This sentence was revised as suggested.

APPENDIX E. EXCLUDED REFERENCES

Exclusion Codes: Reasons for Exclusion*

1 = Non-English language
2 = Ineligible country (*ie*, any country other than the US, UK, Canada, New Zealand, Australia)
3 = Ineligible population or setting (*eg*, children or adolescents, patients with serious comorbidities such as cancer or schizophrenia, nursing home populations, institutionalized populations)
4 = Study does not involve diagnostic accuracy of suicide risk assessment (KQ 1) or a healthcare service intervention to prevent suicide (KQ2)
5 = Study does not have a comparison group
6 = Ineligible outcome
7 = Ineligible study design (*eg*, case reports, case series)
8 = Ineligible publication type (*eg*, letter, editorial, publication only available as an abstract, protocol without results, non-systematic review or regulatory agency analysis)
9 = Ineligible systematic review (due to scope, inclusion criteria, outcomes, or limitations in quality)

*Some citations had multiple reasons for being ineligible; only one exclusion code is listed in the table.

Citation	Key Question	Exclusion Code
Abidin Z, Davoren M, Naughton L, Gibbons O, Nulty A, Kennedy HG. Susceptibility (risk and protective) factors for in-patient violence and self-harm: prospective study of structured professional judgement instruments START and SAPROF, DUNDRUM-3 and DUNDRUM-4 in forensic mental health services. *BMC Psychiatry.* 2013;13(Issue):197.	KQ1	6
Acosta FJ, Vega D, Torralba L, et al. Hopelessness and suicidal risk in bipolar disorder. A study in clinically nonsyndromal patients. *Compr Psychiatry.* 2012;53(Issue):1103-1109.	KQ1	2
Agosti V, Chen Y, Levin FR. Does Attention Deficit Hyperactivity Disorder increase the risk of suicide attempts? *J Affect Disord.* 2011;133(Issue):595-599.	KQ1	4
Albright G, Goldman R, Shockley KM, McDevitt F, Akabas S. Using an Avatar-Based Simulation to Train Families to Motivate Veterans with Post-Deployment Stress to Seek Help at the VA. *Games for Health Journal.* 2011;1(Issue):21-28.	KQ2	6
Alonzo D, Stanley B. A novel intervention for treatment of suicidal individuals. *Psychiatr Serv.* 2013;64(Issue):494.	KQ2	6
Alonzo D, Thompson RG, Stohl M, Hasin D. The influence of parental divorce and alcohol abuse on adult offspring risk of lifetime suicide attempt in the United States. *Am J Orthopsychiatry.* 2014;84(Issue):316-320.	KQ1	4
Altamura AC, Mundo E, Cattaneo E, et al. The MCP-1 gene (SCYA2) and mood disorders: preliminary results of a case-control association study. *Neuroimmunomodulation.* 2010;17(Issue):126-131.	KQ1	2
Anestis M. Predicting Suicide Risk in a Military Population. *Military Suicide Research Consortium.* https://msrc.fsu.edu/funded-research/predicting-suicide-risk-military-population. Accessed September 25, 2015.	KQ1	8*
Anestis MD, Khazem LR, Mohn RS, Green BA. Testing the main hypotheses of the interpersonal-psychological theory of suicidal behavior in a large diverse sample of United States military personnel. *Compr Psychiatry.* 2015;60(Issue):78-85.	KQ1	4
Anestis MD, Silva C, Lavender JM, et al. Predicting nonsuicidal self-injury episodes over a discrete period of time in a sample of women diagnosed with bulimia nervosa: an analysis of self-reported trait and ecological momentary assessment based affective lability and previous suicide attempts. *Int J Eat Disord.* 2012;45(Issue):808-811.	KQ1	6
Antypa N, Antonioli M, Serretti A. Clinical, psychological and environmental predictors of prospective suicide events in patients with Bipolar Disorder. *J Psychiatr Res.* 2013;47(Issue):1800-1808.	KQ1	4
Aomori University of Health and Welfare. A Community-based Depression Screening Intervention for Middle-	KQ2	2

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* Not included as a study in the systematic review because study results are not yet available, but listed in the table of Ongoing Studies of Methods to Identify Suicide Risk (**Table 10**).
† Not included as a study in the systematic review because study results are not yet available, but listed in the table of Ongoing Studies of Healthcare Service Interventions for Suicide Prevention (**Table 11**).