



Evidence Brief: Suicide Prevention in Veterans

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Prepared by:

Evidence-based Synthesis Program (ESP)
Coordinating Center
Portland VA Health Care System
Portland, OR
Mark Helfand, MD, MPH, MS, Director

Investigators:

Kim Peterson, MS
Johanna Anderson, MPH
Donald Bourne, MPH



PREFACE

The VA Evidence-based Synthesis Program (ESP) was established in 2007 to provide timely and accurate syntheses of targeted healthcare topics of particular importance to clinicians, managers, and policymakers as they work to improve the health and healthcare of Veterans. QUERI provides funding for four ESP Centers, and each Center has an active University affiliation. Center Directors are recognized leaders in the field of evidence synthesis with close ties to the AHRQ Evidence-based Practice Centers. The ESP is governed by a Steering Committee comprised of participants from VHA Policy, Program, and Operations Offices, VISN leadership, field-based investigators, and others as designated appropriate by QUERI/HSR&D.

The ESP Centers generate evidence syntheses on important clinical practice topics. These reports help:

- Develop clinical policies informed by evidence;
- Implement effective services to improve patient outcomes and to support VA clinical practice guidelines and performance measures; and
- Set the direction for future research to address gaps in clinical knowledge.

The ESP disseminates these reports throughout VA and in the published literature; some evidence syntheses have informed the clinical guidelines of large professional organizations.

The ESP Coordinating Center (ESP CC), located in Portland, Oregon, was created in 2009 to expand the capacity of QUERI/HSR&D and is charged with oversight of national ESP program operations, program development and evaluation, and dissemination efforts. The ESP CC establishes standard operating procedures for the production of evidence synthesis reports; facilitates a national topic nomination, prioritization, and selection process; manages the research portfolio of each Center; facilitates editorial review processes; ensures methodological consistency and quality of products; produces “rapid response evidence briefs” at the request of VHA senior leadership; collaborates with HSR&D Center for Information Dissemination and Education Resources (CIDER) to develop a national dissemination strategy for all ESP products; and interfaces with stakeholders to effectively engage the program.

Comments on this evidence report are welcome and can be sent to Nicole Floyd, ESP CC Program Manager, at Nicole.Floyd@va.gov.

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EXECUTIVE SUMMARY

Despite the US Department of Veterans Affairs' (VA) increased efforts over the past decade in implementing comprehensive Suicide Prevention Program initiatives, according to the new VA National Suicide Data Report 2005-2015, an average of 20 Veterans continue to die each day by suicide. An important barrier to the success of VA's suicide prevention initiatives may be the lack of adequate evidence in Veterans supporting recommendations of any specific risk assessment method or prevention intervention.

Summary of Key Findings

Among 3,569 new citations identified since our 2015 review (Nelson 2015), we added 8 new studies to the 9 existing studies from the 2015 review in military and Veteran populations. These studies examined numerous different approaches including risk assessment using predictive modeling and various population-level and individual-level interventions (Executive Summary Table 1). For risk prediction, the most promising findings are from the Army Study to Assess Risk and Resilience in Service members (Army STARRS), which identified a few large risk prediction models as fairly to highly accurate in predicting suicide risk in active duty Soldiers (AUC 0.72 to 0.97). However, the applicability of these risk prediction models in service members transitioning to civilian life and/or Veteran populations is not yet known. For suicide prevention interventions, ongoing psychotherapy-focused interventions for individuals in acute suicidal crisis continue to be the most widely studied, with outpatient cognitive behavioral therapy (CBT) still being the most well-established treatment.

Veterans Transitioning from Uniformed Service to Civilian Life

Service members who are separating from active duty into civilian life are at a particularly high risk of suicide. As we found no completed or ongoing studies that specifically focused on this subpopulation, our review confirmed the need for new research in Veterans during their transition from uniformed service to civilian life. Recommendations for future research include: (1) establishment of a clear definition of what specific post-military separation timeframe constitutes the transition period of interest, (2) prioritization of studies with well-defined inclusion criteria that are relevant to the specific post-military separation timeframe of interest, and (3) evaluation of variability in suicide prevention approaches based on differences in key patient characteristics such as the presence of mental health or substance use disorders and life stressors.

Background

The ESP Coordinating Center (ESP CC) is responding to a request from Health Services Research and Development (HSR&D) for an evidence brief update of the 2015 ESP review on suicide prevention, with a special focus on research in Veterans, particularly Veterans transitioning from military to civilian life. Findings from this evidence brief will help support achievement of the goals of HSR&D's Suicide Prevention Roadmap by informing development and funding of new research in suicide prevention and related activities.

Methods

To identify studies, we searched MEDLINE®, Cochrane Database of Systematic Reviews, Cochrane Central Register of Controlled Trials, and other sources up to June 2018. We used prespecified criteria for study selection, data abstraction, and rating internal validity and strength of the evidence. See our PROSPERO protocol for our full methods.



Executive Summary Table 1: Summary of Evidence

Evidence	Summary of Findings (ê for reduction; = for no change)
<i>Suicide risk assessment models</i>	
9 studies ¹⁻⁹ : 5 case-series ^{1-3,5,9} ; 2 RCTs ^{4,7} ; 1 PC ⁸ ; 1 case-control ⁶	Models derived from databases or clinician-rated or patient self-report instruments.
Risk of Bias: 3 low ⁴⁻⁶ ; 2 high ^{1,2} ; 4 unclear ^{3,7-9}	Accuracy: AUC range: 0.61 ⁴ to 0.93 ⁷
SOE: NR	
<i>Healthcare services interventions directed towards populations</i>	
4 studies: 3 before-after ¹⁰⁻¹² ; 1 PC ¹³	Suicide rate: ê 3 interventions: 2 multi-component interventions, ^{10,11} MHEOCC ¹² = 1 intervention: ASIST ¹³
Risk of bias: high (all studies)	Suicide attempt: ê 1 intervention: ASIST ¹³
SOE: Insufficient	
<i>Healthcare services interventions directed towards individuals</i>	
4 RCTs ¹⁴⁻¹⁷	Suicide attempt: ê 1 intervention: CBT ¹⁷ = 3 interventions: CRP, ¹⁴ DBT, ¹⁵ CAMS ¹⁶
Risk of bias: 1 low ¹⁴ ; 3 unclear ¹⁵⁻¹⁷	
SOE: Low	

Abbreviations: ASIST = applied suicide intervention skills training; MHEOCC = VA Mental Environment of Care Checklist; CRP = crisis response plan; DBT = dialectical behavioral therapy; CAMS = collaborative assessment and management of suicidality; CBT = cognitive behavior therapy; RCT = randomized controlled trial; RC = retrospective cohort; PC = prospective cohort; SOE = strength of evidence

Overall Key Evidence Gaps and Future Research Recommendations

In addition to the gaps in evidence in Veterans transitioning from uniformed service to civilian life described above, the table below (Executive Summary Table 2) provides a summary of additional key evidence gaps and associated future research recommendations.

Executive Summary Table 2: Key Evidence Gaps and Future Research Recommendations

Topics	Gaps	Recommendations for Future Research
<i>Populations</i>		
Veterans transitioning from uniformed service to civilian life	• No completed or ongoing studies	• New studies in these populations. Please see above for more detailed recommendations
At-risk Veterans prior to reaching acute suicidal crisis	• Few available studies	• New studies in these populations
At-risk Veterans who have had no contact with the VA	• No completed or ongoing studies	• New studies on community outreach approaches, such as gatekeeper training
<i>Suicide Prevention Approaches</i>		
Risk assessment	• Data on novel objective risk assessment approaches	• New studies of cognitive factors

Population-level healthcare service interventions	<ul style="list-style-type: none"> · Identification of which specific components in multicomponent interventions are most effective · Identification of specific subpopulations that may benefit most · How outcomes differ from a concurrent rather than historical comparison group 	<ul style="list-style-type: none"> · Studies that directly compare different combinations of components · Studies that evaluate if and how effectiveness may vary based on differences in individual patient characteristics · Studies that compare to a concurrent control group instead of a historical control group
Individual-level healthcare service interventions	<ul style="list-style-type: none"> · Although multiple studies exist on various psychotherapy approaches, we have limited confidence in their findings in general because each intervention was evaluated in only a single, small study with other potential weaknesses. · No new studies of several other types of interventions 	<ul style="list-style-type: none"> · Larger, more rigorous RCTs of DBT and Operation Worth Living may still be warranted to more definitely determine their suicide prevention effectiveness. · New studies of (1) interventions designed to bolster protective factors such as psychological resilience, meaningful life, grit, gratitude, and social support, (2) innovative approaches that use technology to support or enhance care, (3) safety planning; (4) peer support specialists; (5) health coaching, (6) motivational interviewing

Abbreviations: RCT = randomized controlled trial, DBT = dialectical behavioral therapy

EVIDENCE BRIEF

INTRODUCTION

PURPOSE

The ESP Coordinating Center (ESP CC) is responding to a request from Health Services Research and Development (HSR&D) for an evidence brief update of the 2015 ESP review (Nelson 2015)¹⁸ on suicide prevention, with a special focus on research in Veterans, particularly Veterans transitioning from military to civilian life. Findings from this evidence brief will help support achievement of the goals of HSR&D's Suicide Prevention Roadmap by informing development and funding of new research in suicide prevention and related activities.

BACKGROUND

Suicide prevention continues to be a shared top clinical priority for the US Department of Veterans Affairs (VA) and the Veterans Health Administration (VHA). According to the new VA National Suicide Data Report 2005-2015, which is an ongoing examination of over 55 million civilian and Veteran death records, an average of 20 Veterans continue to die each day by suicide, although only 6 of these were Veterans who had recently used VHA services.¹⁹ According to the Data Report, the youngest Veterans (aged between 18 and 29) had the highest risk of suicide in 2015.¹⁹

Among other priority areas, recent Veteran suicide prevention initiatives are focusing on reducing risk particularly during the first year following the transition from military service to civilian life (also referred to as 'separation from the military').²⁰⁻²⁴ This is because a 2016 retrospective multivariate analysis of 3,795,823 US service members enrolled between 2001 and 2011 found an approximate doubling of suicide risk in the first year of separating from the military (HR 2.49; 95% CI 2.12 to 2.91).²⁴ Some reasons that separation from the military can be challenging include feelings of separateness, lack of a sufficient social support system or shared experiences with those systems, disconnection from families, deployment-related psychological or physical injuries, and financial, educational, and employment barriers.²⁵

The finding that service members in transition to Veteran status are at higher suicide risk led President Trump to sign an Executive Order (EO 13822) in January 2018 to direct VA, the Department of Defense (DoD), and the Department of Homeland Security (DHS) to provide more seamless access to mental health care and suicide prevention resources for transitioning service members, particularly during their first year of military service separation. In response, a March 2018 Joint Action Plan For Supporting Veterans During Their Transition From Uniformed Service To Civilian Life²¹ and a resulting VA Health Services Research & Development Suicide Prevention Roadmap (HSR&D)²⁶ were issued that describe specific planned actions to achieve the goals of EO 13822. Some examples of implementation efforts include improving mental health resource awareness through outbound education calls to service members within 90 days of separation date, expanded discussion in Transition Assistance Program (TAP) briefing, and the launch of a broad communication campaign.²¹ The 2018 update of the VA National Strategy for Preventing Veteran Suicide calls for a greater focus on strengthening protective factors (*ie*, problem-solving and social support) as a strategic objective to prevent suicide in transitioning service members.²⁷ Additionally, HSR&D anticipates funding

new research to address gaps in knowledge about transitioning Veterans in the areas of epidemiology, risk identification, clinical and public health interventions, and health services.

New VHA Suicide Prevention Initiatives and Standard Approaches

Although suicide risk screening is not a standard of care in US general medical practice,^{28,29} it has been mandatory in the VHA for several years. For example, as primary care encounters have been identified as an important opportunity for suicide risk assessment – a majority of Veterans who die by suicide made contact with primary care in the preceding year (77%)³⁰ – all Veterans are screened with the Patient Health Questionnaire-2 (PHQ-2) annually in primary care. Those that screen positive based on the PHQ-2 will then undergo more comprehensive risk assessment. Until recently, there had been no standardization of the risk assessment process. As of 2018, the VHA has launched a 3-step standardized process including a primary screen (PHQ-9), a secondary screen (Columbia-Suicide Severity Rating Scale Screener) for those who screen positive on the PHQ-9, and a comprehensive assessment of suicide risk to be conducted using the VA Comprehensive Suicide Risk Assessment (CSRA) template in the electronic medical record for those who screen positive on the secondary screen. New performance measures for this standardized risk assessment process will go into effect in Fiscal Year 2019.

Another recently implemented risk prediction initiative is the Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) program. REACH VET is a predictive modeling system that uses a combination of demographic, prior suicide attempt, mental and physical health diagnoses, and VHA service and medication utilization information from Veterans' medical records to identify those at the top 0.1% of risk for various adverse events, including suicide.^{6,31} REACH VET utilizes a dashboard that provides facility-level REACH VET coordinators with the names of Veterans who have been identified as being in the highest tier of risk once a month. Coordinators then notify providers, who assess need for and implement care enhancements.

Traditional approaches to suicide prevention generally include risk assessment (*eg*, self-report scales or checklists) and treatment of individuals at high risk, both at the population level (*eg*, public service announcements, national hotlines, provider education and training, *etc*) and at the individual level (*eg*, suicide-focused psychotherapy, pharmacotherapy). Newer suicide prevention approaches include predictive modeling using data from patient health records to predict risk (such as REACH VET), objective risk assessment methods (*eg*, cognitive factors, biological markers, neuroimaging), restricting access to lethal means, and, for individual-level interventions, health promotion efforts that target known risk factors in individuals before they are in acute suicide crisis, those that target protective factors such as building social support, and technology-based interventions to provide follow-up and continued contact, such as a smartphone application and caring contacts via email. Although the most recent (2013) VHA/Department of Defense (DoD) *Clinical Practice Guideline for the Assessment and Management of Suicide Risk* does not currently recommend any specific approaches due the limitations in pre-2013 research, a very broad systematic review is underway to update the guideline over the coming year.³²

As of our last review in 2015,¹⁸ although new evidence had emerged on some of the newer approaches, very few studies existed that evaluated the effectiveness and harms of any of these approaches specifically in Veteran populations, and particularly in service members transitioning

to civilian life. Therefore, we are updating this review to evaluate new evidence in general and with a special focus on transitioning service members.

SCOPE

The objective of this evidence brief is to synthesize new evidence in Veterans that has emerged since the 2015 ESP suicide prevention review on diagnostic accuracy of suicide risk assessment methods and the effectiveness of healthcare service interventions in preventing suicidal self-directed violence. This evidence brief will address the following key questions and inclusion criteria:

KEY QUESTIONS

Key Question 1: What are the accuracy and adverse effects of methods to identify Veterans and military personnel at increased risk for suicide and other suicidal self-directed violence?

- a) Do accuracy and adverse effects vary by setting, delivery mode, targeted population (*ie*, transitioning Veterans (military to civilian)), or other factors?

Key Question 2: What are the efficacy/effectiveness and adverse effects of suicide prevention interventions in reducing rates of suicide and other suicidal self-directed violence in Veterans and military personnel?

- a) Do efficacy/effectiveness and adverse effects vary by setting, delivery mode, targeted population (*ie*, transitioning Veterans (military to civilian)), or other factors?

Key Question 3: What are important areas of ongoing research and current evidence gaps in research on suicide prevention in Veterans and military personnel, and how could they be addressed by future research?

ELIGIBILITY CRITERIA

The ESP included studies that met the following criteria:

- **P**opulation: US Veterans or military personnel aged ≥ 18 years, regardless of care setting or payer; or military or Veterans from the UK, Canada, New Zealand, or Australia
- **I**ntervention: Suicide risk identification methods or suicide prevention interventions. Specific interventions of interest include US-relevant population-directed healthcare services (*eg*, hotlines, outreach programs) and/or individual-directed healthcare services (*eg*, case management, follow-up) and not interventions that primarily treat co-existing conditions, including pharmacotherapy. Studies only of associations between risk and protective factors and suicide are also not included.
- **C**omparator: Any
- **O**utcomes: For KQ1, studies need to report a measure of diagnostic accuracy. For KQ2, the primary outcomes of interest are suicidal self-directed violence, including suicide

attempts and suicide-specific mortality. Additional secondary outcomes will be collected as available from studies designed primarily to capture suicidal self-directed violence.

- Harms: Any (*eg*, potential unintentional iatrogenic effects such as anxiety, distress, stigma), including direct adverse effects of an assessment or intervention or those of subsequent interventions
- **Timing**: Any, no follow-up timeframe restrictions
- **Setting**: Veteran or military inpatient or outpatient setting
- **Study design**: Any, but may prioritize to accommodate timeline using a best-evidence approach

METHODS

To identify articles relevant to the key questions, our research librarian searched MEDLINE, PubMed, PsycINFO, SocINDEX, Cochrane Central Register of Controlled Trials, and the Cochrane Database of Systematic Reviews using terms related to suicide and risk assessment (see Supplemental Materials for complete search strategies) up to June 2018. Additional citations were identified from hand-searching reference lists, relevant program websites (Military Operational Medicine Research Program, Military Suicide Research Consortium, Army STARRS), and consultation with content experts. We limited the search to published and indexed articles involving human subjects available in the English language from the date of the last systematic search (09/2015) forward. Study selection was based on the eligibility criteria described above. Titles and abstracts were first single-reviewed using Abstrackr software.³³ A second reviewer then re-screened 90% of the titles and abstracts excluded by the first reviewer until the Abstrackr software predicted no further citations were likely relevant ('sequential review').^{33,34} Full-text articles were sequentially reviewed by 2 investigators. All disagreements were resolved by a third reviewer.

We used pre-specified tools to rate the internal validity of diagnostic accuracy studies,³⁵ randomized controlled trials,³⁶ and comparative cohort studies.³⁷ We abstracted data from all included studies and results for each included outcome. All data abstraction and internal validity ratings were first completed by one reviewer and then checked by another. All disagreements were resolved by consensus.

We graded the strength of the evidence for intervention studies for Key Question 2 based on the AHRQ Methods Guide for Comparative Effectiveness Reviews.³⁸ This approach incorporates 4 key domains: study limitations (includes study design and aggregate quality), consistency, directness, and precision of the evidence. It also considers other optional domains that may be relevant for some scenarios, such as a dose-response association, plausible confounding that would decrease the observed effect, strength of association (magnitude of effect), and publication bias. Strength of evidence is graded for each key outcome measure and ratings range from high to insufficient, reflecting our confidence that the evidence reflects the true effect.

Where studies were appropriately homogenous, we synthesized outcome data quantitatively using StatsDirect statistical software (StatsDirect Ltd. 2013, Altrincham, UK) to conduct random-effects meta-analysis to estimate pooled effects. We assessed heterogeneity using the Q statistic and the I² statistic. Where meta-analysis was not suitable due to limited data or heterogeneity, we synthesized the evidence qualitatively.

The complete description of our full methods can be found on the PROSPERO international prospective register of systematic reviews (<http://www.crd.york.ac.uk/PROSPERO/>; registration number CRD42018103412).

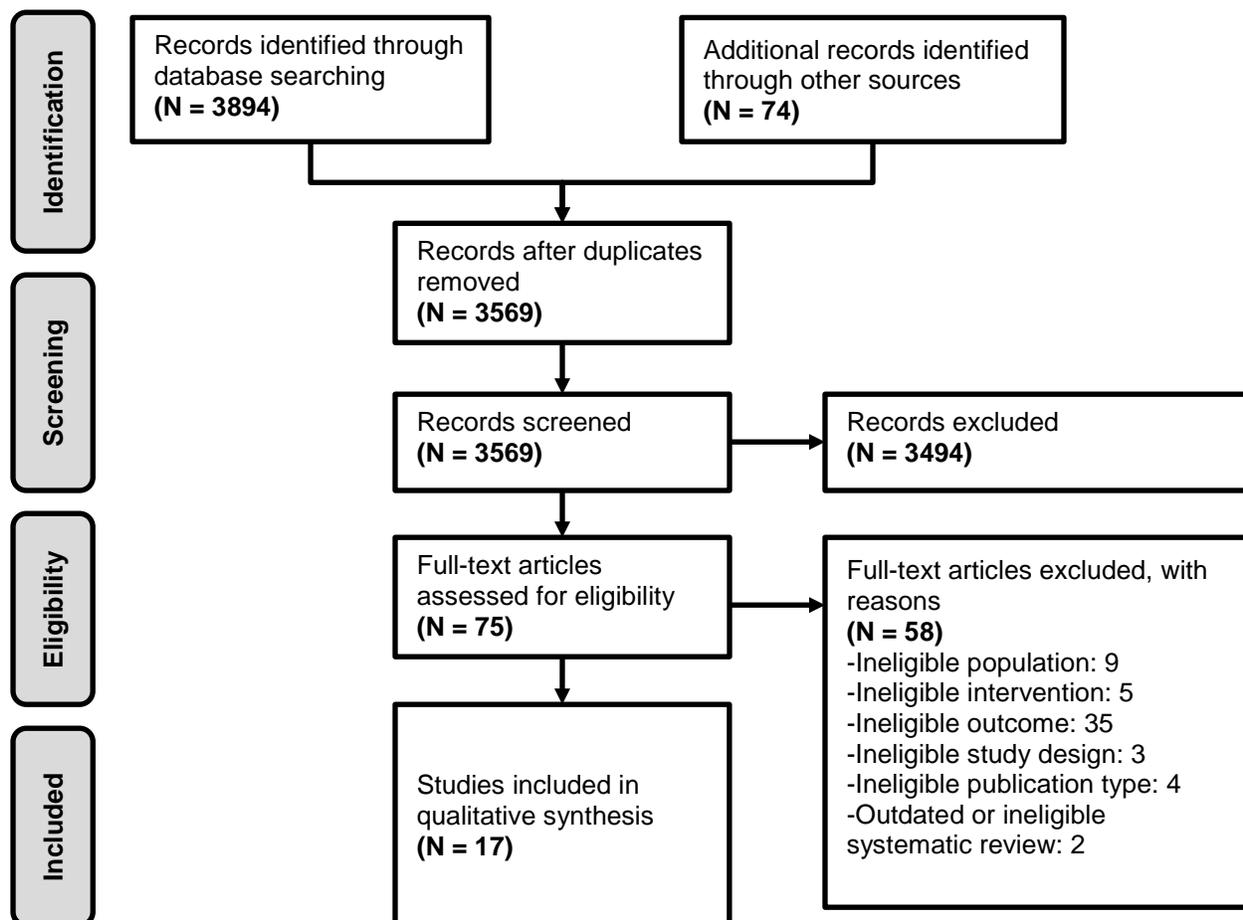
A draft version of this report was reviewed by peer reviewers as well as clinical leadership. Their comments and our responses are presented in the Supplemental Materials.

RESULTS

LITERATURE FLOW

The literature flow diagram (Figure 1) summarizes the results of the search and study selection processes.

Figure 1: Literature Flowchart



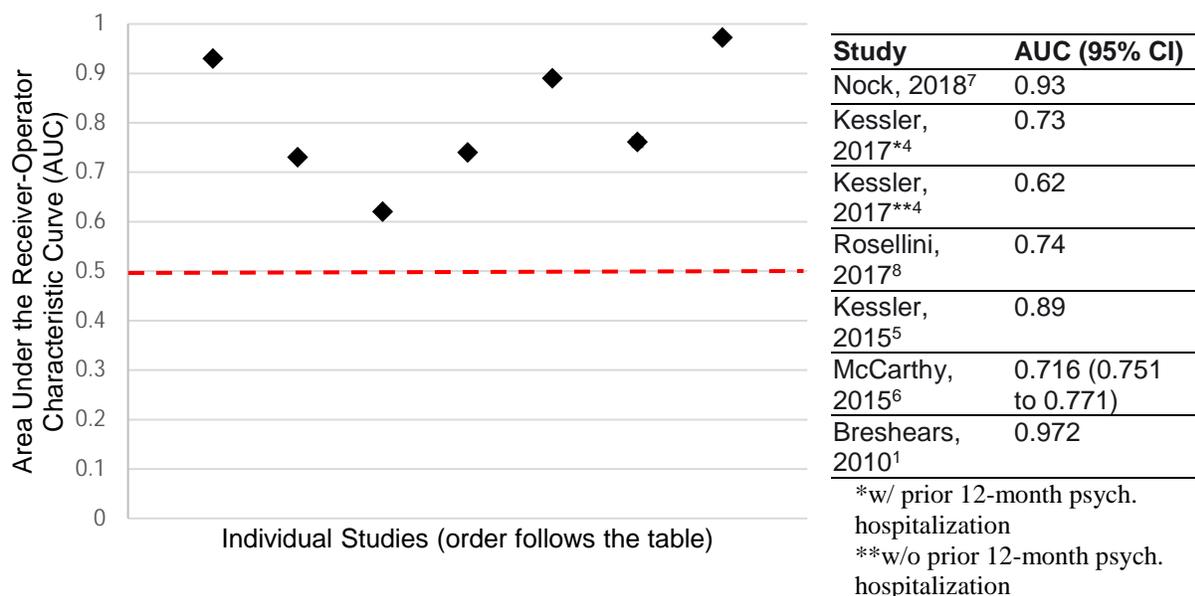
LITERATURE OVERVIEW

Searches resulted in 3,569 unique potentially relevant articles. We included 9 studies¹⁻⁹ for Key Question 1 and 8 studies¹⁰⁻¹⁷ for Key Question 2 (see Supplemental Materials for list of excluded studies). Nine of these studies^{1-3,5,6,9-11,17} were identified in the previous VA ESP review.¹⁸ Most studies^{4,5,7,8,10,11,13,14,16,17} (59%) were conducted in military populations, and the other studies^{1-3,6,9,12,15} (41%) were conducted in Veterans. None focused on service members transitioning to civilian life or reported length of time since discharge. The size of these studies ranged from 91¹⁵ to 5,969,662⁶ participants. Most studies^{3,7-9,15-17} had an unclear risk of bias, 4 studies^{4-6,14} had a low risk of bias, and 3 studies^{1,2,13} had a high risk of bias. The risk of bias was not assessed in before-after studies.¹⁰⁻¹² See supplemental materials for full data tables.

KEY QUESTION 1: What are the accuracy and adverse effects of methods to identify Veterans and military personnel at increased risk for suicide and other suicidal self-directed violence?

For evaluation of the accuracy of methods to identify military members at risk for suicide and other suicidal self-directed violence, we identified 3 recently published studies^{4,7,8} and 6 from the Nelson 2015 review (Table 1).^{1-3,5,6,9} None specifically evaluated suicide risk in service members transitioning to civilian life. None evaluated potential adverse effects of risk assessment methods or how effects may vary based on differences in other population characteristics, timing, delivery modes, or other factors.

All 3 of the newer studies and one from the Nelson 2015 review⁵ evaluated the accuracy of various population-level prediction models drawn from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS) study.^{4,7,8} Each involved a unique focus, including evaluating characteristics of suicidal thoughts hypothesized to predict incident attempts in those with lifetime suicidal ideation,⁷ risk of suicide within 12 months of outpatient mental health visits in male nondeployed regular Army Soldiers,⁴ risk of suicide attempt within 24 months after completing self-report surveys at the beginning of service in new Army Soldiers,⁸ and prediction of suicide in the 12 months after US Army Soldier inpatient treatment of a psychiatric disorder.⁵ Data sources primarily involved administrative databases^{4,5,8} or survey samples.⁷ Among the remaining 4 studies from Nelson 2015, 3 used one or more clinician-rated or patient self-report instruments to assess individual levels of risk.^{1-3,9} These include the Suicide Potential Index and Suicidal Ideation subscales of the Personality Assessment Inventory (PAI),¹ the Affective States Questionnaire,³ and the Beck Depression Inventory (BDI).² The last one used a decision tree derived from the Addiction Severity Index and variables from VA databases.⁹ The majority of the studies exclusively reported predictive accuracy based on area under the receiver-operator characteristic curve (ROC AUC) analysis, which is an analysis of how well a test separates groups with and without a risk factor. Values of 1 represent perfect accuracy, whereas 0.5 represents accuracy that is no better than flipping a coin. Figure 2 illustrates the reported AUC values.^{1,4-8} Three older studies previously evaluated in Nelson 2015 only reported accuracy in the form of sensitivity, specificity, positive predictive value, and negative predictive value.^{2,3,9}

Figure 2. Summary of Studies of Methods to Identify Suicide Risk Reporting Area Under the Receiver-Operator Characteristic Curve (AUC)

The majority of studies had few or no important methodological deficiencies.^{3-5,7-9} Two older studies that used the PAI to predict suicidal behaviors in Veterans with TBI¹ and the BDI to predict suicide attempts in Veterans with PTSD,² respectively, were the only exceptions. The Nelson 2015 review rated these as having high risk of bias due to the studies having the major limitations of small sample sizes, high or unclear levels of missing data, and potentially biased participant selection and risk factor assessment.

The majority of the predictive model methods^{1,4-8} had fair or better accuracy in discriminating between patients with and without suicide behaviors. This was demonstrated by ROC AUC estimates of ≥ 0.70 (range, 0.72 to 0.97). Accuracy was much lower among methods using clinician-rated or patient self-report instruments to assess individual levels of risk (sensitivity range, 33% to 63%).^{2,3,9} Three models stand out as having the highest accuracy based on ROC AUC estimates ≥ 0.80 .^{1,4,7} The method with the highest accuracy (AUC 0.972) was use of a cut-point of ≥ 15 on the Suicide Potential Index plus pre-assessment suicidal behavior in a small sample of Veterans with TBI (N = 154),¹ but we have little confidence in the stability of this finding due to the major deficiencies described above. The method with the next highest predictive accuracy (AUC 0.93) used a 26-factor model of characteristics of suicidal thoughts to predict incident attempts in Army soldiers with lifetime suicidal ideation.⁷ Study authors indicated that the most powerful predictors were “recent onset of ideation, presence and recent onset of a suicide plan, low controllability of suicidal thoughts, extreme risk-taking or ‘tempting fate,’ and failure to answer questions about the characteristics of one’s suicidal thoughts.” Finally, the model with the third highest predictive accuracy (AUC 0.89) was a 73-factor model of various characteristics (*ie*, sociodemographic, US Army career, criminal justice, medical, and pharmacy) used to predict suicides that occurred 12 months after US Army soldiers were discharged for inpatient treatment of a psychiatric disorder.⁵ Study authors indicated that the strongest predictors included male sex, late age of enlistment, verbal violence, weapons possession, prior suicidality, number of antidepressant prescriptions filled in the past 12 months, and diagnosis of nonaffective psychosis during the focal hospitalization.

Table 1. Studies of the Accuracy of Methods to Identify Individuals at Risk for Suicide and Other Suicidal Self-directed Violence in Veteran and Military Populations

Author, Year	Study Design; Approach	N; Population; Patient Characteristics; Setting	Risk Assessment Method	Outcome	Measures of Accuracy
<i>Recently Published Studies</i>					
Nock, 2018 ⁷	Retrospective analysis; used administrative data from the Historical Administrative Data System of the Army STARRS Consolidated All-Army Survey (AAS), a study that combines 3 large survey samples, each administered to a large and representative sample of active duty Soldiers.	3,916; United States Army Soldiers, with lifetime suicide ideation, drawn from a large (N = 29,982), representative sample, serving between 2011-2013.	Population-level prediction model derived from administrative data systems.	Suicide attempt	· 26-predictor net model: AUC 0.93
Kessler, 2017 ⁴	Retrospective analysis; used administrative data from the Historical Administrative Data System of the Army STARRS and machine learning methods (regression trees and penalized regressions) to develop a risk algorithm to predict posthospitalization suicides.	975,057; Regular Army Soldiers serving between 2004–2009.	Population-level prediction model derived from 38 US Army and Department of Defense administrative data systems (nearly 1000 predictor variables were constructed).	Suicides within 12 months of hospital discharge.	With prior 12-month psychiatric hospitalizations: · 14-predictor Elastic net model: AUC 0.72 · 14-predictor Logistic model: AUC 0.73 · 7-predictor Logistic model: AUC 0.72 Without prior 12-month psychiatric hospitalizations: · 10-predictor Elastic net model: AUC 0.61 · 10-predictor Logistic model: AUC 0.62
Rosellini, 2017 ⁸	Prospective cohort; used a self-administered questionnaire (New Soldier Survey) linked to outcomes data from the Historical Administrative Data System of the Army STARRS and penalized	21,832; new regular US Army Soldiers starting in April 2011-November 2012 prior to beginning Basic Combat Training at	Population-level prediction model derived from 14 US Army and Department of Defense	Suicide attempt at 24-months post survey.	· 23-predictor Elastic net model: AUC 0.74

	regression methods to develop a risk algorithm to predict suicide attempt.	Fort Benning, GA, Fort Jackson, SC, and Fort Leonard Wood, MO.	administrative data systems (772 individual predictor variables).		
<i>Studies Included in Previous ESP Reviews (Nelson, 2015¹⁸ & Haney, 2012³⁹)</i>					
Kessler, 2015 ⁵	Case series; used administrative data from the Historical Administrative Data System of the Army STARRS and machine learning methods (regression trees and penalized regressions) to develop a risk algorithm to predict posthospitalization suicides.	40,820 active duty US Army Soldiers with 53,769 psychiatric hospitalizations.	Population-level prediction model derived from 38 US Army and Department of Defense administrative data systems (421 individual predictor variables).	Suicides within 12 months of hospital discharge.	20-predictor model: AUC 0.84 73-predictor model: AUC 0.89 421-predictor model: AUC 0.85
McCarthy, 2015 ⁶	Nested, case-control study; predictive model derived from clinical records; included patients who died from suicide (case patients) and a random 1% of living patients (control patients), divided randomly into development and validation sets; determined AUC estimates.	5,969,662 Veterans alive as of September 2010 and who had encounters with the Veterans Health Administration in the US in the previous 2 years.	Population-level prediction model derived from Veterans Health Administration clinical records (381 total measures including 31 interaction terms).	Suicide within 12 months according to the National Death Index.	AUC 0.761 (95% CI 0.751 to 0.771)
Breshears, 2010 ¹	Case series; used hierarchical multiple regression and AUC estimates to determine optimum cut-points to estimate sensitivity and specificity.	154 Veterans with traumatic brain injury in the US.	Suicide Potential Index and Suicidal Ideation subscales of the Personality Assessment Inventory.	Suicide and suicidal behavior (not defined) within 2 years of assessment.	Suicide Potential Index: Cut-point ≥15: 90.9% sensitivity, 76.5% specificity; AUC 0.903. Cut-point ≥15 plus pre-assessment suicidal behavior: 90.9% sensitivity, 95.1% specificity; AUC 0.972. Cut-point ≥11 plus pre-assessment suicidal behavior: 100.0% sensitivity, 86.0% specificity.



					The Suicidal Ideation subscale scores did not increase incremental validity ($P = .65$, diagnostic accuracy not determined).
Hendin, 2010 ³	Case series; used AUC estimates to determine sensitivity and specificity.	283 inpatients and outpatients at a VA Medical Center in the US with affective disorder, or affective disorder plus substance abuse or anxiety disorders.	Affective States Questionnaire; a positive score was determined by rating at least 3 of the 7 affects as "severe" or "extreme."	Suicidal behavior* within 3 months of assessment.	Sensitivity 60%; Specificity 74%; PPV 32%; NPV 90%;
Tiet, 2006 ⁹	Case series; a decision tree for identifying high-risk patients was derived from the Addiction Severity Index and variables from VA databases; used AUC estimates to determine optimum cut-points to estimate sensitivity and specificity for 3 models.**	5,671 adults with suicidal ideation from a national cohort seeking substance abuse treatment at 150 VA Medical Centers in the US.	Decision tree included significant predictors of suicide attempts.†	Suicide attempts in the past 30 days assessed with the Addiction Severity Index face-to-face interview.	<ul style="list-style-type: none"> · 30% model: 33% sensitivity, 87% specificity; PPV 37%, NPV 85%. · 20% model: 72% sensitivity, 63% specificity; PPV 30%, NPV 90%. · 10% model: 89% sensitivity, 42% specificity; PPV 25%, NPV 95%.
Hartl, 2005 ²	Case series; used signal detection methods and AUC estimates to determine optimum cut-points to estimate sensitivity and specificity.	630 male Veterans with a primary posttraumatic stress disorder (PTSD) diagnosis entering a residential treatment program for PTSD in the US.	Beck Depression Inventory.	Suicide attempt within 4 months of discharge.	Beck Depression Inventory ≥ 46 and suicide attempt in the 4 months prior to intake: 63% sensitivity, 80% specificity in the exploratory sample; 11% sensitivity, 84% specificity in the replication sample.

*Attempts, interrupted or aborted attempts, or preparatory acts/behaviors, with some degree of intent to die; or hospitalization/institutionalization.

** Based on the results of the decision tree, sensitivity and specificity were calculated for 3 hypothetical models using varying cut points of the percentages (10%, 20%, and 30%) of patients who attempted suicide in the past 30 days. A model that uses a cut-point at 30% means that the model requires the true-positive rate to be at least a 30% and that 30% or more of patients are predicted to attempt suicide.

† Suicide attempt/ideation history, recent alcohol abuse, recent cocaine abuse, violent behavior, hallucinations, and employment status.



KEY QUESTION 2: What are the efficacy/effectiveness and adverse effects of suicide prevention interventions in reducing rates of suicide and other suicidal self-directed violence in Veterans and military personnel?

Population-level Interventions

Three population-level interventions¹⁰⁻¹² reduced suicide rates in US military members^{10,11} and Veterans with acute mental health admissions¹² in 2 before-after studies^{10,12} and one post-intervention series (Table 2).¹¹ Additionally, high versus low levels of suicide intervention skills training reduced suicide attempts but not suicide death in a prospective cohort of Army Reserve members.¹³ Of these, 2 were included and discussed in detail in the previous ESP report.¹⁸

The VA Mental Health Environment of Care Checklist (MHEOCC), developed to reduce environmental hazards and encourage architectural changes (*ie*, anchor points for hanging) related to suicide risk, was implemented in November 2007 in each VA hospital with a mental health unit treating actively suicidal patients.¹² Suicide rates significantly decreased from the time period prior to implementation of the checklist to after implementation. This study is large, including counts of suicides on a mental health unit from all VHA hospitals from 2000 to 2015, but is limited by lack of a concurrent control group.

The Applied Suicide Intervention Skills Training (ASIST), a service-wide training initiative for leadership in suicide peer assessment and counseling, was assessed among 131 Army Reserve members.¹³ As all units were required to participate in training, and outcomes were compared between platoons who had relatively high ($\geq 80\%$) and low ($< 80\%$) percentage of Soldiers receiving training in the calendar year. There were no deaths by suicide during the assessment period, but there was a significantly greater number of attempts in the low-training group compared to the high-training group. However, methodological flaws, including no control for ongoing ASIST training (ongoing training may have changed the percentage of Soldiers trained in the designated high- and low-level training platoons), selection of participants from different platoons for pre- and post-test reporting (2 platoons at pre-test and 2 different platoons at post-test), and unclear levels of missing data (study conducted during “rapid deployment cycle”) limit our confidence in these findings.

The 2 studies included in the previous report^{10,11} showed improvements in suicide rates with a multicomponent US Air Force suicide prevention initiative¹⁰ in over 5 million service personnel and a multicomponent deployment intervention in over 40,000 deployed service members.¹¹ These findings are limited by lack of concurrent control group¹⁰ or lack of information on comparison group intervention(s).¹¹

Individual-level Interventions

We found no studies that evaluated effects of individual-focused treatments specifically in recently returned or transitioning service members or on suicide death. Compared to treatment as usual or standard safety planning, the only individual-focused treatment to statistically significantly reduce suicide attempts in active duty service members or Veterans with suicide risk irrespective of psychiatric diagnosis was outpatient cognitive behavioral therapy (CBT) (HR 0.31; 95% CI 0.13 to 0.75) after 2 years (Table 3).¹⁷ The ESP’s Nelson 2015 review already

reported this finding, indicating, “these results are consistent with earlier studies that found the cognitive therapy was effective in reducing suicide re-attempt rates compared to usual care.”¹⁸

The 3 newer RCTs that emerged since the Nelson 2015 review evaluated comparisons of dialectical behavioral therapy versus treatment as usual in Veterans,¹⁵ crisis response planning (CRP) versus standard safety contracts,¹⁴ and Collaborative Assessment and Management of Suicidality (CAMS) versus enhanced usual care (Operation Worth Living) in active duty US Army Soldiers (Table 3).¹⁶ Compared to standard contract for safety (CFS), Standard and Enhanced Crisis Response Plans (S-CRP, E-CRP) (Table 3) reduced 6-month suicide attempts in unadjusted analyses (hazard ratio = 0.24, 95% CI 0.06 to 0.96).¹⁴ However, after adjustment for baseline suicidal ideation, which was slightly higher in the CFS group (Beck Scale for Suicidal Ideation [BSSI]: CFS = 18.5, S-CRP = 16.1, E-CRP = 15.8), the effect was no longer significant (HR = 0.29; 95% CI 0.06 to 1.18). For suicidal ideation, CRP was associated with a significantly faster decline in suicide ideation compared to CFS ($F(3,195) = 18.64, P < .001$), first detected at 1 month (BSSI: S-CRP = 5.3 vs E-CRP = 3.6 vs CFS = 5.3; $P = .006$) and sustained at 6 months (BSSI: S-CRP = 2.9 vs E-CRP = 2.0 vs CFS = 6.7; $P < .001$). Dialectical behavioral therapy (DBT) has been previously shown to reduce suicide risk in randomized trials of primarily civilians with borderline personality disorder after one year of treatment,⁴⁰⁻⁴⁶ and has reduced service utilization and cost in an observational study of male and female Veterans seen in VA outpatient mental health service settings.⁴⁷ However, it did not significantly reduce 6-month suicide attempts or ideation in a randomized trial of 91 Veterans with high suicide risk irrespective of psychiatric diagnosis (~50% borderline personality disorder).¹⁵ Trial authors suggested 3 possible reasons for the discrepancy between their results and previous studies in people with borderline personality disorder: (1) treatment as usual in VA may be more intensive than in other non-VA settings and there may be less room for improvement; (2) DBT’s typical effectiveness may have been “diluted” due to its adaption for VA practice, including use of VA screening instruments and lower thresholds for psychiatric admission; and (3) DBT’s effectiveness may not translate to patients with broader and more complex psychiatric profiles, such as those in this study in which only 50% had BPD. Other authors have more recently identified inadequate time to support full implementation of all of DBT’s multiple and complex treatment modes (*ie*, phone coaching outside of business hours) and other challenges as potential key barriers to successful implementation of DBT in the VA.^{48,49} Finally, in the ‘Operation Worth Living’ trial, Collaborative Assessment and Management of Suicidality (CAMS) also did not significantly reduce suicide attempts over 6 months versus enhanced usual care.¹⁶ As for suicidal ideation, like with Standard and Enhanced Crisis Response Plans¹⁴ CAMS seemed to reduce suicidal ideation earlier, with significantly fewer Soldiers having suicidal ideation at 3 months (37% vs 61%; $P = .028$) but its advantage was not sustained at 6 months (33% vs 36%; $P = .769$) or 12 months (38% vs 40%; $P = .895$). Trial authors suggested this may have primarily been due to the inadvertent over-enhancement of treatment as usual in the control group compared to “typical” clinical care as the control group sessions were also digitally recorded and potentially observed by the research team. Although these interventions generally did not statistically significantly reduce suicide attempts, CAMS¹⁶ and CRP¹⁴ led to faster declines in at least initial suicidal ideation and thus may be considered for preliminary use or study. Because each intervention was evaluated in only a single, small study, however, we have limited confidence in their findings in general.

Table 2. Studies of Population-level Healthcare Service Interventions for Suicide Prevention

Author, Year	Study Design	N; Population; Patient Characteristics; Setting	Intervention	Outcomes	Results
<i>Recently Published Studies</i>					
Smith-Osborne, 2017 ¹³	Prospective cohort	131 Army Reserve members (71% male)	- Applied Suicide Intervention Skills Training (ASIST): training stakeholders to serve as peer assessors/counselors with harm reduction strategies and community health education - Low (< 80% of platoon members received training during calendar year) vs high levels of training	Suicide and Suicide Attempt	0 completions + 4 attempts low training group vs 0 completions or attempts high training group ($P = .01$)
Watts, 2017 ¹²	Before-after study	77,893 acute mental health admissions per year from 2000-2015 across all VHA medical centers	VA Mental Health Environment of Care Checklist (MHEOCC) which includes specific recommendations for use and suggested abatements for potential hazards.	Inpatient suicide	4.2 suicides/100,000 admissions before implementation vs 0.74 suicides/100,000 admissions after implementation
<i>Studies Included in Previous ESP Reviews (Nelson, 2015¹⁸ & Haney, 2012³⁹)</i>					
Knox, 2010 ¹⁰	Before-after study	> 5 million service personnel in the US Air Force; 1981-2008.	11-component initiative implemented starting in 1997: leadership involvement, suicide prevention education, commander guidelines for use of mental health services, community prevention services, community education and training, investigative interview policy, trauma stress response, integrated delivery system and community action information board, limited privilege suicide prevention program (increased confidentiality), assessment, and suicide event surveillance.	Suicide	Mean quarterly suicide rate: 3.033/100,000 pre-intervention vs 2.387/100,000 post-intervention ($P < .01$).
Warner, 2011 ¹¹	Post intervention series	40,283 in US deployed Army military unit; 15 months in Iraq (March 2007-May 2008).	Multiple component intervention for deployed unit included: - Pre-Deployment Phase: suicide risk recognition and response training, early	Suicide	Suicide rate: 16.0/100,000 intervention unit during the deployment cycle vs 24.0/100,000 for service



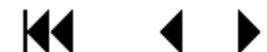
identification, and resiliency training for Soldiers and families.
 · Deployment: education, suicide prevention review board and suicide risk management teams, unit behavioral health needs assessment, unit behavioral health advocates, incident response, and trend monitoring.
 · Re-Deployment: education, post deployment health assessment, and risk stratification.
 · Reintegration: complete redeployment tasks, prepare for reuniting with families, address post-deployment health issues.

members in theater and 19.2/100,000 for US Army specifically.

Abbreviations: CI = confidence interval

Table 3. Studies of Individual-level Healthcare Service Interventions for Suicide Prevention

Author, Year N	Setting	Risk of Bias (RoB)	Suicide risk determination	% male Mean age Military status	Psychiatric Diagnosis Suicide attempt history Baseline suicide ideation severity	Intervention and Comparison	Results
<i>Recently Published Studies</i>							
Bryan, 2017 ¹⁴ N = 97 Fort Carson, Colorado Low RoB	Presenting for emergency behavioral health appointment with suicide ideation during the past week and/or lifetime history of suicide attempt			78% male 26.1 years 100% active duty US Army	44% any adjustment disorder 39% any depressive disorder 56% 1-2+ suicide attempts BSSI: range, 16-18	- Crisis response plan (CRP): suicide risk assessment, supportive listening, warning signs, self-management skills, social support, crisis resources, and referral to treatment - Enhanced crisis response plan (E-CRP): same as above with addition of "reasons for living" therapy - Contract for safety (CFS): suicide risk assessment, supportive listening, crisis resources, referral to treatment, and contract for safety	6-month suicide attempt: 3.1% CRP vs 6.2% E-CRP vs 19.0% CFS Crisis response planning (standard or enhanced) vs contract for safety HR = 0.29 (95% CI 0.06 to 1.18) adjusted for baseline suicide ideation.



Goodman, 2016 ¹⁵ N = 91 James J. Peters VA Medical Center Unclear RoB	High suicide risk irrespective of diagnosis with any of the following: (1) Recent suicide attempt; (2) suicidal ideation > 3m; (3) suicide prevention coordinator	67% male 38 years 100% Veterans	64% MDD 67% substance abuse 50% PTSD C-SSRS suicide attempts total score: 2.6	- Dialectical behavioral therapy (DBT): weekly skills training, weekly individual treatment, telephone coaching - Treatment as usual (TAU): treatment according to recommendations of mental health treatment team	6-month trial and 6-month follow-up suicide attempt: 6.5% DBT vs 11.1% TAU ($P < .487$)
Jobes, 2017 ¹⁶ "Operation Worth Living" (OWL) N = 148 Army medical Center Unclear RoB	Index score of ≥ 13 on Beck Scale for Suicidal Ideation	80.4% male 26.8 years 100% active duty Army	62.6% depressive disorder 50.7% PTSD 15.8% alcohol abuse/dependence Multiple lifetime suicide attempts: 27% Median SSI: 19	- Collaborative Assessment and Management of Suicidality (CAMS): multipurpose assessment, treatment-planning, tracking, and outcome tool with collaborative assessment and treatment-planning - Enhanced care as usual (E-CAU): treatment by on-site military clinical social workers	Past-year suicide attempts change from baseline: 0.63 ($P = .66$) CAMS vs 1.17 ($P = .004$) E-CAU; no between-group differences
<i>Studies Included in Previous ESP Reviews (Nelson, 2015¹⁸)</i>					
Rudd, 2015* ¹⁷ N = 152 Ft. Carson, CO Unclear RoB	Admitted to inpatient psychiatric hospitalization due to presence of suicidal ideation with intent to die during the past week and/or a suicide attempt within the past month	87.5% male 27 years 100% Active duty US Army	78% MDD 39% PTSD 13% substance dependence Prior suicide attempts: 1 = 38%, $\geq 2 = 38\%$ 62% antidepressants	· Brief outpatient cognitive behavioral therapy: 12 sessions, 1-2 weeks apart; first session 90 minutes, following sessions 60 minutes; 3 phases included assessment, cognitive strategies to reduce beliefs and assumptions that serve suicidal thoughts, and relapse prevention. · Usual care: treatment as usual.	After 2 years follow-up, at least one suicide attempt by 8 individuals in therapy vs 18 in usual care (14% vs 40%, $P = .02$); multivariate Cox regression controlled for baseline risk (hazard ratio 0.31, 95% CI 0.13 to 0.75).

Abbreviations: CI = confidence interval, DBT = dialectical behavior therapy, PTSD = post-traumatic stress disorder; HR = hazard ratio, TAU = treatment as usual



KEY QUESTION 3: What are important areas of ongoing research and current evidence gaps in research on suicide prevention in Veterans and military personnel, and how could they be addressed by future research?

Methods to Identify Risk

Population-level Risk Assessment

In the Nelson 2015 review, several newer innovative machine learning approaches were introduced as potentially being the most promising direction for suicide risk assessment in the near future, including use of a decision tree,⁵⁰ analysis of text from clinician notes in the electronic medical record,⁵¹ predictive modeling based on psychiatric hospitalization data,⁵ and use of taxometric evaluation of multiple indicators to stratify risk.⁵² Since 2015, several more machine learning clinical applications have emerged.

For example, 2 highly-accurate predictive models (AUC 0.89 to 0.93) have been identified for active duty Army Soldiers.^{4,7} However, future research on their applicability to Veteran populations is still needed. The recent implementation of REACH VET – the risk prediction initiative, Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment – will provide the best opportunity to directly study risk prediction in Veteran populations.³¹ Early data from the first year of implementation has already found that REACH VET has had positive impacts on 6-month patient outcomes, including greater completion of suicide prevention safety plans and less all-cause mortality.⁵³ A full report on REACH VET's first year of implementation is expected later in 2018. Also, ongoing research in other large integrated community health systems, such as Kaiser's risk prediction approach⁵⁴ and associated care management intervention for high-risk individuals⁵⁵ may have relevancy to VA use.

Individual-level Risk Assessment

Lack of concerted replication and in-depth examination of the most promising risk assessment and treatment approaches remains a concern. However, the ongoing study by Drs. Joiner and Gutierrez⁵⁶ identified in the Nelson 2015 review,¹⁸ designed to compare the accuracy of Columbia-Suicide Severity Rating Scale versus the Self-Harm Behavior Questionnaire, Suicidal Behaviors Questionnaire-Revised and the Beck Scale for Suicide Ideation in 900 military personnel, has been completed and results are expected shortly (Thomas Joiner, PhD, written communication, 7/20/2018). Hopefully, the results of this study will contribute greatly to the field.

Objective Risk Assessment

The Nelson 2015 review identified several novel objective approaches to predicting suicide behaviors, including use of certain patterns of cognitive deficits and biological markers. Examples of cognitive factors explored in relation to suicide risk include semantic stimuli reaction time (Implicit Association Test),⁵⁷ eye blink reaction (Affective Startle Measure),⁵⁸ attentional bias (Stroop test),⁵⁹ and general neurocognitive function and mathematic processing.⁶⁰ Biological factors explored in relation to suicide risk include various candidate genes (*TPHI*, *SLC6A2*, *5HTTLPR*, *GRIN2B*, *ODCI*, *MRAP2* and many others)⁶¹⁻⁷⁰ and neural correlates (*eg*, hyperactivation of prefrontal cortex and anterior cingulate, white matter hyperintensities).⁷¹⁻⁷⁴

We did not find any newly completed or ongoing studies on any of these objective factors. However, the Million Veterans Program (MVP) – VA’s national medical databases of blood samples and health information from one million Veteran volunteers to study how genes affect health – will likely be a valuable resource to study the association between genetic markers and suicide risk.⁷⁵

Healthcare Service Interventions for Suicide Prevention

Population-level Interventions

The many essential gaps in evidence on population-level interventions identified by the Nelson 2015 review, including which components in multicomponent interventions are effective, whether characteristics of individuals nonresponsive to the intervention differ from those who were responsive, and how outcomes differ from a concurrent rather than historical comparison group, still largely have not been addressed.¹⁸ In addition to the complex multicomponent interventions identified in Nelson 2015,^{10,11} 2 newly identified population-level suicide prevention interventions focused on skills training¹³ and the use of the VA Mental Health Environment of Care Checklist (MHEOCC).¹² These studies are similarly limited by lack of comparison to a concurrent control group^{12,13} and a narrow focus on inpatient mental health units.¹² In order to further validate and establish portable services packages from the complex, multi-component, population-level interventions previously identified,^{10,11} we agree with the Nelson 2015 recommendations that future studies should be conducted in additional populations, provide additional details about program implementation and fidelity, evaluate if and how effectiveness may vary based on differences in individual patient characteristics and/or specific program components, evaluate restricted access to lethal means, and be based on comparison to a concurrent control group instead of a historical control group.

Individual-level Interventions

Among the highest priority individual-level intervention areas, the most notable gaps in research are studies targeting transition to civilian life, those of health-promotion approaches that target individuals who are not in acute crisis but have known suicide risk factors, and those involving peer support specialists. Ongoing psychotherapy-focused interventions continue to be the most widely studied, encompassing all of the newly completed studies and many of the newly identified ongoing studies. We identified other ongoing studies in the areas of interventions designed to bolster protective factors,⁷⁶ novel technology approaches,^{77,78} safety planning-focused,^{79,80} and those designed to promote access of crisis services.⁸¹ However, we found no new completed or ongoing studies in other priority areas including interventions targeting known high-risk populations, such as transition to civilian life,²² and peer support specialists.

The 3 recently-published¹⁴⁻¹⁶ studies and the earlier study¹⁷ that evaluated individual-level healthcare service interventions for suicide prevention in Veterans all focused on psychotherapy or care management approaches for individuals in acute suicidal crisis. Overall, outpatient cognitive behavioral therapy (CBT) is still the most well-established individual-focused treatment, as it has consistent evidence of statistically significantly reducing suicide attempts compared to treatment as usual or standard safety planning in active duty service members or Veterans with suicide risk irrespective of psychiatric diagnosis.¹⁷ Although the other individual-focused interventions did not similarly demonstrate significant reductions in suicide attempts or suicide death, we have limited confidence in their findings in general because each intervention

was evaluated in only a single, small study with other potential weaknesses, including potential “dilution” of DBT because it was adapted for VA practice¹⁵ and inadvertent over-enhancement of treatment as usual in the control group in the ‘Operation Worth Living’ trial of Collaborative Assessment and Management of Suicidality (CAMS).¹⁶ Although we identified numerous ongoing studies on psychotherapy, none address these specific gaps (Table 4). Instead, all ongoing psychotherapy studies are focused on adaptations of cognitive behavioral therapy, including Post-Admission Cognitive Therapy (PACT),⁸²⁻⁸⁴ cognitive behavioral therapy to prevent suicide specifically in Veterans with substance use disorders,⁸⁵ cognitive therapy that integrates mindfulness and meditation,⁸⁶ and another study of an adaptation of the Window to Hope for Veterans cognitive therapy for Veterans with traumatic brain injury.⁸⁷ Therefore, larger, more rigorous RCTs of DBT and Operation Worth Living may still be warranted to more definitely determine their suicide prevention effectiveness.

We did not find any new completed studies of several other types of interventions called for by the Nelson 2015 review, including (1) health-promotion approaches that target individuals with known risk factors (*eg*, depression, traumatic brain injury, recently transitioning from military service, *etc*), irrespective of recent suicide attempts; (2) those designed to bolster protective factors such as psychological resilience, meaningful life, grit, gratitude, and social support⁸⁸⁻⁹² that are negatively associated with suicidal ideation; (3) innovative approaches that use technology to support or enhance care, such as email and text message for follow-up^{76,77,93} or crisis support⁹⁴ and other online chat and smartphone applications;⁹⁴⁻⁹⁶ (4) safety planning; or (5) peer support specialists.^{97,98}

Experts in the field within VA, the Department of Defense, and the Centers for Disease Control and Prevention have called for additional research to develop health-promotion approaches that target known suicide risk factors such as depression and traumatic brain injury,⁹⁹⁻¹⁰⁴ such as Window to Hope for Veterans.⁹⁹ The period of separation from the military has also been identified as a period of elevated suicide risk,²³ likely due to challenges in adjusting to new family and social circumstances, deployment-related psychological and physical injuries, finances, and employment and education barriers.²² Despite this, we did not identify any such studies in this update. Instead, studies of individual-level interventions for suicide prevention in Veterans have still exclusively targeted individuals in acute suicidal crisis.

Regarding interventions designed to bolster protective factors such as psychological resilience, meaningful life, grit, gratitude, and social support⁸⁸⁻⁹² that are negatively associated with suicidal ideation, we identified quite a bit of recent Caring Contacts work. Caring Contacts “traditionally entail the routine sending of brief nondemanding messages that express caring concern to patients following discharge from treatment” to promote a feeling of caring connection using various contact modalities (*ie*, mailed letters, postcards, greeting cards, emails, and text messages).^{76,105} Recent work includes a review that provides “recommendations for the implementation of the Caring Contacts intervention across diverse settings,”¹⁰⁵ a preliminary study of the acceptability of Caring Contacts with Veterans,¹⁰⁶ a pilot implementation of centralized Caring Contacts for Veterans identified by REACH VET (Sara J. Landes, PhD, written communication, 8/30/2018), ongoing evaluation of how to implement Caring Contacts in the emergency department at VA (Sara J. Landes, PhD, written communication, 8/30/2018), and a completed study with preliminary unpublished data¹⁰⁷ which found that caring contacts sent via text message reduced the risk of suicide attempts and suicidal ideation over one year follow-up in 657 active duty service members. Health coaching – an intervention that focuses on

facilitation of personal goal achievement through use of reflective listening, motivational interviewing, assessment, and accountability strategies which can be delivered by a broad range or licensed or non-licensed providers – is another emerging approach that is being evaluated as a potential intervention for bolstering protective factors. For example, we identified 2 recently completed pilot studies of health coaching with findings currently under review, one of which focuses on reducing suicidal ideation in post-9/11 Veterans with recent suicidal ideation, and the other that focuses on feasibility and acceptability of implementation as an upstream suicide prevention approach in at-risk post-9/11 Veterans without current suicide ideation (Lauren Denneson, PhD, written communication, 8/30/2018). Both may include Veterans transitioning from uniformed service to civilian life as both enrolled post-9/11 Veterans with no restrictions on time since military separation and mean ages were younger than 40 years.

For novel technology approaches, since the Nelson 2015 review, new evidence emerged on the impact of the Virtual Hope Box (VHB) smartphone app.⁷⁸ In Veterans in active mental health treatment who had recently expressed suicidal ideation, the Virtual Hope Box significantly improved ability to cope with unpleasant emotions and thoughts at 3 and 12 weeks, compared with a control group. This finding is promising and provides rationale for further study of Virtual Hope Box's effect on reducing suicide behavior.⁷⁸ In addition, we identified an ongoing study of the telephone-based Coping Long Term with Active Suicide Program (CLASP-VA).¹⁰⁸

Safety planning typically involves provider-led documentation of suicide warning signs, supportive resources, and the patient's commitment to avoiding suicide behavior. Despite its continued widespread use, its effectiveness continues to be questioned and concerns about its safety have been raised.¹⁴ In fact, in one RCT included in this review, a crisis response plan intervention that outlines steps for identifying warning signs, using coping strategies, activating social support, and accessing professional services was associated with a significantly faster decline in suicide ideation than a safety plan (suicide risk assessment, supportive listening, provision of crisis resources, referral to a mental health professional, and a verbal contract for safety).¹⁴ However, efforts to evaluate safety planning continue,^{79,80} including one ongoing study that is evaluating the potential added benefit of incorporating family involvement, including construction of a parallel safety plan.⁸⁰ Another safety planning-focused intervention being evaluated in an ongoing study is the Teachable Moment Brief Intervention, which is a single-session intervention designed for delivery prior to inpatient psychiatric hospitalization discharge to promote ongoing stabilization through development of a suicide-specific treatment plan.¹⁰⁹ Studies designed to promote access of available crisis resources, such as crisis lines, have also begun. For example, in response to a survey of Veterans in an inpatient psychiatric unit following a suicidal crisis which revealed that less than 50 percent had accessed a suicide hotline prior to their hospitalization,⁸¹ a study of a single-session Crisis Line Facilitation intervention has been initiated. This intervention is delivered to individuals in inpatient psychiatric units following a suicide crisis and is designed to promote use of the Crisis Line by identifying and removing perceived barriers and making practice calls.⁸¹

Peer support specialist interventions involve individuals who have lived through and recovered from acute suicidal crises helping to provide social support and mental health assistance to their peers in current crisis. As noted in Nelson 2015, there are ongoing efforts to evaluate use of suicide prevention peer supporters.^{97,98} We did not identify any newly completed or ongoing studies that assess the impact of suicide prevention peer supporters on suicidal behavior

outcomes; thus, future research on establishing the effectiveness on these health outcomes, as well as training requirements, functions, and eligibility of peer supporters, is still a priority.

Table 4. Ongoing Studies of Methods to Identify Suicide Risk*

Principal Investigator(s)/ Institution	Sponsors and Collaborators	Study Title/ NCT Identifier	Population	Purpose of Study
Anestis, M. ¹¹⁰ University of Southern Mississippi	Military Suicide Research Consortium	Predicting Suicide Risk in a Military Population.	1,000 Veterans at an Army National Guard base.	Test a number of models for predicting suicidal behavior to see which are most effective for Veterans. Assessments will be taken at baseline, 6, 12, and 18 months, and will include standard measures of depression and hopelessness, as well as an Implicit Association Test to objectively detect unreported suicidal thoughts. The study will also examine whether additional information provided by a collateral reporter (<i>ie</i> , the person to whom the Veteran feels closest) can improve the accuracy of predicting future suicide attempts.
Bagge, C. & Conner, K. ¹¹¹ VISN 2 Center of Excellence for Suicide Prevention; University of Mississippi Medical Center; University of Rochester Medical Center	Military Suicide Research Consortium	Looking for Suicide Warning Signs.	500 Veterans and civilians with recent suicide attempts.	Identify warning signs that indicate when a suicide attempt is imminent. This will be accomplished by examining a comprehensive list of potential warning signs to see which can effectively distinguish when a suicide attempt is likely to occur in the next 6, 24, and 48 hours.
Joiner, T. & Gutierrez, P. ⁵⁶ Florida State University; Denver VA Medical Center	Military Suicide Research Consortium	Toward a Gold Standard for Suicide Risk Assessment for Military Personnel.	900 military personnel seeking services from or referred to inpatient psychiatry, outpatient behavioral health services, or an emergency department because of concerns about suicide risk.	Identify a gold standard for clinical suicide risk assessment by testing 4 widely used measures against each other to determine which measure or combination of measures offers the most accurate prediction of suicide-related behaviors 3 months later. Measures include Columbia Suicide Severity Rating Scale, the Self-Harm Behavior Questionnaire, the Suicidal Behaviors Questionnaire-Revised, and the Beck Scale for Suicide Ideation.

*Ongoing studies were selected from websites and other sources identified by a search of grey literature based on their relevance to the key questions. The list of ongoing studies is likely incomplete because not all ongoing studies are included in these accessible sources.



Table 5. Ongoing Studies of Healthcare Service Interventions for Suicide Prevention*

Principal Investigator(s)/ Institution	Sponsors and Collaborators	Study Title/ NCT Identifier	Population	Suicidal Self-Directed Violence Outcomes	Purpose of Study	Estimated Study Completion/ Updates
Barnes, S.M. ¹¹² VA Eastern Colorado Health Care System, Denver, CO	VA Office of Research and Development	ACT for Life: A Brief Intervention for Maximizing Recovery After Suicidal Crises NCT02751983	VHA patients (number not reported).	None**	A novel protocol detailing the application of Acceptance and Commitment Therapy (ACT) to recovery from suicidal crises.	October 2018 As of March 2018, status is active and enrolling by invitation.
Brenner, L. ⁸⁷ VA Eastern Colorado Health Care System	Military Suicide Research Consortium (MSRC)	Window to Hope - Evaluating a Psychological Treatment for Hopelessness Among Veterans With Traumatic Brain Injury (WtoH) NCT01691378	Up to 15 US military personnel/Veterans	None**	To adapt Window to Hope for psychological treatment for suicide prevention in individuals with moderate to severe traumatic brain injury.	January 2020 As of May 2017, status is active and not recruiting.
Holloway, M. ⁸² Uniformed Services University of the Health Sciences	Henry M. Jackson Foundation for the Advancement of Military Medicine; Department of Veterans Affairs	Post Admission Cognitive Therapy (PACT) for the Inpatient Treatment of Military Personnel with Suicidal Behaviors. NCT01359761	218 military service members and beneficiaries hospitalized for severe suicide ideation or recent suicide attempt.	Repeat suicide attempt at 12 months (using the C-SSRS).	Evaluate the efficacy of a cognitive behavioral intervention program, the Post Admission Cognitive Therapy (PACT), for military service members and beneficiaries admitted for inpatient care due to severe suicide ideation and/or recent suicide attempt.	February 2019 As of June 2017, status is active and recruiting.
Holloway, M. ⁸³	Henry M. Jackson Foundation for the	Inpatient Post Admission	24 service members and beneficiaries	Repeat suicide attempt at 3	Evaluate a new manual of Post-Admission Cognitive	December 2018

Uniformed Services University of the Health Sciences	Advancement of Military Medicine; National Alliance for Research on Schizophrenia and Depression	Cognitive Therapy (PACT) for the Prevention of Suicide Attempts.	hospitalized for recent suicide attempts.	months (using the C-SSRS).	Therapy (PACT) as a targeted inpatient treatment for individuals admitted for a recent suicide attempt to a military hospital.	As of April 2018, status is active not recruiting.
NCT01340859						
Holloway, M. ⁸⁴ Uniformed Services University of the Health Sciences	Henry M. Jackson Foundation for the Advancement of Military Medicine, Congressionally Directed Medical Research Programs	Pilot Trial of Inpatient Cognitive Therapy for the Prevention of Suicide in Military Personnel (CDMRP).	50 service members and beneficiaries with symptoms of acute stress disorder or posttraumatic stress disorder hospitalized for a recent suicide attempt.	Repeat suicide attempt at 3 months (using the C-SSRS).	Evaluate an inpatient-based cognitive behavioral care plan, the Post-Admission Cognitive Therapy (PACT), for service members and beneficiaries with symptoms of either Acute Stress Disorder or Posttraumatic Stress Disorder, who are admitted for hospitalization following a recent suicide attempt.	December 2018 As of April 2018, status is active not recruiting.
NCT01356186						
Holloway, M. ¹¹³ VA Eastern Colorado Health Care System	VA Eastern Colorado Health Care System; Department of Veterans Affairs; Department of Defense	A Brief intervention to Reduce Suicide Risk in Military Service Members and Veterans – Study 1 (SAFE VET).	600 Veterans at VA emergency departments.	Suicide attempt at 6 months (using CSSRS).	Evaluate the Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment (SAFE VET) intervention, designed to attenuate suicide risk by helping Veterans manage suicidal thoughts and behaviors, and adhere to prescribed clinical care.	December 2018 As of June 2017, status is active and not recruiting.
NCT01334541						
Holloway, M. ⁷⁹ Henry M. Jackson Foundation for the Advancement of Military Medicine	Henry M. Jackson Foundation for the Advancement of Military Medicine; US Army Medical Research and Materiel Command; United States Department	A Brief Intervention to Reduce Suicide Risk in Military Service Members and Veterans - Study 2 (SAFEMIL)	186 patients	None**	To evaluate the efficacy of the Safety Planning for Military (SAFE MIL) on suicide ideation, suicide-related coping, and attitudes toward help seeking for hospitalized military personnel at high suicide risk.	December 2018 As of April 2018, status is active and not recruiting.



	of Defense; VA Office of Research and Development; University of Pennsylvania; University of Rochester; Columbia University	NCT01360736				
Ilgen, M. ⁸¹ VA Ann Arbor Healthcare System	Department of Veterans Affairs	Crisis Line Facilitation (CLF). NCT02459587	500 Veterans under treatment for a suicidal crisis in a Veterans Health Administration inpatient psychiatric unit.	Suicide attempt at 12 months (using CSSRS).	Test a new single-session intervention, Crisis Line Facilitation (CLF), which addresses Veterans' perceived barriers and facilitators of crisis line use during periods of suicidal crisis. The intervention will be compared to an enhanced usual care condition, with outcomes including suicide attempt and utilization of the Veterans Crisis Line.	June 2019 As of June 2018, status is active and recruiting.
Ilgen, M. ⁸⁵ University of Michigan	University of Michigan; US Army Medical Research and Materiel Command; Department of Defense; Department of Veterans Affairs	Intervening to Reduce Suicide Risk in Veterans with Substance Use Disorders. NCT02439762	300 Veterans with a Substance Use Disorder and current suicidal ideation.	Suicide attempt at 24 months (using the C-SSRS).	Evaluate the impact of a Cognitive Behavioral Therapy intervention compared to a Supportive Psychoeducational Control in reducing the frequency and intensity of suicidal thoughts and behaviors in Veterans with substance use disorders over a 2-year follow-up period.	June 2020 As of May 2018, status is active and recruiting.
Interian, A. ⁸⁶ Lyons Campus of the VA New Jersey Health Care System	Department of Veterans Affairs	Mindfulness-Based Cognitive Therapy for Suicide Prevention (MBCTS).	164 Veterans at high risk for suicide.	Suicidal behaviors at 12 months (using VA's Self-Directed Violence	Test a psychotherapeutic intervention, the Mindfulness-Based Cognitive Therapy, which integrates cognitive therapy and mindfulness meditation	July 2018 As of March 2018, status is active and



		NCT01872338		Classification System); Suicide attempt at 12 months (using C-SSRS).	techniques to prevent suicide in military Veterans.	enrolling by invitation.
Luxton, D. ⁷⁶ National Center for Telehealth and Technology	National Center for Telehealth and Technology, Department of Defense, US Army Medical Research and Materiel Command	Caring Letters for Military Suicide Prevention. NCT01473771	4,730 active duty military members or Veterans who are current psychiatric inpatients.	Suicide at 2 years (using death certificates in the National Death Index Plus); suicidal behaviors requiring hospital admission (using electronic medical records).	Determine if the Caring Letters intervention is effective in preventing suicide and suicidal behaviors among US service members and Veterans.	February 2018 As of September 2017, status is active and not recruiting.
Goodman, M. ⁸⁰	VA Office of Research and Development	SAFER: A Brief Intervention Involving Family Members in Suicide Safety Planning (SAFER) NCT03034863	60 moderate suicide risk Veterans and their family members.	None**	To integrate family and couples communication skills training with suicide safety planning. The goal is the sharing of Veteran suicide safety plans with family members and the construction of a parallel family member safety plan, in efforts to mobilize and support family involvement.	February 2020 As of June 2018, status is active and recruiting.
O'Connor, S. ¹⁰⁹ Louisville VA Medical Center	Louisville VA Medical Center; University of Louisville	Teachable Moment Brief Intervention for Veterans Following a Suicide Attempt NCT03533075	50 Veterans at VA inpatient psychiatry unit	Beck Scale for Suicide Ideation and Suicide Attempt Self-Injury Count at 3 months. Self-Directed Violence at 12 months.	Determine whether there is a signal of effectiveness supporting the TMBI in improving the recovery trajectory of Veterans following discharge to the community.	April 2019 As of May 2018, status is active and recruiting.

Primack, J. M. ¹⁰⁸ Providence VA Medical Center	Department of Veterans Affairs; Butler Hospital	Veterans Coping Long- term With Active Suicide (CLASP-VA).	300 Veterans at high risk for suicide discharged from a VA hospital	Suicidal attempts at 12 months (using CSSRS).	Test the efficacy of the Veterans Coping Long Term with Active Suicide Program (CLASP-VA) intervention to reduce suicide behaviors in Veterans. CLASP-VA is a telephone-based intervention that combines elements of individual therapy, case management, and significant other/family therapy, and directly targets high-risk patients at the time of hospital discharge.	August 2018 As of May 2018, status is active and not recruiting.
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[NCT01894841](https://clinicaltrials.gov/ct2/show/study/NCT01894841)

*Ongoing studies were selected from websites and other sources identified by a search of grey literature based on their relevance to the key questions. The list of ongoing studies is likely incomplete because not all ongoing studies are included in these accessible sources. **Included suicidal ideation outcomes that do not fit inclusion criteria of current review



SUMMARY AND DISCUSSION

Veteran suicide rates remain high despite VA's increased efforts over the past decade in implementing the comprehensive Suicide Prevention Program initiatives, such as the Veterans Crisis Line, hiring Suicide Prevention Coordinators (SPCs) at every VA hospital, and enhanced monitoring. Two important barriers to the success of these suicide prevention initiatives are that a majority of Veterans who die by suicide are non-VHA users and for those that are, there is a lack of adequate evidence in Veterans supporting recommendations of any specific risk assessment method or prevention intervention. As the number of suicide prevention studies in military populations has increased since our 2015 review,¹⁸ this update was needed to determine whether any new, stronger evidence had emerged to support any specific suicide prevention approach – particularly for innovative methods and/or in certain high-risk subpopulations, such as service members in transition to civilian life.

Despite an almost doubling of the number of studies in active duty service member and Veteran populations since our last review in 2015, several previously identified major evidence gaps remain. The 8 new studies in military populations we identified in this update evaluated numerous different approaches including risk assessment using predictive modeling^{4,7,8} and various population-level^{12,13} and individual-level interventions.¹⁴⁻¹⁶ The potentially most promising findings are from the Army Study to Assess Risk and Resilience in service members (Army STARRS) study, which identified a few large risk prediction models as fairly to highly accurate in predicting suicide risk in active duty Soldiers (AUC 0.72 to 0.97).^{4,7,8} However, the applicability of these risk prediction models in service members transitioning to civilian life and/or Veteran populations is not yet known. Perhaps the most surprising finding is that dialectical behavioral therapy (DBT) did not significantly reduce 6-month suicide attempts or ideation in a trial of 91 Veterans with high suicide risk irrespective of psychiatric diagnosis.¹⁵ This finding conflicts with previous research showing that DBT reduces suicide risk in civilian populations with borderline personality disorder.⁴¹⁻⁴⁶ Trial authors suggested that possible reasons for their contrasting results include that treatment as usual in VA may be more intensive than in other non-VA settings and so there may be less room for improvement, DBT's effectiveness may have been “diluted” due to its adaption for VA practice, and DBT's effectiveness may not translate to representative Veterans with broader and more complex psychiatric profiles. Otherwise, as in previous studies, newer evidence on various other population-level^{12,13} and individual-level interventions^{14,16} remained limited because they involved single small studies that were likely underpowered to detect impact on suicide behavior outcomes and other important methodological deficiencies.

Veterans Transitioning from Uniformed Service to Civilian Life

Service members who are separating from active duty into civilian life are at high risk of suicide. In response to the January 2018 Executive Order 13822 directing improved suicide prevention resources to Veterans during their transition from uniformed service to civilian life, HSR&D anticipates funding new research to address gaps in knowledge about risk identification and clinical and public health interventions – particularly in the highest-risk first year of separation. Our review confirmed the need for such research in Veterans during their transition from uniformed service to civilian life as we found no completed or ongoing studies that specifically focus on this subpopulation. However, we did identify 2 recently completed studies that evaluated the effects of health coaching on suicidal ideation in post-9/11 era Veterans with or

without suicidal ideation that may be considered to include Veterans during their transition from civilian life because the population mean age was under 40 years of age and there were no enrollment restrictions related to time since military separation (Lauren Denneson, PhD, written communication, 8/30/2018). Although there appears to be general consensus around the first year following the transition from military service to civilian life as being a primary transition period of interest, to increase consistency and thus facilitate comparison of effects across studies, we recommend that HSR&D establish clearer guidelines about what specific post-separation timeframe constitutes the transition period of interest. To improve applicability of research to the target population, we suggest prioritizing studies with inclusion criteria that clearly focus on a specific and relevant post-military separation time frame. Finally, to determine whether certain subgroups of Veterans transitioning from uniformed service to civilian life may benefit more or less from particular risk assessment or health service interventions, we recommend evaluating whether suicide prevention approaches differ based on patient characteristics such as the presence of mental health or substance use disorders and non-military life stressors (*eg*, financial stability, housing, employment status and relationships).

Other evidence gaps include evaluation of the potential direct and indirect adverse effects of suicide prevention efforts and evaluation of suicide prevention efforts that specifically target other high-risk populations, such as Veterans with a history of repeat suicide attempts, and those that focus on key social determinants of health and access to lethal means.

For risk assessment, although 2 highly accurate predictive models (AUC 0.89 to 0.93) have been identified for active duty Army Soldiers, future research on their applicability to Veteran populations is still needed. The recent implementation of REACH VET – the risk prediction initiative, Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment – will provide the best opportunity to directly study risk prediction in Veteran populations. A full report on REACH VET’s first year of implementation is expected later in 2018.⁵³ Also, ongoing research in other large integrated community health systems, such as Kaiser’s risk prediction approach and associated care management intervention for high-risk individuals, may have relevancy to VA use. Regardless, future research is still needed on novel approaches to suicide risk assessment, including use of cognitive deficits, biological markers, and neuroimaging.

As most population-level interventions have involved complex, multi-component interventions, more research is needed in additional populations, on implementation factors and fidelity, and on determination of key components to establish portable service packages that are more easily and widely translatable to other settings.

For individual-level interventions, it is encouraging that some progress has been made in newly completed and ongoing research in addressing previous evidence gaps. For example, there are a few ongoing cognitive behavioral therapy studies that are planned to potentially be more adequately powered than in the previous study (N = 200 to 300 vs N = 152). Also, for technology-based interventions, new evidence has emerged about impact on suicidal ideation and more is in progress. Studies are still needed that evaluate eligibility and training requirements of peer support specialists and that target known risk factors in Veterans before they are in acute suicide crisis – particularly in service members transitioning to civilian life and those with a history of repeat attempts.

One overarching critical barrier to the success of any of the suicide prevention approaches discussed in this report is that they are not yet reaching the large proportion of Veterans who die by suicide who are not VHA users. Many community-based gatekeeper outreach initiatives exist to engage Veterans in suicide prevention activities through contact at schools, colleges and universities, primary care, emergency departments, faith communities, workplaces, and more.¹¹⁴ For example, many gatekeeper trainings exist that can last anywhere from an hour to 5 days and are designed to help community members identify and refer persons at risk of suicide to appropriate treatment or supporting services in VHA.^{114,115} Such gatekeeper trainings typically aim to convey knowledge about suicide, change beliefs and attitudes about prevention, reduce stigma, and increase self-efficacy to intervene unintentionally. Operation S.A.V.E. (S=signs of suicidal thinking, A=ask questions, V=validate the person's experience, and E=encourage treatment and expedite getting help) is one such VA suicide prevention gatekeeper training that has been piloted in 5 states and received good ratings from its participants.¹¹⁶ However, more research on these and other types of community outreach programs is still needed.

Table 6. Summary of Findings

Evidence	Risk of Bias, SOE, Limitations	Summary of Findings
<i>KQ 1: What are the accuracy and adverse effects of methods to identify Veterans and military personnel at increased risk for suicide and other suicidal self-directed violence?</i>		
9 studies ¹⁻⁹ : 5 case-series ^{1-3,5,9} ; 2 RCs ^{4,7} ; 1 PC ⁸ ; 1 case-control ⁶	<ul style="list-style-type: none"> • Risk of bias: 3 studies low⁴⁻⁶; 2 high^{1,2}; 4 unclear.^{3,7-9} • SOE: Not applicable. • Limitations: Unclear selection criteria for the study populations; non-standardized risk assessment procedures. 	<ul style="list-style-type: none"> • Studies used models derived from databases or clinician-rated or patient self-report instruments.¹⁻⁹ • Accuracy varied across methods and cut-points; AUC: 0.61⁴ to 0.93⁷ • Adverse effects: Not reported.
<i>KQ 2: What are the efficacy/effectiveness and adverse effects of suicide prevention interventions in reducing rates of suicide and other suicidal self-directed violence in Veterans and military personnel?</i>		
Healthcare services directed towards populations		
4 studies ¹⁰⁻¹³ : 3 before-after ¹⁰⁻¹² ; 1 PC ¹³	<ul style="list-style-type: none"> • Risk of bias: 4 studies high¹⁰⁻¹³ • SOE: Insufficient¹⁰⁻¹³ • Limitations: unclear selection criteria for the study populations; risk of performance bias; lack of adjustment for confounders; unclear loss to follow-up. 	<ul style="list-style-type: none"> • Suicide rates were lower in 3 interventions¹⁰⁻¹² and unchanged in one intervention.¹³ • Suicide attempts were lower in one intervention.¹³ • Adverse effects: Not reported.
Healthcare services directed towards individuals		
4 studies ¹⁴⁻¹⁷ : 4 RCTs ¹⁴⁻¹⁷	<ul style="list-style-type: none"> • Risk of bias: 1 study low¹⁴; 3 unclear.¹⁵⁻¹⁷ • SOE: Low¹⁴⁻¹⁷ • Limitations: unclear randomization methods; unclear allocation concealment; unclear handling of missing data. 	<ul style="list-style-type: none"> • Suicide attempts were lower in one intervention¹⁷ and unchanged in 3 interventions.¹⁴⁻¹⁶ • Adverse effects: Not reported.
<i>KQ 3: What are important areas of ongoing research and current evidence gaps in research on suicide prevention in Veterans and military personnel, and how could they be addressed by future research?</i>		
18 studies ^{56,76,77,79-87,108-113}	Not applicable	<ul style="list-style-type: none"> • 3 studies^{56,110,111} focusing on methods to identify suicide risk; 15 studies^{76,77,79-87,108,109,112,113} focusing on healthcare service interventions for suicide prevention.

Abbreviations: KQ = key question; RCT = randomized controlled trial; RC = retrospective cohort; PC = prospective cohort; SOE = strength of evidence

CONCLUSIONS

Recent years have brought an almost doubling of the number of new studies in active duty service member and Veteran populations that have evaluated numerous different approaches to suicide prevention, including risk assessment using predictive modeling based on Army STARRS and various population-level and individual-level interventions. For suicide risk prediction, models incorporating health record and other data appear most promising and REACH VET will provide the best opportunity to directly study this approach in Veterans. For suicide prevention interventions, ongoing psychotherapy-focused interventions for individuals in acute suicidal crisis continue to be the most widely studied, with outpatient cognitive behavioral therapy (CBT) still being the most well-established treatment. The largest gaps in evidence that may be the highest priorities for future VHA research are evaluation of the adverse effects of suicide prevention efforts and evaluation of suicide prevention efforts that specifically target high-risk populations, such as those service members transitioning to civilian life and those with a history of repeat suicide attempts, and those that focus on key social determinants of health and access to lethal means.

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Operational Partners

Operational partners are system-level stakeholders who have requested the report to inform decision-making. They recommend Technical Expert Panel (TEP) participants; assure VA relevance; help develop and approve final project scope and timeframe for completion; provide feedback on draft report; and provide consultation on strategies for dissemination of the report to field and relevant groups.

Naomi Tomoyasu, PhD
Deputy Director, HSR&D

Robert O'Brien, PhD, MA
Scientific Project Manager, Mental and Behavioral Health Portfolio

Peer Reviewers

The Coordinating Center sought input from external peer reviewers to review the draft report and provide feedback on the objectives, scope, methods used, perception of bias, and omitted evidence. Peer reviewers must disclose any relevant financial or non-financial conflicts of interest. Because of their unique clinical or content expertise, individuals with potential conflicts may be retained. The Coordinating Center and the ESP Center work to balance, manage, or mitigate any potential nonfinancial conflicts of interest identified.

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