# Management of Suicidal Thoughts and Behaviors in Youth: A Systematic Review

## Appendix Contents



## Appendix Figure and Tables

# Appendix A. Search Strategy

## Ovid

Database(s): APA PsycInfo 1806 to November Week 3 2023, EBM Reviews - Cochrane Central Register of Controlled Trials November 2023, EBM Reviews - Cochrane Database of Systematic Reviews 2005 to November 22, 2023, Embase 1974 to 2023 November 22, Ovid MEDLINE(R) and Epub Ahead of Print, In-Process, In-Data-Review & Other Non-Indexed Citations, Daily and Versions 1946 to November 22, 2023
Search Strategy:

| # | Searches |
|---|---|
| 1 | Suicidal Ideation/ or Suicide, Attempted/ |
| 2 | exp suicidal behavior/ |
| 3 | exp Attempted Suicide/ |
| 4 | ((suicid* adj3 (attempt* or behavior or behaviour or ideation or plan* or think* or thought*)) or suicidality).ti,ab,kf. |
| 5 | 1 or 2 or 3 or 4 |
| 6 | Therapeutics/ |
| 7 | (dm or dt or th).fs. |
| 8 | exp Psychotherapy/ |
| 9 | Drug Therapy/ or Clomipramine/ or Duloxetine Hydrochloride/ or Escitalopram/ or Fluoxetine/ or Ketamine/ or Sertraline/ or "Serotonin and Noradrenaline Reuptake Inhibitors"/ or Selective Serotonin Reuptake Inhibitors/ |
| 10 | exp Complementary Therapies/ or exp Phototherapy/ |
| 11 | exp alternative medicine/ |
| 12 | exp Dietary Supplements/ |
| 13 | exp Integrative Medicine/ |
| 14 | Hallucinogenic Drugs/ |
| 15 | hallucinogens/ or lysergic acid diethylamide/ or n,n-dimethyltryptamine/ or psilocybin/ |
| 16 | Banisteriopsis/ |
| 17 | exp Brain Stimulation/ |
| 18 | exp Deep Brain Stimulation/ |
| 19 | exp dialectical behavior therapy/ |
| 20 | exp Motivational Interviewing/ |
| 21 | exp Transcranial Magnetic Stimulation/ |
| 22 | exp Cognitive Therapy/ |
| 23 | exp Cognitive Behavior Therapy/ |
| 24 | exp lithium/ |
| 25 | exp Clozapine/ |
| 26 | exp Olanzapine/ |

27 exp Mood Stabilizers/

28 exp mood stabilizer/

29 exp "Acceptance and Commitment Therapy"/

30 exp Wearable Devices/

31 exp wearable sensor/

32 exp Internet/

33 exp *Social Media/

34 exp Psychopharmacology/

35 Pharmacology/

((social adj2 network*) or "acceptance and commitment therap*" or "Acoustic Stimulation" or Acupressure or Acupuncture or agent* or alternative or Anafranil or antidepress* or "anti-depress*" or Aromatherap* or "Art Therap*" or arTMS or Auriculotherap* or "Autogenic Training" or ayahuasca or ayahuascas or Ayurvedic or baidu or banisteriopses or banisteriopsis or "Behavioral therap*" or Biofeedback or Bioresonance or blog* or "Brain Stimulation" or "Breathing Exercise*" or "Bright light therap*" or CAM or carbamazepine or CBT or clomipramine or Clozapine or "Cognitive behavioral therap*" or "Cognitive therap*" or "Cognitive-Behavioral Analysis" or "Color Therap*" or "combination therap*" or complementary or "couples therap*" or Cupping or Cymbalta or "Dance Therap*" or "dialectical behavior therap*" or "dialectical behavior treatment*" or "dialectical behavioral therap*" or "dialectical behavioral treatment*" or "dialectical behaviour therap*" or "dialectical behavioural therap*" or Digital or dimethyltryptamine or DMT or doximity or drug or drugs or "Dry Needling" or Duloxetine or "electric convulsive therap*" or "electric convulsive treatment*" or "electric shock therap*" or "electric shock treatment*" or Electroacupuncture or "electroconvulsant therap*" or "electroconvulsant treatment*" or "electroconvulsive shock therap*" or "electroconvulsive shock treatment*" or "electroconvulsive therap*" or "electroconvulsive treatment*" or "electroshock therap*"

36 or "electroshock treatment*" or escitalopram or Exercise or Facebook or "Faith Healing" or "Family therap*" or Fluoxetine or "Functional neurosurg*" or "Group Therap*" or Hallucinogen* or Homeopath* or "Horticultural Therap*" or Hypnosis or Instagram or Integrative or Internet or "Interpersonal therap*" or intervention* or Ketamine or lamotrigine or "Laughter Therap*" or Lexapro or "Life-Review*" or linkedin or Lithium or LSD or "lysergic acid diethylamide" or manag* or medication* or Meditation or "Mental Healing" or Mentalization or Mesotherap* or "Mind-Body Therap*" or Mindfulness or MomMD or "mood stabiliz*" or "Motivational Interviewing" or Moxibustion or "Multicomponent intervention*" or "Music Therap*" or myspace or "N N-dimethyltryptamine" or Naturopathy or Neurofeedback or neuropsychopharmacolog* or Neurotherapeutic* or nonpharmaco* or Olanzapine or Organotherap* or "Parent Child Interaction therap*" or pharmaceutical* or pharmaco* or Pharmacolog* or pharmacopsycholog* or phototherap* or Phytotherap* or pinterest or "Play Therap*" or podcast* or "Problem-solving therap*" or Prolotherap* or Prozac or psilocybin or psychedelic* or psychiatri* or Psychodrama* or psychodynamic* or Psychopharmacolog* or psychosocial or psychotherap* or psycologist* or Qigong or "Quantia MD" or QuantiaMD or Radiesthesia or reddit or Reflexotherap* or reiki or "Relaxation Therap*" or "Role Playing" or rTMS or "selective serotonin uptake inhibitor*" or "Sensory Art

Therapies" or sermo or "Serotonin and Noradrenaline Reuptake Inhibitor*" or Sertraline or snapchat or SNRI* or "social media" or "social worker*" or "Spiritual Therap*" or SSRI* or supplement* or "Supportive therap*" or Symbyax or "Tai Chi" or "Tai Ji" or therap* or "Therapeutic Touch" or therapist* or "Theta Burst Stimulat*" or tieba or TikTok or TMS or "traditional Medicine" or "transcranial magnetic stimulat*" or "trans-cranial magnetic stimulat*" or treat* or Tumblr or tweet* or Twitter* or "Vagus Nerve Stimulat*" or "valproic acid" or viber or wearable* or wechat or weibo or WeMedUp or whatsapp or wiki* or wikia or Yoga or "You Tube" or YouTube or Zoloft or zuranolone).ti,ab,kf.

37 or/6-36

38 5 and 37

39 (adolescen* or boy or boys or child* or college* or girl or girls or juvenile* or paediatric* or pediatric* or preadolescen* or prepubescen* or preschooler* or "pre-schooler*" or preteen or "pre-teen" or preteen* or preteens or "pre-teens" or pubescen* or school* or student* or teen or teen* or teenager* or teens or universit* or "young adult*" or "young adulthood" or "young men" or "young people" or "young women" or youth or youths).ti,ab,kf,hw.

40 38 and 39

41 exp "Systematic Review"/

42 exp Meta-Analysis/

43 exp Controlled Clinical Trial/

44 exp Guideline/

45 exp Treatment Guidelines/

46 exp practice guideline/

47 Case-Control Studies/ or Cohort Studies/ or Comparative Study/ or Controlled Before-After Studies/ or Cross-Sectional Studies/ or Epidemiologic Studies/ or exp Evaluation Studies as Topic/ or Follow-Up Studies/ or Historically Controlled Study/ or Interrupted Time Series Analysis/ or Longitudinal Studies/ or Prospective Studies/ or Retrospective Studies/

48 (((comparative or epidemiologic or evaluation) adj3 study) or ((evidence or review or scoping or systematic or umbrella) adj3 (review or synthesis)) or (historic* adj4 control*) or "before-after" or "case-control" or cohort1 or control or controlled or controls or "cross-sectional" or "follow-up" or "interrupted time" or longitudinal* or metaanal* or "meta-anal*" or placebo* or prospective* or random* or retrospective* or trial*).ti,ab,kf.

49 guideline*.ti,ab,kf.

50 or/41-49

51 40 and 50

52 limit 51 to yr="2022 -Current"

53 remove duplicates from 52

54 limit 51 to yr="2020 -2021"

55 remove duplicates from 54

56 limit 51 to yr="2018 -2019"

57 remove duplicates from 56

58 limit 51 to yr="2016 -2017"
59 remove duplicates from 58
60 limit 51 to yr="2013 -2015"
61 remove duplicates from 60
62 limit 51 to yr="2010 -2012"
63 remove duplicates from 62
64 limit 51 to yr="2005 -2009"
65 remove duplicates from 64
66 limit 51 to yr="2000 -2004"
67 remove duplicates from 66
68 52 or 54 or 56 or 58 or 60 or 62 or 64 or 66
69 51 not 68
70 remove duplicates from 69
71 53 or 55 or 57 or 59 or 61 or 63 or 65 or 67 or 70

## Scopus

1 TITLE-ABS-KEY((suicid* W/3 (attempt* or behavior or behaviour or ideation or plan* or think* or thought*)) or suicidality)

2 TITLE-ABS-KEY((social W/2 network*) OR "acceptance and commitment therap*" OR "Acoustic Stimulation" OR Acupressure OR Acupuncture OR agent* OR alternative OR Anafranil OR antidepress* OR "anti-depress*" OR Aromatherap* OR "Art Therap*" OR arTMS OR Auriculotherap* OR "Autogenic Training" OR ayahuasca OR ayahuascas OR Ayurvedic OR baidu OR banisteriopses OR banisteriopsis OR "Behavioral therap*" OR Biofeedback OR Bioresonance OR blog* OR "Brain Stimulation" OR "Breathing Exercise*" OR "Bright light therap*" OR CAM OR carbamazepine OR CBT OR clomipramine OR Clozapine OR "Cognitive behavioral therap*" OR "Cognitive therap*" OR "Cognitive-Behavioral Analysis" OR "Color Therap*" OR "combination therap*" OR complementary OR "couples therap*" OR Cupping OR Cymbalta OR "Dance Therap*" OR "dialectical behavior therap*" OR "dialectical behavior treatment*" OR "dialectical behavioral therap*" OR "dialectical behavioral treatment*" OR "dialectical behaviour therap*" OR "dialectical behavioural therap*" OR Digital OR dimethyltryptamine OR DMT OR doximity OR drug OR drugs OR "Dry Needling" OR Duloxetine OR "electric convulsive therap*" OR "electric convulsive treatment*" OR "electric shock therap*" OR "electric shock treatment*" OR Electroacupuncture OR "electroconvulsant therap*" OR "electroconvulsant treatment*" OR "electroconvulsive shock therap*" OR "electroconvulsive shock treatment*" OR "electroconvulsive therap*" OR "electroconvulsive treatment*" OR "electroshock therap*" OR "electroshock treatment*" OR escitalopram OR Exercise OR Facebook OR "Faith Healing" OR "Family therap*" OR Fluoxetine OR "Functional neurosurg*" OR "Group Therap*" OR Hallucinogen* OR Homeopath* OR "Horticultural Therap*" OR Hypnosis OR Instagram OR Integrative OR Internet OR "Interpersonal therap*" OR intervention* OR Ketamine OR lamotrigine OR "Laughter Therap*" OR Lexapro OR "Life-Review*" OR linkedin

OR Lithium OR LSD OR "lysergic acid diethylamide" OR manag* OR medication* OR Meditation OR "Mental Healing" OR Mentalization OR Mesotherap* OR "Mind-Body Therap*" OR Mindfulness OR MomMD OR "mood stabiliz*" OR "Motivational Interviewing" OR Moxibustion OR "Multicomponent intervention*" OR "Music Therap*" OR myspace OR "N N-dimethyltryptamine" OR Naturopathy OR Neurofeedback OR neuropsychopharmacolog* OR Neurotherapeutic* OR nonpharmaco* OR Olanzapine OR Organotherap* OR "Parent Child Interaction therap*" OR pharmaceutical* OR pharmaco* OR Pharmacolog* OR pharmacopsycholog* OR phototherap* OR Phytotherap* OR pinterest OR "Play Therap*" OR podcast* OR "Problem-solving therap*" OR Prolotherap* OR Prozac OR psilocybin OR psychedelic* OR psychiatri* OR Psychodrama* OR psychodynamic* OR Psychopharmacolog* OR psychosocial OR psychotherap* OR psycologist* OR Qigong OR "Quantia MD" OR QuantiaMD OR Radiesthesia OR reddit OR Reflexotherap* OR reiki OR "Relaxation Therap*" OR "Role Playing" OR rTMS OR "selective serotonin uptake inhibitor*" OR "Sensory Art Therapies" OR sermo OR "Serotonin and Noradrenaline Reuptake Inhibitor*" OR Sertraline OR snapchat OR SNRI* OR "social media" OR "social worker*" OR "Spiritual Therap*" OR SSRI* OR supplement* OR "Supportive therap*" OR Symbyax OR "Tai Chi" OR "Tai Ji" OR therap* OR "Therapeutic Touch" OR therapist* OR "Theta Burst Stimulat*" OR tieba OR TikTok OR TMS OR "traditional Medicine" OR "transcranial magnetic stimulat*" OR "trans-cranial magnetic stimulat*" OR treat* OR Tumblr OR tweet* OR Twitter* OR "Vagus Nerve Stimulat*" OR "valproic acid" OR viber OR wearable* OR wechat OR weibo OR WeMedUp OR whatsapp OR wiki* OR wikia OR Yoga OR "You Tube" OR YouTube OR Zoloft OR zuranolone)

3 TITLE-ABS-KEY(adolescen* or boy or boys or child* or college* or girl or girls or juvenile* or paediatric* or pediatric* or preadolescen* or prepubescen* or preschooler* or "pre-schooler*" or preteen or "pre-teen" or preteen* or preteens or "pre-teens" or pubescen* or school* or student* or teen or teen* or teenager* or teens or universit* or "young adult*" or "young adulthood" or "young men" or "young people" or "young women" or youth or youths)

4 TITLE-ABS-KEY(((comparative or epidemiologic or evaluation) W/3 study) or ((evidence or review or scoping or systematic or umbrella) W/3 (review or synthesis)) or (historic* W/4 control*) or "before-after" or "case-control" or cohort1 or control or controlled or controls or "cross-sectional" or "follow-up" or "interrupted time" or longitudinal* or metaanal* or "meta-anal*" or placebo* or prospective* or random* or retrospective* or trial* or guideline*)

5 1 and 2 and 3 and 4

6 INDEX(embase) OR INDEX(medline) OR PMID(0* OR 1* OR 2* OR 3* OR 4* OR 5* OR 6* OR 7* OR 8* OR 9*)

7 5 and not 6

## Clinical Trial Registries

Search 1

Condition or disease
suicidal ideation

age child, adult

Search 2

Condition or disease
suicide, attempted

age child, adult

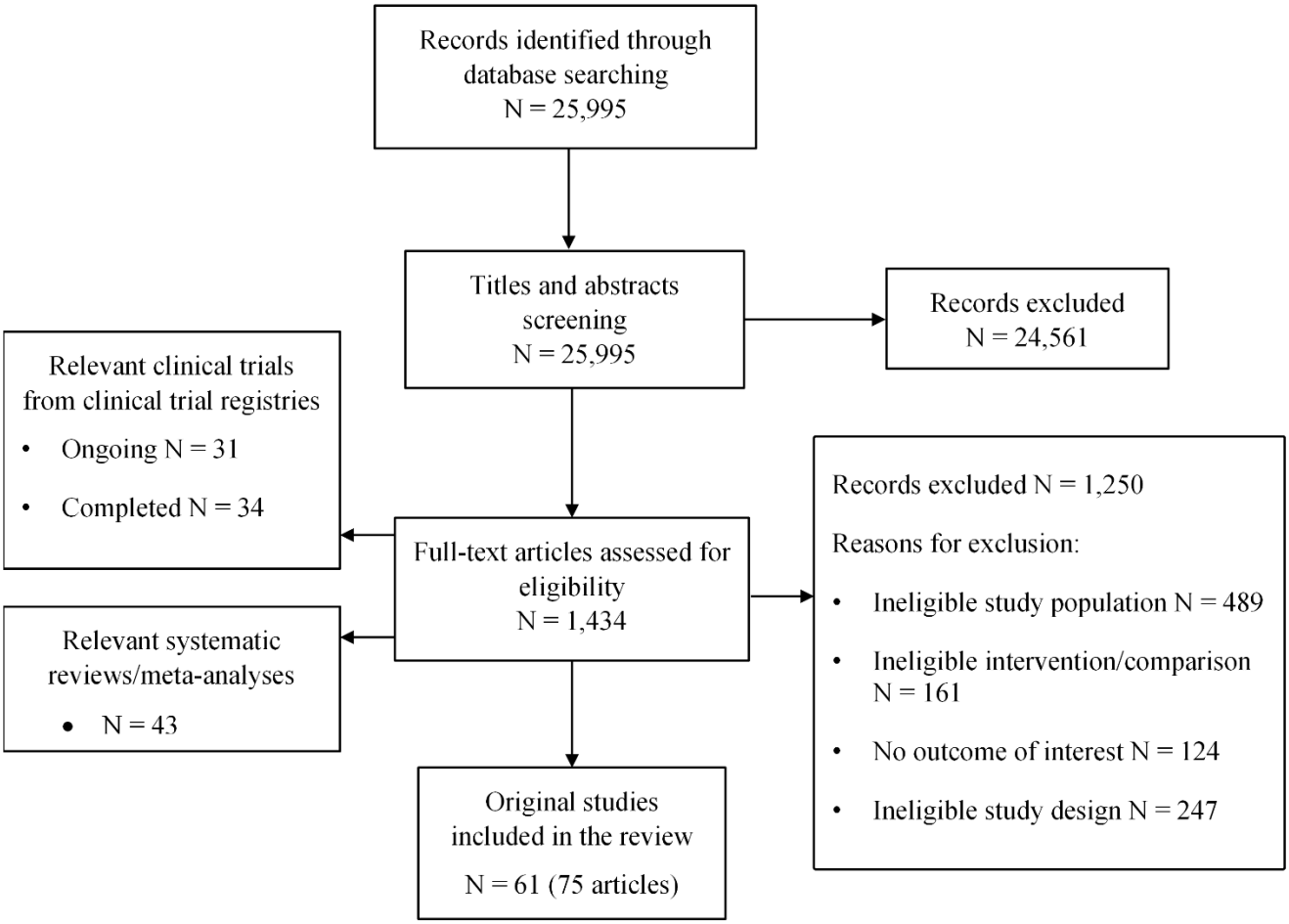
Search 3

Condition or disease
Suicide gesture

age child, adult

# Appendix B. Flow Chart

**Figure B.1. Flow Chart**




Abbreviations: N = number

# Appendix C. List of Excluded Studies Upon Full-Text Review

1. Treatment of Adolescent Suicide Attempters (TASA). 2004. PMID: CN-02023463. *Outcome*
2. The Postcard Study. 2006. PMID: CN-02441594 NEW. *Study Design*
3. A Multi-Centre, Double-Blind, Randomised, Parallel Group, Placebo-Controlled and Active Controlled Phase III Study of the Efficacy and Safety of Quetiapine Fumarate Sustained Release (Seroquel SRTM) as Mono-Therapy in the Treatment of Adult Patients with Major Depressive Disorder (AMBER STUDY) - Amber Study. 2006. PMID: CN-01798800. *Study Design*
4. Family Intervention for Suicidal Youth: emergency Care. 2007. PMID: CN-02013985. *Intervention*
5. Inpatient Post Admission Cognitive Therapy (PACT) for the Prevention of Suicide Attempts. 2011. PMID: CN-01486129. *Population*
6. Mindfulness-based treatment of depression and behavioral activation treatments for depression in depressed patients. 2013. PMID: CN-01875529. *Study Design*
7. AFFIRM-SA trial. 2013. PMID: CN-01823407. *Study Design*
8. A Double-blind Study to Assess the Efficacy and Safety of Intranasal Esketamine for the Rapid Reduction of the Symptoms of Major Depressive Disorder, Including Suicidal Ideation, in Participants Who Are Assessed to be at Imminent Risk for Suicide. 2014. PMID: CN-02044495. *Population*
9. Effect of Ketamine vs. Active Placebo on Suicidal Ideation in Depressed Inpatients With Major Depressive Disorder or Bipolar Depression. 2015. PMID: CN-01493435. *Population*
10. RCT of the Clinical and Cost Effectiveness of Cognitive Behaviour Therapy (CBT) Delivered Remotely Versus Treatment as Usual in Adolescents and Young Adults With Depression Who Repeatedly Self-harm. 2015. PMID: CN-01504698. *Population*
11. MYRIAD: my Resilience in Adolescence, a study examining the effectiveness and cost-effectiveness of a mindfulness training programme in schools compared with normal school provision. 2016. PMID: CN-01872391. *Study Design*
12. MYPLAN - Effectiveness of a Safety Plan App to Manage Crisis of Persons at Risk of Suicide. 2016. PMID: CN-02032839. *Population*
13. A multi-centre, parallel-group, randomised controlled trial to evaluate the NEVERMIND system in preventing and treating depression in patients with a severe somatic disease. 2017. PMID: CN-01890115. *Study Design*
14. Mass media campaign material designed to prevent youth suicide: a randomised controlled trial. 2017. PMID: CN-01803806. *Study Design*
15. Testing the efficacy of an Emotion Regulation Group Therapy for adolescent non-suicidal self-injury in Aotearoa New Zealand. 2017. PMID: CN-01888137. *Study Design*
16. Online study: effects of videos on coping with depression and suicidal ideation for suicide prevention - Effects of suicide prevention videos. 2018. PMID: CN-01907598. *Study Design*
17. Southwest Hub for American Indian Youth Suicide Prevention Research. 2018. PMID: CN-01660010. *Population*

18. The BEACON Study: smartphone-Assisted Problem-Solving Therapy in Men Presenting to the ED With Self-Harm (Protocol A). 2018. PMID: CN-01567843. *Population*

19. Effectiveness of a Personalized Inpatient Program for Persistent Depressive Disorder. 2018. PMID: CN-01661847. *Population*

20. Brief Alcohol Intervention and mHealth Booster for Suicidal Adolescents. 2018. PMID: CN-01661607. *Intervention*

21. Reducing Help-Seeking Stigma in Young Adults at Elevated Suicide Risk. 2018. PMID: CN-01662636. *Population*

22. Eye Movement Desensitization and Reprocessing (EMDR) for Adult Inpatients With Suicidal and/or Self-injurious Behavior. 2019. PMID: CN-02010262. *Study Design*

23. BRITEPath, Component 3 of iCHART (Integrated Care to Help At-Risk Teens). 2019. PMID: CN-01952856. *Intervention*

24. Engaging Black Youth in Depression and Suicide Prevention Treatment Within Urban Schools. 2019. PMID: CN-01931901. *Intervention*

25. A trial of a smartphone-based youth suicide prevention application. 2019. PMID: CN-02065012. *Study Design*

26. A Study to evaluate the efficacy and safety of Esketamine combined with oral antidepressants in the treatment of depression with suicidal ideatione. 2020. PMID: CN-02448420 NEW. *Population*

27. A Single Ketamine Infusion Combined With Music for Suicidal Ideation. 2020. PMID: CN-02206229. *Population*

28. Preventing Suicide in African American Adolescents. 2020. PMID: CN-02080016. *Intervention*

29. A Trial of Online LGBTQ-affirmative Cognitive Behavioral Therapy to Reduce Depression and Associated Health Risks Among Young Adults. 2020. PMID: CN-02125024. *Intervention*

30. Evaluation of the Efficacy of Non-drug Therapy (SMS Intervention) for Children and Adolescents With Repeated NSSI. 2020. PMID: CN-02145460. *Intervention*

31. A Pilot Study of Creatine Monohydrate as an Augmenting Agent for ECT in Persons With Major Depressive Disorder. 2020. PMID: CN-02145922. *Population*

32. IRIS-A: a brief and easily applicable two-session smartphone app-supported program of Imagery Rescripting of Imagery Self-Injury – for Adolescents with nonsuicidal self-injury disorder (NSSID). 2021. PMID: CN-02328786. *Study Design*

33. Transcranial Magnetic Stimulation (TMS) as a Treatment/Intervention for Depression in Adolescents and Young adults. 2021. PMID: CN-02327256. *Study Design*

34. A randomised controlled trial of the effect of a m-health app and digital engagement strategy on treatment adherence and suicidal outcomes. 2021. PMID: CN-02327297. *Study Design*

35. Smartphone-based Ecological Momentary Intervention for Suicide Prevention: a Randomised Clinical Trial. 2021. PMID: CN-02249391. *Population*

36. Skills to Enhance Positivity in Suicidal Youth. 2021. PMID: CN-02291294. *Population*

37. Single dose of esketamine for suicidality. 2021. PMID: CN-02255478. *Study Design*

38. CAMPUS - Feasibility Sub-Study. 2021. PMID: CN-02234517. *Outcome*

39. Study on the Intervention of Collaborative Assessment and Management of Suicidality (CAMS) for Suicidal College Students. 2022. PMID: CN-02569749 NEW. *Study Design*

40. A Double-Blind, Randomized, Midazolam-Controlled Study of Esketamine in an Adaptive Treatment Protocol to Assess Safety and Efficacy in Treatment-Resistant Depression and/or Depression With Imminent Risk for Suicide Among Adolescents. 2022. PMID: CN-02525642 NEW. *Study Design*

41. Leverage Noninvasive Transcutaneous Vagus Nerve Stimulation to Reduce Suicidal Behaviors in Vulnerable Adolescents. 2022. PMID: CN-02494068 NEW. *Intervention*

42. Effectiveness of a CBT Based Mobile Application. 2022. PMID: CN-02366710. *Population*

43. Digital Narrative Bibliotherapy as a Scalable Intervention for Suicidal Thoughts. 2022. PMID: CN-02404836. *Population*

44. TBS Treatment for Treatment-Resistant Depression. 2022. PMID: CN-02405258. *Population*

45. Intervention Effect of High Definition Transcranial Direct Current Stimulation (HD-tDCS) on Anxiety Disorder. 2022. PMID: CN-02391760. *Population*

46. The Mental Imagery for Suicidality in Students Trial (MISST). 2022. PMID: CN-02391719. *Population*

47. Efficacy and safety of alternative spray in the treatment of adolescent self-injury. 2023. PMID: CN-02606761 NEW. *Study Design*

48. Behavioural activation for young people. 2023. PMID: CN-02595294 NEW. *Outcome*

49. Effectiveness of Muslim prayer in mental health illness. 2023. PMID: CN-02599104 NEW. *Study Design*

50. Brain effect mechanism of adolescent depression suicide risk prediction and intervention based on fNIRS and multimodal fMRI. 2023. PMID: CN-02595732 NEW. *Study Design*

51. Intervention for university students with symptoms of Depression and Suicidal Ideation during Covid-19 pandemic. 2023. PMID: CN-02594511 NEW. *Study Design*

52. Dynamic Deconstructive Psychotherapy Versus Brief Intervention and Contact for Suicidal Adolescents and Young Adults. 2023. PMID: CN-02589906 NEW. *Study Design*

53. Ketamine & Crisis Response Plan for Suicidal Ideation in the ED. 2023. PMID: CN-02517939 NEW. *Study Design*

54. Suicide Prevention for Sexual and Gender Minority Youth (Randomized Controlled Trial). 2023. PMID: CN-02511474 NEW. *Population*

55. Abbar M, Demattei C, El-Hage W, et al. Ketamine for the acute treatment of severe suicidal ideation: double blind, randomised placebo controlled trial. Bmj. 2022 02 02;376:e067194. doi: https://dx.doi.org/10.1136/bmj-2021-067194. PMID: 35110300. *Population*

56. Abbott CH, Zisk A, Bounoua N, et al. Predicting Patterns of Treatment Response and Outcome for Adolescents Who Are Suicidal and Depressed. J Am Acad Child Adolesc Psychiatry. 2019 09;58(9):897-906. doi: https://dx.doi.org/10.1016/j.jaac.2018.12.013. PMID: 30877051. *Intervention*

57. Abbott CH, Zisk A, Herres J, et al. Exploring the relations between interpersonal risk and adolescent suicidality during treatment. J Consult Clin Psychol. 2021 Jun;89(6):528-36. doi: https://dx.doi.org/10.1037/ccp0000656. PMID: 34264700. *Intervention*

58. Abbott-Smith S, Ring N, Dougall N, et al. Suicide prevention: What does the evidence show for the effectiveness of safety planning for children and young people? - A systematic scoping review. J Psychiatr Ment Health Nurs. 2023 Oct;30(5):899-910. doi: https://dx.doi.org/10.1111/jpm.12928. PMID: 37052321. *Study Design*

59. Abdulah DM, Abdulla BMO. Suicidal ideation and attempts following a short-term period of art-based intervention: An experimental investigation. Arts in Psychotherapy. 2020 March;68 (no pagination). doi: https://dx.doi.org/10.1016/j.aip.2020.101648. PMID: 2005182709. *Population*

60. Abojaradeh AM, Shehadeh J, Abojaradeh A, et al. Effectiveness of community-based mental health education programs on mental health issues awareness level among students in Jordan. Malays J Med Health Sci. 2019;15:54-9. *Intervention*

61. Abraham ZK, Sher L. Adolescent suicide as a global public health issue. International Journal of Adolescent Medicine and Health. 2019 Aug;31(4):1-9. doi: https://dx.doi.org/10.1515/ijamh-2017-0036. PMID: 2019-56920-002. *Study Design*

62. Abreu RL, Kenny MC. Cyberbullying and LGBTQ Youth: A Systematic Literature Review and Recommendations for Prevention and Intervention. J. 2018 Mar;11(1):81-97. doi: https://dx.doi.org/10.1007/s40653-017-0175-7. PMID: 32318140. *Outcome*

63. Abrial E, Chalancon B, Leaune E, et al. Investigating Predictive Factors of Suicidal Re-attempts in Adolescents and Young Adults After a First Suicide Attempt, a Prospective Cohort Study. Study Protocol of the SURAYA Project. Front Psychiatr. 2022;13:916640. doi: https://dx.doi.org/10.3389/fpsyt.2022.916640. PMID: 35845461. *Intervention*

64. Ackerman JP, Horowitz LM. Youth suicide prevention and intervention: Best practices and policy implications.ST - SpringerBriefs in psychology: Advances in child and family policy and practice. (2022) Youth suicide prevention and intervention: Best practices and policy implications xvi, 169pp Cham, Switzerland: Springer Nature Switzerland AG; Switzerland. 2022. *Conference Abstract*

65. Acolin J. Economic Evaluation of Dialectical Behavioral Therapy Versus Cognitive Behavioral Therapy for Suicide Prevention. Journal of Mental Health Policy and Economics. 2022;25(4):123-31. PMID: 2026885590. *Population*

66. Addiction Cf, Health M, Foundation TPSI. Digital Dialectical Behavioral Therapy (d-DBT) Skills for Acute Suicidality in Psychiatric Inpatients. https://classic.clinicaltrials.gov/show/NCT05045677; 2022. *Population*

67. Addiction Cf, Health M, Foundation TPSI. rTMS for Suicidality in Opioid Use Disorder. https://classic.clinicaltrials.gov/show/NCT04785456; 2022. *Population*

68. Adebiyi OA, Khetarpal S, Esque J, et al. 48.3 Phone-Based Intervention for Suicidal Transitional-Age Adults. Journal of the American Academy of Child and Adolescent Psychiatry. 2020 October;59(10 Supplement):S244-S5. doi: https://dx.doi.org/10.1016/j.jaac.2020.08.389. PMID: 2008336734. *Conference Abstract*

69. Adjorlolo S, Anum A, Amin JM. Validation of the Suicidal Behaviors Questionnaire-Revised in adolescents in Ghana. J Ment Health. 2022 Jun;31(3):302-8. doi: https://dx.doi.org/10.1080/09638237.2020.1739239. PMID: 32174227. *Intervention*

70. Adrian M, Blossom JB, Chu PV, et al. Collaborative assessment and management of suicidality for teens: A promising frontline intervention for addressing adolescent suicidality. Pract. 2022 Jun;7(2):154-67. doi: https://dx.doi.org/10.1037/pri0000156. PMID: 2021-78176-001. *Study Design*

71. Adu MK, Shalaby R, Eboreime E, et al. Apparent Lack of Benefit of Combining Repetitive Transcranial Magnetic Stimulation with Internet-Delivered Cognitive Behavior Therapy for the Treatment of Resistant Depression: Patient-Centered Randomized Controlled Pilot Trial. Brain sci. 2023 February;13(2) (no pagination). doi: https://dx.doi.org/10.3390/brainsci13020293. PMID: 2021765761. *Outcome*

72. Aggarwal S, Berk M, Shah N, et al. Evaluating the acceptability of atman intervention for self-harm in youth in india: A pilot study. International Journal of Mental Health. 2023 Jun:No Pagination Specified. doi: https://dx.doi.org/10.1080/00207411.2023.2230041. PMID: 2023-89032-001. *Population*

73. Aggarwal S, Patton G. Engaging families in the management of adolescent self-harm. Evid Based Ment Health. 2018 02;21(1):16-22. doi: https://dx.doi.org/10.1136/eb-2017-102791. PMID: 29311249. *Intervention*

74. Ahmadi A, Ytterstad B. Prevention of self-immolation by community-based intervention. Burns. 2007 Dec;33(8):1032-40. PMID: 17544221. *Population*

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# Appendix D. Characteristics of Included Studies

**Table D.1. Characteristics of Included Studies for Cognitive-Behavioral Therapy (CBT)**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Duarté-Vélez-, 2022**[1] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 1/2016–2/2018 | Inclusion: Latinx or Hispanic participants aged 13–17 years who are fluent in English or Spanish, have experienced suicidal ideation in the past month or attempted suicide within the past two months, and have a legal guardian's participation.<br><br>Exclusion: Having a psychotic disorder, severe substance use disorder as assessed by DSM-5 criteria, insufficient cognitive skills to engage in psychotherapy, currently receiving any other form of psychotherapy, or involvement in a legal procedure that would require psychological care mandated by the judicial system. | 12 months | Socio-Cognitive-Behavioral Therapy Protocol for Suicidal Behaviors (SCBT-SB)<br>(N=24) | 1.5–3 hours/week+ collateral case management support as needed, home-based services usually lasted from 6–14 weeks | Age (SD): 15. 8 years (1.2 years)<br>Female: 83%<br>Self-identified Male: 8.3%<br>Self-identified Trans-Gender fluid: 8.7%<br>Heterosexual: 38%<br>Bisexual: 38%<br>Don't know/ Not sure (Gender Identity): 21%<br>Gay or Lesbian: 4.2%<br>Hispanic-White: 35%<br>Hispanic-Mix: 22%<br>Hispanic-African American: 15%<br>Non Hispanic African American: 7%<br>Asian: 2.1%<br>American Indian: 2.1%<br>Othe race/ethnicity: 16%(total population)<br>Sexual trauma: 25%<br>Mood disorders: 92%<br>Bipolar disorder: 4%<br>PTSD and stressor related disorder: 67%<br>Schizophrenia/psychosis: 8%<br>Anxiety disorders: 71%<br>OCD: 4%<br>Panic Attack: 67%<br>ODD: 25%<br>Conduct & Unspecified Disruptive Disorder: 25%<br>Substance use disorder: 21%<br>Bulimia & unspecified eating disorder: 8%<br>ADHD: 13%<br>Prior suicidal attempt: 91% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Duarté-Vélez-, 2022[1] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 1/2016–2/2018 | Inclusion: Latinx or Hispanic participants aged 13–17 years who are fluent in English or Spanish, have experienced suicidal ideation in the past month or attempted suicide within the past two months, and have a legal guardian's participation.<br><br>Exclusion: Having a psychotic disorder, severe substance use disorder as assessed by DSM-5 criteria, insufficient cognitive skills to engage in psychotherapy, currently receiving any other form of psychotherapy, or involvement in a legal procedure that would require psychological care mandated by the judicial system. | 12 months | Treatment as Usual (TAU) (N=22) | 1.5–3 hours/week+ collateral case management support as needed, home-based services usually lasted from 6–14 weeks | Age (SD): 15.1 years (1.4 years)<br>Female: 77%<br>Self-identified female: 64%<br>Self-identified male: 23%<br>Self-identified trans-gender fluid: 13.3%<br>Heterosexual: 59%<br>Bisexual: 23%<br>Don't Know/ No sure (Gender Identity): 14%<br>Gay or Lesbian: 4.5%<br>Hispanic-White: 35%<br>Hispanic-Mix: 22%<br>Hispanic-African American: 15%<br>Non Hispanic African American: 7%<br>Asian: 2.1%<br>American Indian: 2.1%<br>Other race/ethnicity: 16%(total population)<br>Sexual Trauma: 14%<br>Mood Disorders: 86%<br>Bipolar Disorder: 5%<br>PTSD and stressor related disorder: 23%<br>Schizophrenia/psychosis: 14%<br>Anxiety disorders: 68%<br>OCD: 18%<br>Panic attack: 50%<br>ODD: 36%<br>Conduct & unspecified disruptive disorder: 27%<br>Substance use disorder: 5%<br>Bulimia & unspecified eating disorder: 27%<br>ADHD: 23%<br>Prior suicidal attempt: 89% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Sinyor, 2020**[2] | Country: Canada<br>Study Design: RCT<br>Patient Enrollment Period: 9/2016–2/2018 | Inclusion: Youth aged 16–26 years, admitted to hospital following an episode of self-harm, defined as any intentional destructive action regardless of suicidal intent, and have ability to read and understand English.<br><br>Exclusion: Patients with current or previous psychotic symptoms. | 12 months | Brief Cognitive Behavioral Therapy (BCBT) (N=12) | 10 weekly 45 min sessions occurring over the first 15 weeks of enrollment with 3 booster sessions occurring at 6, 9 and 12-months after enrollment | Age (SD): 18 years (2.7 years)<br>Female: 83%<br>MDD: 83%<br>GAD: 83%<br>Bipolar II disorder: 42%<br>Borderline personality disorder: 42%<br>PTSD: 25%<br>Prior self-injurious behaviors: 100% |
| | Country: Canada<br>Study Design: RCT<br>Patient Enrollment Period: 9/2016–2/2018 | Inclusion: Youth aged 16–26 years, admitted to hospital following an episode of self-harm, defined as any intentional destructive action regardless of suicidal intent, and have ability to read and understand English.<br><br>Exclusion: Patients with current or previous psychotic symptoms. | 12 months | Minimal-directive supportive psychotherapy (MDSP) (N=12) | 10 weekly 45 min sessions occurring over the first 15 weeks of enrollment with 3 booster sessions occurring at 6, 9 and 12-months after enrollment | Age (SD): 18 years (3.2 years)<br>Female: 58%<br>MDD: 92%<br>GAD: 75%<br>Bipolar II disorder: 42%<br>Borderline personality disorder: 17%<br>PTSD: 42%<br>Prior self-injurious behaviors: 100% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Esposito-Smythers, 2019**[3] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 12–18 years who are English speaking, met criteria for major depressive disorder, dysthymia, depression, or mood disorder not otherwise specified; were hospitalized for a suicide attempt or suicidal ideation; and had at least one of the following co-occurring risk factors: a suicide attempt prior to the index admission, nonsuicidal self-injury, or a substance use disorder.<br><br>Exclusion: Adolescents with cognitive or developmental delays, a diagnosis of autism spectrum disorder, a primary diagnosis of a psychotic disorder, obsessive–compulsive disorder, an eating disorder, or used “hard” illicit substances such as opiates. | 18 months | Family-focused Cognitive Behavioral Therapy (F-CBT) (N=74) | Weekly sessions in the initial 6 months, then biweekly, and then monthly sessions for both adolescents and parents in the later stages of the 12-month period | Age (SD): 15.05 years (1.44 years)<br>Female: 77.03%<br>White 86.49%<br>African American: 1.35%<br>Asian/Pacific Islander: 4.05%<br>Multiracial: 8.11%<br>MDD: 93.24%<br>GAD: 47.95%<br>PTSD: 18.31%<br>ADHD: 22.54%<br>Disruptive behavior disorder (CD or ODD): 21.92%<br>Alcohol/substance use disorder: 18.06%<br>Prior self-injurious behaviors: 79.73 %<br>Prior suicidal attempt: 64.86% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Esposito-Smythers, 2019[3] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 12–18 years who are English speaking, met criteria for major depressive disorder, dysthymia, depression, or mood disorder not otherwise specified; were hospitalized for a suicide attempt or suicidal ideation; and had at least one of the following co-occurring risk factors: a suicide attempt prior to the index admission, nonsuicidal self-injury, or a substance use disorder.<br><br>Exclusion: Adolescents with cognitive or developmental delays, a diagnosis of autism spectrum disorder, a primary diagnosis of a psychotic disorder, obsessive–compulsive disorder, an eating disorder, or used “hard” illicit substances such as opiates. | 18 months | Enhanced treatment as usual (E-TAU)<br>(N=73) | Provided at the discretion of the individual provider. | Age (SD): 14.75 years (1.56 years)<br>Female: 75.34 %<br>White: 84.51%<br>African American: 2.82%<br>Asian/Pacific Islander: 1.41%<br>Multiracial: 11.27%<br>MDD: 84.93%<br>GAD: 30.99%<br>PTSD: 18.31%<br>ADHD: 30.56%<br>Disruptive behavior disorder (CD or ODD): 15.49%<br>Alcohol/substance use disorder: 26.39%<br>Prior self-injurious behaviors: 83.10%<br>Prior suicidal attempt: 66.20% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Asarnow, 2017**[4] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 3/2011–1/2015 | Inclusion: Adolescents aged 11–18, recent (past 3 months) suicide attempt or Non suicidal self-injury (NSSI), repetitive self-harm (≥3 lifetime self-harm episodes), living in a stable family situation, at least one parent willing to participate in trauma.<br><br>Exclusion: Symptoms interfering with participation (e.g., psychosis, substance dependence), non English-speaking participants. | 12 months | Safe Alternatives for Teens and Youths (SAFETY) (N=20) | Weekly/bi-weekly sessions over 3 months duration | Age (SD): 14.35 years (1.81 years)<br>Female: 90%<br>LGB: 21.5%<br>White, non Hispanic: 90%<br>African American: 5%<br>Hispanic: 20%<br>Asian: 5%<br>Other race/ethnicity: 5%<br>MDD: 40%<br>Substance abuse: 50%<br>Prior self-injurious behaviors: 50% (past 3 months)<br>Prior suicidal attempt: 50% (past 3 months) |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 3/2011–1/2015 | Inclusion: Adolescents aged 11–18, recent (past 3 months) suicide attempt or nonsuicidal self-injury (NSSI), repetitive self-harm (≥3 lifetime self-harm episodes), living in a stable family situation, at least one parent willing to participate in trauma.<br><br>Exclusion: Symptoms interfering with participation (e.g., psychosis, substance dependence), non English-speaking participants. | 12 months | Enhanced Treatment as Usual (E-TAU) (N=22) | 1 parents session followed by 3 telephone calls | Age (SD): 14.86 years (1.86 years)<br>Female: 86.4%<br>LGB: 21.5%<br>White, non Hispanic: 77.3%<br>African American: 4.6%<br>Hispanic/Latino: 22.7%<br>Asian: 18.2%<br>Other race/ethnicity: 9.1%<br>MDD: 68%<br>Substance abuse: 45.5%<br>Prior self-injurious behaviors: 50% (past 3 months)<br>Prior suicidal attempt: 50% (past 3 months) |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Spirito, 2015[5]** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 11–17 years, met DSM-IV criteria for current major depressive episode (MDE), Clinical Depression Severity Rating Scale (CDRS) score ≥ 65, current or past suicidality as reported on Beck Depression Inventory II (BDI-II) or Kiddie Schedule for Affective Disorders and Schizophrenia-Present Version (K-SADS-P), and parents had a minimum BDI score of 15 for current MDE and 10 for past MDE<br><br>Exclusion: bipolar disorder, substance use disorder, developmental/cognitive delays, and psychosis. | 11 months | Parent-Adolescent Cognitive Behavioral Therapy (PA-CBT) (N=16) | Weekly sessions for 12 weeks, followed by a maintenance phase of biweekly sessions for another 12 weeks | Age (SD): 14.69 years (1.78 years)<br>Female: 87.5%<br>Prior suicidal attempt: 50% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Spirito, 2015[5] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 11–17 years, met DSM-IV criteria for current major depressive episode (MDE), Clinical Depression Severity Rating Scale (CDRS) score ≥ 65, current or past suicidality as reported on BDI-II or Kiddie Schedule for Affective Disorders and Schizophrenia-Present Version (K-SADS-P), and parents had a minimum BDI score of 15 for current MDE and 10 for past MDE<br><br>Exclusion: bipolar disorder, substance use disorder, developmental/cognitive delays, and psychosis. | 11 months | Adolescent Only Cognitive Behavioral Therapy (AO-CBT)<br>(N=8) | Weekly sessions for 12 weeks, followed by a maintenance phase of biweekly sessions for another 12 weeks | Age (SD): 14 years (1.69 years)<br>Female: 75%<br>Prior suicidal attempt: 0% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Esposito-Smythers, 2011**[6] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 11/2004–02/2007 | Inclusion: Adolescents aged 13–17 years, had made a suicide attempt within the prior 3 months or reported clinically significant suicidal ideation during the past month (score ≥ 41 on the Suicide Ideation Questionnaire), had an alcohol or cannabis use disorder and lived in the home with a parent/guardian willing to participate.<br><br>Exclusion: had a Verbal IQ estimate < 70, were actively psychotic, were homicidal, had bipolar disorder or were dependent on substances other than alcohol and marijuana. | 18 months | Integrated Cognitive Behavioral Therapy (I-CBT) (N=20) | Acute phase: weekly/biweekly sessions with parents for 6 months<br>Continuation phase: biweekly sessions with parents for 3 months<br>Maintenance phase: as needed monthly sessions with parents for 3 months | Age (SD): 15.79 years (0.98 years)<br>Female: 68.4%<br>White: 89.5%<br>Hispanic: 15.8%<br>Unipolar mood disorder: 94.7%<br>Anxiety disorder: 57.9%<br>Disruptive behavior disorder:42.1%<br>Alcohol use disorder: 52.6%<br>Cannabis use disorder: 78.9%<br>Other substance abuse: 10.5%<br>Prior self-injurious behaviors: 73.7%<br>Prior suicidal attempt: 73.7% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Esposito-Smythers, 2011[6] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 11/2004–02/2007 | Inclusion: Adolescents aged 13–17 years, had made a suicide attempt within the prior 3 months or reported clinically significant suicidal ideation during the past month (score ≥ 41 on the Suicide Ideation Questionnaire), had an alcohol or cannabis use disorder and lived in the home with a parent/guardian willing to participate.<br><br>Exclusion: had a Verbal IQ estimate < 70, were actively psychotic, were homicidal, had bipolar disorder or were dependent on substances other than alcohol and marijuana. | 18 months | Enhanced Treatment as Usual (E-TAU) (N=20) | NR | Age (SD): 15.65 years (1.41 years)<br>Female: 64.7%<br>White: 88.2%<br>Hispanic: 11.8%<br>Unipolar mood disorder: 94.1%<br>Anxiety disorder: 52.9%<br>Disruptive behavior disorder: 58.8%<br>Alcohol use disorder: 76.5%<br>Cannabis use disorder: 88.2%<br>Other substance abuse: 17.6%<br>Prior self-injurious behaviors: 70.6%<br>Prior suicidal attempt: 76.5% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Donaldson, 2005**[7] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 12–17 years old, who presented to a general pediatric emergency department or inpatient unit of an affiliated child psychiatric hospital in the Northeast after a suicide attempt.<br><br>Exclusion: primary language other than English, psychosis as indicated on mental status examination, or clinician judgment that intellectual functioning precluded outpatient psychotherapy. | 12 months | Skills-Based Treatment (SBT) (N=15) | Active phase: 6 individual sessions and 1 family the first 3 months<br>Maintenance phase: 3 monthly sessions | Age (SD): 15 years (1.7 years) (total population)<br>Female: 82% (total population)<br>White: 85% (total population)<br>Hispanic: 10% (total population)<br>African American: 5% (total population)<br>Major depressive disorder: 27%<br>Disruptive behavior disorder: 27%<br>Alcohol use disorder: 13%<br>Cannabis use disorder: 40%<br>Prior suicidal attempt: 53% |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 12–17 years old, who presented to a general pediatric emergency department or inpatient unit of an affiliated child psychiatric hospital in the Northeast after a suicide attempt.<br><br>Exclusion: primary language other than English, psychosis as indicated on mental status examination, or clinician judgment that intellectual functioning precluded outpatient psychotherapy. | 12 months | Supportive-Relationship Treatment (SRT) (N=16) | Active phase: 6 individual sessions and 1 family the first 3 months<br>Maintenance phase: 3 monthly sessions | Age (SD): 15 years (1.7 years) (total population)<br>Female: 82% (total population)<br>White: 85% (total population)<br>Hispanic: 10% (total population)<br>African American: 5% (total population)<br>MDD: 31%<br>Disruptive behavior disorder: 63%<br>Alcohol use disorder: 25%<br>Cannabis use disorder: 50%<br>Prior suicidal attempt: 44% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
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| **Slesnick, 2019[8]** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Homeless youth aged 18–24, not requiring hospitalization, able to provide informed consent, and scoring >16 on SSI-W.<br><br>Exclusion: Diagnosed with psychotic disorder, cognitive or intellectual disabilities, or a ward of the state. | 9 months | Cognitive Therapy for Suicide Prevention + Treatment as Usual (CTSP + TAU)<br>(N=75) | 10 session (50-min each) including weekly/bi-weekly meetings; followed by optional 9 maintenance sessions | Age (SD): 20.99 years (1.96 years)<br>Female: 40.7%<br>American Indian: 0.7%<br>Asian/Asian-American or Pacific Islander: 0.7%<br>African American: 38.0%<br>Hispanic: 1.3%<br>White not of Hispanic origin: 39.3%<br>Other race/ethnicity: 20.0%<br>Prior suicidal attempt: 77% (CTSP + TAU group) and 84% (TAU group) |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Homeless youth aged 18–24, not requiring hospitalization, able to provide informed consent, and scoring >16 on SSI-W.<br><br>Exclusion: Diagnosed with psychotic disorder, cognitive or intellectual disabilities, or a ward of the state. | 9 months | Treatment as Usual (TAU)<br>(N=75) | 50 min sessions | Age (SD): 20.99 years (1.96 years)<br>Female: 40.7%<br>American Indian: 0.7%<br>Asian/Asian-American or Pacific Islander: 0.7%<br>African American: 38.0%<br>Hispanic: 1.3%<br>White not of Hispanic origin: 39.3%<br>Other race/ethnicity: 20.0%<br>Prior suicidal attempt: 77% (CTSP + TAU group) and 84% (TAU group) |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Zullo, 2021**[9] | Country: United States<br>Study Design: Comparative Observational Study<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 12–18 years enrolled in school, may be receiving any medication(s), other trauma(s), or none; and are English speaking.<br><br>Exclusion: Concurrent mental retardation, active psychosis, or any neurological disorders that would impact ability to complete questionnaires; delayed more than two years from age-appropriate grade level; dropped out of IOP prior to completion of five teen groups; and previously completed IOP. | 1 months | Suicide Prevention and Resilience (SPARC) + Intensive outpatient program (IOP) (N=62) | Twice a week for the teen therapy group sessions; once a week for individual therapy sessions; once a week for parent skills group sessions and multifamily groups Delivered for 4 to 6 weeks | Age (SD): 14.98 years (1.66 years)<br>Female: 72.6%<br>Caucasian: 85.5%<br>African American: 6.5%<br>Asian:1.5%<br>Hispanic: 24.2%<br>Other race/ethnicity: 6.5%<br>MDD: 95.2%<br>Other disorders: 4.8%<br>Prior self-injurious behaviors: 71%<br>Prior suicidal attempt: 54.8% |
| | Country: United States<br>Study Design: Comparative Observational Study<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 12–18 years enrolled in school, may be receiving any medication(s), other trauma(s), or none; and are English speaking.<br><br>Exclusion: Concurrent mental retardation, active psychosis, or any neurological disorders that would impact ability to complete questionnaires; delayed more than two years from age-appropriate grade level; dropped out of IOP prior to completion of five teen groups; and previously completed IOP. | 1 months | Standard intensive outpatient program (IOP) (N=61) | Twice a week for the teen therapy group sessions; once a week for individual therapy sessions; once a week for parent skills group sessions and multifamily groups Delivered for 4 to 6 weeks | Age (SD): 15 years (1.59 years)<br>Female: 73.8%<br>Caucasian: 82%<br>African American: 5%<br>Asian: 9.8%<br>Hispanic: 24.6%<br>Other race/ethnicity: 3.2%<br>MDD: 98.4%<br>Other disorders: 1.6%<br>Prior self-injurious behaviors: 75.4%<br>Prior suicidal attempt: 67.2% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Vitiello, 2009**[10] | Country: United States<br>Study Design: Comparative Observational Study<br>Patient Enrollment Period: 12/2003–06/2006 | Inclusion: Youth aged 12–18 years, with a suicide attempt in the last 90 days; met current criteria for major depressive disorder, dysthymic disorder, or depressive disorder not otherwise specified on the Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version; and had a score of 36 or higher on the Children's Depression Rating Scale-Revised (CDRS-R).<br><br>Exclusion: substance dependence, bipolar disorder, psychosis, and pervasive developmental disorders. | 6 months | Cognitive Behavioral Therapy with focus on Suicide Prevention (CBT-SP)<br>(N=17) | 22 sessions over 6 months | Age (SD): 15.7 years (1.5 years)<br>Female: 94.1%<br>White 70.6%<br>MDD: 94.1%<br>Dysthymic disorder: 0%<br>MDD and dysthymic disorder: 0%<br>Depressive disorder not otherwise specified: 5.9%<br>Anxiety: 23.5%<br>ADHD: 11.8%<br>ODD/conduct disorder: 0%<br>Prior suicidal attempt: 35.3% |
| | Country: United States<br>Study Design: Comparative Observational Study<br>Patient Enrollment Period: 12/2003–06/2006 | Inclusion: Youth aged 12–18 years, with a suicide attempt in the last 90 days; met current criteria for major depressive disorder, dysthymic disorder, or depressive disorder not otherwise specified on the Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version; and had a score of 36 or higher on the Children's Depression Rating Scale-Revised (CDRS-R).<br><br>Exclusion: substance dependence, bipolar disorder, psychosis, and pervasive developmental disorders. | 6 months | Medications<br>(N=14) | NR | Age (SD): 15.6 years (1.4 years)<br>Female: 92.9%<br>White 85.7%<br>MDD: 92.9%<br>Dysthymic disorder: 0%<br>MDD and dysthymic disorder: 7.1%<br>Depressive disorder not otherwise specified: 0%<br>Anxiety: 28.6%<br>ADHD: 14.3%<br>ODD/conduct disorder: 35.7%<br>Prior suicidal attempt: 28.6% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Vitiello, 2009[10] continued** | Country: United States<br>Study Design: Comparative Observational Study<br>Patient Enrollment Period: 12/2003–06/2006 | Inclusion: Youth aged 12–18 years, with a suicide attempt in the last 90 days; met current criteria for major depressive disorder, dysthymic disorder, or depressive disorder not otherwise specified on the Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version; and had a score of 36 or higher on the Children's Depression Rating Scale-Revised (CDRS-R).<br><br>Exclusion: substance dependence, bipolar disorder, psychosis, and pervasive developmental disorders. | 6 months | Combination of both CBT and antidepressant pharmacotherapy (Comb)<br>(N=93) | NR | Age (SD): 15.7 years (1.6 years)<br>Female: 72%<br>White 80.7%<br>MDD: 82.8%<br>Dysthymic disorder: 1.1%<br>MDD and dysthymic disorder: 12.9%<br>Depressive disorder not otherwise specified: 3.2%<br>Anxiety: 63.4%<br>ADHD: 23.7%,<br>ODD/CD: 15.1%<br>Prior suicidal attempt: 47.3% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Kennard, 2018**[11] | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: 1/1/2014–9/31/2016 | Inclusion: Adolescents aged 12 to 18 years who had recently attempted suicide or experienced worsening suicidal ideation<br><br>Exclusion: Patients with severe cognitive impairment, those requiring direct transfer to a medical unit or residential placement, and those residing outside the geographic area. | 6 months | Intensive Outpatient Program (IOP) (N=364) | 3 hours of group therapy twice weekly for 4–6 weeks, 1-hour weekly for parents' group | Age (SD): 14.9 years (1.4 years)<br>Female: 79.95%<br>Hispanic: 9.9%<br>Non Hispanic: 89.3%<br>White: 86.3%<br>Unknown race/ethnicity: 0.8%<br>African American: 7.1%<br>Asian: 2.5%<br>Indian: 0.3%<br>Multiracial: 0.5%<br>Unknown: 3.3%<br>Anxiety disorder: 39.8%<br>ADHD: 10.2%<br>PTSD: 4.1%<br>Eating disorder: 3.8%<br>Bipolar disorder: 0.8%<br>Depression: 89.3%<br>ODD: 0.3%<br>Disruptive behavior disorder: 0.3%<br>Gender dysphoria: 1.7%<br>Autism spectrum disorder: 0.6%<br>OCD: 0.8%<br>Substance use disorder: 2.5%<br>Other diagnosis: 0.3%<br>Prior self-injurious behaviors: 74%<br>Prior suicidal attempt: 68%<br>C-SSRS score: Mean (SD)= 1.4 (2.6) |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Duarté-Vélez, 2016[12]** | Region: Puerto Rico<br>Study Design: Before–After study<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 13 to 17, admitted to an emergency department (ED) for suicide ideation or a suicide attempt, hospitalized, stabilized, and then referred for outpatient care, having a legal guardian willing to participate.<br><br>Exclusion: Presence of a psychotic disorder or a pervasive developmental disorder, IQ below 70, already receiving psychotherapy (psychiatric care with psychotropic drugs was accepted), involvement in a legal procedure requiring psychological care mandated by the judicial system. | 6 months | The Socio-Cognitive Behavioral Treatment for Suicidal Behavior (SCBT-SB) (N=11) | Weekly, for 6 months, followup biweekly booster sessions provided, when necessary, individual sessions were 60 minutes and family sessions were 60 to 120 minutes | Age: 15.36 years<br>Female: 54.5%<br>Puerto Rican: 100%<br>Recent hospital discharge for mental health trauma: 9.1% |

Abbreviations: ADHD = attention-deficit/hyperactivity disorder; AO-CBT = adolescent only cognitive behavioral therapy; ASQ = ages and stages questionnaires; BCBT = brief cognitive behavioral therapy; CBT = cognitive-behavioral therapy; CD = conduct disorder; C-SSRS = Columbia-suicide severity rating scale; CTSP = cognitive therapy for suicide prevention; DSM-5 = diagnostic and statistical manual of mental disorders, fifth edition; E-TAU = enhanced trauma-as-usual; F-CBT = family-focused cognitive behavioral therapy; I-CBT = integrated outpatient cognitive-behavioral therapy; IOP = intensive outpatient program; MDD = major depressive disorder; MDE = major depressive episode; MDSP = minimally-directive supportive psychotherapy control; N = number of patients; NR = not reported; OCD = obsessive compulsive disorder; ODD = oppositional defiant disorder; PA-CBT = parent-adolescent cognitive behavioral therapy; PHQ = patient health questionnaire; PTSD = posttraumatic stress disorder; RCT = randomized clinical trial; SAFETY = safe alternatives for teens and youths; SCBT-SB = socio-cognitive behavioral trauma for suicidal behavior; SCBT-SB = socio-cognitive-behavioral therapy protocol for suicidal behaviors; SD = standard deviation; SPARC = suicide prevention and resilience; SSI-W = scale for suicide ideation – worst; TAU = treatment as usual

**Table D.2. Characteristics of Included Studies for Dialectical Behavior Therapy (DBT)**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **McCauley, 2018**[13] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 1/1/2012–8/31/2014 | Inclusion: Adolescents aged 12–18 years, at least one lifetime suicide attempt, elevated past-month suicidal ideation (≥24 on the SIQ-JR), repetitive self-injury (≥3 lifetime self-harm episodes, including one in the 12 weeks before screening), 3 or more borderline personality disorder criteria, IQ of 70 or higher.<br><br>Exclusion: IQ less than 70, primary problem of psychosis, mania, anorexia, or life-threatening condition, lack of fluency in English (adolescent) or parent without fluency in English or Spanish. | 12 months | Dialectical Behavior Therapy (DBT) (N=86) | Weekly individual and group therapy for 6 months | Age (SD): 14.77 years (1.50 years)<br>Female: 95.30%<br>White: 58.14%<br>American Indian: 1.16%<br>African American: 8.14%<br>Asian American: 4.65%<br>Hispanic: 26.70%<br>Other race ethnicity: 1.16%<br>Depressive disorder: 79.10%<br>Anxiety disorder: 48.80%<br>Eating disorder: 1.16% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **McCauley, 2018[13] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 1/1/2012–8/31/2014 | Inclusion: Adolescents aged 12 – 18 years, at least one lifetime suicide attempt, elevated past-month suicidal ideation (≥24 on the SIQ-JR), repetitive self-injury (≥3 lifetime self-harm episodes, including one in the 12 weeks before screening), 3 or more borderline personality disorder criteria, IQ of 70 or higher.<br><br>Exclusion: IQ less than 70, primary problem of psychosis, mania, anorexia, or life-threatening condition, lack of fluency in English (adolescent) or parent without fluency in English or Spanish. | 12 months | Individual and Group Supportive Therapy (IGST) (N=87) | Weekly individual and group therapy for 6 months | Age (SD): 15.04 years (1.43 years)<br>Female: 94.19%<br>White: 55.29%<br>Native American: 0%<br>African American: 5.88%<br>Asian American: 7.06%<br>Hispanic: 28.24%<br>Other race/ethnicity: 3.53%<br>Depressive disorder: 88.50%<br>Anxiety disorder: 59.30%<br>Eating disorder: 0% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Pistorello, 2012**[14] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 01/2006–01/2009 | Inclusion: College students seeking services at the college counseling center at a medium-sized public university in the western United States; aged between 18 and 25; reported suicidal ideation at baseline; endorsed at least one act of lifetime NSSI and/or suicide attempt; met three or more criteria for BPD.<br><br>Exclusion: Patients with psychosis; needed for inpatient care; with prior DBT trauma and had to refrain from taking part in other psychotherapy during the trauma portion of the study. | 18 months | Dialectical Behavior Therapy (DBT) (N=31) | Weekly 50-minute individual session; weekly 90-min group session; skills coaching as needed via telephone, email, or texting between sessions; weekly 90-min group supervision/consultation for therapists; as-needed family interventions, for 7–12 months | Age (SD): 20.42 years (1.56 years)<br>Female: 77.4%<br>LGBT: 32.3%<br>White: 74.2%<br>African American: 6.5%<br>Asian/Asian American: 3.2%<br>Hispanic: 3.2%<br>American Indian: 9.7%<br>Other race/ethnicity: 3.2%<br>MDD: 87.0%<br>Substance-use disorder: 38.7%<br>Anxiety disorder: 71.0%<br>Eating disorder: 22.6%<br>Prior self-injurious behaviors: 66.7% (SASII; any occurrence), 60% (SBQ; any occurrence)<br>Prior suicidal attempt: 19.4% (SASII; any occurrence), 22.6% (SBQ-23; any occurrence) |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Pistorello, 2012[14] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 01/2006–01/2009 | Inclusion: College students seeking services at the college counseling center at a medium-sized public university in the western United States; aged between 18 and 25; reported suicidal ideation at baseline; endorsed at least one act of lifetime NSSI and/or suicide attempt; met three or more criteria for BPD.<br><br>Exclusion: Patients with psychosis; needed for inpatient care; with prior DBT trauma and had to refrain from taking part in other psychotherapy during the trauma portion of the study. | 18 months | Optimized Treatment as Usual (O-TAU) (N=32) | Weekly 50-minute individual session; weekly, 90-min group supervision/consultation for therapists; as-needed family interventions, for 7–12 months | Age (SD): 21.28 years (2.14 years)<br>Female: 84.4%<br>LGBT: 31.2%<br>White: 65.6%<br>African American: 0.0%<br>Asian/Asian American: 9.4%<br>Hispanic: 18.8%<br>American Indian: 0.0%<br>Other race: 6.3%<br>MDD: 75.0%<br>Substance-use disorder: 34.4%<br>Anxiety disorder: 87.5%<br>Eating disorder: 9.4%,<br>Prior self-injurious behaviors: 80.6% (SASII; any occurrence), 76.7% (SBQ; any Occurrence)<br>Prior suicidal attempt: 6.3% (SASII; any occurrence), 12.5% (SBQ-23; Any occurrence) |
| **Swart, 2014[15]** | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: NR | Inclusion: Participants with previous suicide or nonsuicidal self-injury behaviors.<br><br>Exclusion: NR | 11 months | Mode Deactivation Therapy (MDT) (N=20) | 8–11 months | African American: 60%<br>European American: 30%<br>Hispanic American: 10%<br>CD: 60%<br>ODD: 40%<br>Anxiety disorder: 30%<br>PTSD: 45% |
| | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: NR | Inclusion: Participants with previous suicide or nonsuicidal self-injury behaviors.<br><br>Exclusion: NR | 11 months | Treatment as Usual (TAU) (N=20) | 8–11 months | African American: 65%<br>European American: 25%<br>Hispanic American: 10%<br>CD: 55%<br>ODD: 35%<br>Anxiety disorder: 35%<br>PTSD: 35% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Tebbett-Mock, 2020**[16] | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 12–17 years who were hospitalized on a coeducational, acute-care inpatient unit within a private psychiatric hospital, admitted either voluntarily or involuntarily via local emergency departments because of imminent safety concerns.<br><br>Exclusion: Moderate to severe intellectual disability. | 8 months | Dialectical Behavior Therapy (DBT) (N=425) | 9 skills groups per week, 3 individual sessions per week, 1 to 2 family/collateral sessions per week | Age (SD): 15.67 years (1.44 years)<br>Female: 66.3%<br>White: 40.9%<br>Multiracial: 20.2%<br>African American: 19.8%<br>Asian 9.9%<br>Unknown/declined race: 8.9%<br>American Indian: 0.2%<br>Non Hispanic: 74.4%<br>Hispanic: 13.9%<br>Unknown/declined ethnicity: 11.8%.<br>ADHD: 0.7%<br>Anxiety disorder: 2.6%<br>Bipolar and related disorder: 32.9%<br>Depressive disorder: 46.4%<br>Disruptive, impulse control, conduct: 2.6<br>Eating disorder: 0.5%<br>OCD: 0.7%<br>Schizophrenia spectrum disorder: 7.8%<br>Trauma and stress-related disorder: 4.7%<br>Sleep disorder: 0.2%<br>Substance use disorder: 0.9%<br>Recent hospital discharge for mental health trauma: 100% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Tebbett-Mock, 2020[16] continued** | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 12–17 years who were hospitalized on a coeducational, acute-care inpatient unit within a private psychiatric hospital, admitted either voluntarily or involuntarily via local emergency departments because of imminent safety concerns.<br><br>Exclusion: Moderate to severe intellectual disability. | 8 months | Treatment as Usual (TAU) (N=376) | 3 to 4 skills groups per week, 10 activity groups per week, 3 individual sessions per week, 1 to 2 family/collateral sessions per week | Age (SD): 15.59 years (1.54 years)<br>Female: 62.7%<br>White: 52.7%<br>African American: 22.1%<br>Multiracial 12.8%<br>Asian: 8%<br>Unknown/declined race: 4.5%<br>Non Hispanic: 81.9%<br>Hispanic: 13%<br>Unknown/declined ethnicity: 5.1% .<br>ADHD: 2.4%<br>Anxiety disorder: 0.8%<br>Bipolar and related disorder: 36.4%<br>Depressive disorder: 47.1%<br>Disruptive, impulse control, conduct: 4.3%<br>Eating disorder: 0%<br>OCD: 0.8%<br>Schizophrenia spectrum disorder: 5.9%<br>Trauma and stress-related disorder: 1.9%<br>Sleep disorder: 0%<br>Substance use disorder: 0.5%<br>Recent hospital discharge for mental health trauma: 100% |
| **Katz, 2004[17]** | Country: Canada<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: NR | Inclusion: Patients aged 14–17 years, admitted for a suicidal attempt or suicidal ideation; agreed to stay in hospital for brief trauma.<br>Exclusion: mental retardation; psychosis; bipolar affective disorder or severe learning disabilities. | 12 months | Dialectical Behavior Therapy (DBT) (N=26) | Daily group therapy, twice-weekly individual session for 2 weeks | Age (SD): 15.4 years (0.8 years) (total population)<br>Female: 83.9% (total population)<br>White: 72.6% (total population)<br>Hispanic: 1.6% (total population)<br>African American: 0% (total population)<br>Asian/Pacific Islander: 4.8% (total population)<br>First Nations Populations: 19.4% (total population)<br>Other backgrounds: 1.6% (total population) |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Katz, 2004[17] continued** | Country: Canada<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: NR | Inclusion: Patients aged 14–17 years, admitted for a suicidal attempt or suicidal ideation; agreed to stay in hospital for brief trauma.<br>Exclusion: mental retardation; psychosis; bipolar affective disorder or severe learning disabilities. | 12 months | Treatment as Usual (TAU) (N=27) | Daily group therapy, once-weekly individual session for 2 weeks | Age (SD): 15.4 years (0.8 years) (total population)<br>Female: 83.9% (total population)<br>White: 72.6% (total population)<br>Hispanic: 1.6% (total population)<br>African American: 0% (total population)<br>Asian/Pacific Islander: 4.8% (total population)<br>First nations populations: 19.4% (total population)<br>Other backgrounds: 1.6% (total population) |
| **Rathus, 2002[18]** | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: NR | Inclusion: For DBT group: a suicide attempt within the last 16 weeks or current suicidal ideation and a diagnosis of borderline personality disorder or a minimum of three borderline personality features (as measured by the SCID-II).<br><br>Exclusion: NR | 3 months | Dialectical Behavior Therapy (DBT) (N=29) | Twice weekly sessions for 3 months | Age (SD): 16.1 years (1.2 years)<br>Female: 93%<br>Hispanic: 67.6% (total population)<br>African American: 17 .1 % (total population)<br>White: 8.1 % (total population)<br>Asian American: 0.9% (total population)<br>Other race: 6.3% (total population)<br>Depressive disorders: 92%<br>Substance abuse disorders: 48%<br>Anxiety disorders: 40%<br>Disruptive behavior disorders: 19.8%<br>Adjustment disorders: 20.8%<br>Psychotic disorders: 6.1 %<br>Borderline personality disorder: 88%<br>Prior self-injurious behaviors: 32.1% (total population)<br>Prior suicidal attempt: 1.5 (SD =2.1) (total population)<br>Recent hospital discharge for mental health trauma: 65.5% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Rathus, 2002[18] continued** | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: NR | Inclusion: For DBT group: a suicide attempt within the last 16 weeks or current suicidal ideation and a diagnosis of borderline personality disorder or a minimum of three borderline personality features (as measured by the SCID-II).<br><br>Exclusion: NR | 3 months | Treatment as Usual (TAU) (N=82) | Twice weekly sessions for 3 months | Age (SD): 15 years (1.7 years)<br>Female: 73%<br>Hispanic: 67.6% (total population)<br>African American: 17 .1 % (total population)<br>White: 8.1 % (total population)<br>Asian American: 0.9% (total population)<br>Other race: 6.3% (total population)<br>Depressive disorders: 72.7%<br>Substance abuse disorders: 5.3%<br>Anxiety disorders: 20.8%<br>Disruptive behavior disorders: 19.8%<br>Adjustment disorders: 20.8%<br>Psychotic disorders: 6.1 %<br>Borderline personality disorder: 15.8%<br>Prior self-injurious behaviors: 32.1% (total population)<br>Prior suicidal attempt: 1.5 (SD = 2.1) (total population)<br>Recent hospital discharge for mental health trauma: 31.7%: |
| **Sunseri, 2004[19]** | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: 4/1997–8/2002 | Inclusion: All residential center trauma facility clients for adolescent girls.<br><br>Exclusion: NR | 29 months | Pre Dialectical Behavior Therapy (DBT) (N=42) | NR | Age (SD): 14 years (1.8 years)<br>Female: 100%<br>White: 76%<br>Disruptive behavior disorders: 71%<br>Anxiety disorders: 55%<br>Eating disorders: 14%<br>Substance abuse disorders: 21%<br>Mood disorders: 56%<br>Borderline personality disorder: 38% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Sunseri, 2004[19] continued** | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: 4/1997–8/2002 | Inclusion: All residential center trauma facility clients for adolescent girls.<br><br>Exclusion: NR | 29 months | Post-Dialectical Behavior Therapy (DBT) (N=26) | Weekly individual sessions, twice per week 90-minute group sessions, telephone as needed, for 1 year | Age (SD): 15.2 years (1.3 years)<br>Female: 100%<br>White: 88%<br>Disruptive behavior disorders: 50%<br>Anxiety disorders: 58%<br>Eating disorders: 4%<br>Substance abuse disorders: 39%<br>Mood disorders: 85%<br>Borderline personality disorder: 85% |
| **Darrow, 2022[20]** | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: NR | Inclusion: Current or history of suicidal behaviors (ideation, plans, or attempts) or NSSI and at least three traits of borderline personality disorder; at least one caregiver willing to participate in DBT-A<br><br>Exclusion: untreated psychosis, substance dependence requiring a high level of care, unable to learn within skills training format, inadequate safety and support available from environmental conditions | 6 months | Dialectical Behavior Therapy - Adolescent (N=132) | Weekly individual, multifamily skills groups, family therapy and phone coaching as needed for 6 months plus extra weeks if necessary. | Age (SD): 17.53 years (2.8 years)<br>Female: 75.8%<br>Transgender (male to female): 2.8%<br>Nonbinary/agender: 6.75%<br>Heterosexual: 63.8%<br>Homosexual: 11.25%<br>Bisexual: 7.3%<br>Asexual: 2.3%<br>Pansexual: 2.3%<br>Unsure/unknown sexual orientation: 2.85%<br>European-American: 64.35%<br>Hispanic: 8.5%<br>Asian: 9%<br>Multiracial: 14.1%<br>African American: 3.4%<br>American Indian/Pacific Islander: 0.6%<br>Borderline personality disorder traits (SD): 5.9 (1.9)<br>Prior suicidal attempt: 66.7% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Cloutier, 2022**[21] | Country: Canada<br>Study Design: Before–After study<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 13–17 years with mild-to-moderate suicidal ideation (SI without plan or gesture) who were able to read and write in English at a Grade 6 level and had at least one caregiver willing to participate.<br><br>Exclusion: Suicide ideation with a plan or suicidal gesture; comorbid psychosis, schizophrenia, developmental disabilities, and major substance abuse; diagnosis of an externalizing disorder (e.g., CD); current MH services involvement at least weekly; or being currently under the care of child protection services. | 1 month | Building Resilience and Attachment in Vulnerable Adolescents (BRAVA) (N=46) | Six, concurrent (parent, adolescent), 90-minute, group sessions weekly for 6 weeks | Age (SD): 14.5 years (1 years)<br>Female: 96.8<br>White: 48.4%<br>Multiracial: 25.8%<br>Recent hospital discharge for mental health trauma: 67.4% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Berk, 2020**[22] | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: 12/2010–4/2013 | Inclusion: Adolescents aged 12–17 years referred to a DBT program due to a recent history of suicidal and/or self-harm behaviors. To be eligible, youth had to have at least one suicide attempt and/or nonsuicidal self-injury behavior within the past 4 months and meet at least three diagnostic criteria for borderline personality disorder (including the self-injury criterion).<br><br>Exclusion: Youth who did not speak English and parents who did not speak English or Spanish. | 6 months | Dialectical Behavior Therapy (DBT) (N=24) | Weekly individual sessions, 75-minute, weekly multi-family group sessions over 6 months | Age (SD): 15.21 years (1.32 years)<br>Female: 92%<br>White: 17%<br>Hispanic: 63%<br>Other ethnicity: 21%<br>Prior self-injurious behaviors: 96%<br>Prior suicidal attempt: 46% |
| **Courtney, 2015**[23] | Country: Canada<br>Study Design: Before–After study<br>Patient Enrollment Period: 2007–2012 | Inclusion: Adolescents with features of borderline personality disorder (BPD) and self-injurious thoughts and behaviors (SITB).<br><br>Exclusion: frank psychosis and developmental delay. | 4 months | Adapted Dialectical Behavior Therapy for Adolescents (A-DBT-A) (N=61) | 15 weekly group sessions, 14 weekly individual sessions | Age (SD): 16.5 years (0.8 years)<br>Female: 93.4%<br>Mood disorder: 54%<br>Anxiety disorder: 28%<br>Disruptive behavior disorder: 11%<br>Other disorders: 7%<br>Prior self-injurious behaviors: 59% |

Abbreviations: A-DBT-A = adapted dialectical behavior therapy for adolescents; ADHD = attention-deficit/hyperactivity disorder; ASQ = ages and stages questionnaires; BPD = borderline personality disorder; BRAVA = building resilience and attachment in vulnerable adolescents; CAMS = collaborative assessment and management of suicide; CD = conduct disorder; C-SSRS = Columbia-suicide severity rating scale; DBT = dialectical behavior therapy; IGST = individual and group support therapy; MDD = major depressive disorder; MDT = mode deactivation therapy; MH = mental health; N = number of patients; NR = not reported; NSSI = nonsuicidal self-injury; OCD = obsessive compulsive disorder; O-TAU = optimized treatment as usual; PHQ = patient health questionnaire; PTSD = posttraumatic stress disorder; RCT = randomized clinical trial; SASII = self-

injurious thoughts and behaviors; SBQ = suicide behaviors questionnaire; SCID-II = structured clinical interview for dsm-iv axis ii disorders; SD = standard deviation; SI = suicide ideation; SIQ-JR = suicidal ideation questionnaire—junior; SITB = self-injurious thoughts and behaviors; TAU = treatment as usual

**Table D.3. Characteristics of Included Studies for Attachment-Based Family Therapy (ABFT)**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Diamond, 2019**[24] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 5/1/2012–12/31/2015 | Inclusion: Adolescents aged 12–18 years with clinically significant levels of suicidal ideation (SIQ-JR score ≥ 31) and moderate levels of depressive symptoms (BDI-II score > 20) at two pretrauma screens. At least one primary caregiver was required to participate.<br><br>Exclusion: Imminent risk of harm to self or others that could not be safely treated on an outpatient basis; psychotic features; severe cognitive impairment based on educational records, parent report, and/or clinical impression; and non English-speaking participating parent. Participants who began psychiatric medication within 3 weeks of the initial pretrauma screening | 4 months | Attachment-Based Family Therapy (ABFT)<br>(N=66) | 1–2 weekly sessions to incorporate both patient and parent sessions, delivered over 16 weeks | Age (SD): 14.87 years (1.68 years)<br>Female: 83.3%<br>Heterosexual: 57.6%<br>Lesbian/gay: 12.1%<br>Bisexual: 19.7%<br>Questioning: 10.6%<br>American Indian: 0.0%<br>Asian: 3%<br>White: 31.8%,<br>African American: 47%<br>Native Hawaiian/Pacific Islander: 0%<br>Biracial/multiracial: 9.1%<br>Hispanic: 16.7%<br>Other race/ethnicity: 9.1%<br>Physical abuse: 13.6%<br>Sexual abuse: 19.7%<br>Any mood disorder: 48.2%<br>Any anxiety disorder: 48.2%<br>Any substance disorder: 12.5%<br>ODD: 5.4%<br>Prior self-injurious behaviors: 48.4%<br>Prior suicidal attempt: 43.9% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Diamond, 2019[24] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 5/1/2012–12/31/2015 | Inclusion: Adolescents aged 12–18 years with clinically significant levels of suicidal ideation (SIQ-JR score ≥ 31) and moderate levels of depressive symptoms (BDI-II score > 20) at two pretrauma screens. At least one primary caregiver was required to participate.<br><br>Exclusion: Imminent risk of harm to self or others that could not be safely treated on an outpatient basis; psychotic features; severe cognitive impairment based on educational records, parent report, and/or clinical impression; and non-English-speaking participating parent. Participants who began psychiatric medication within 3 weeks of the initial pretrauma screening | 4 months | Family-Enhanced Nondirective Supportive Therapy (FE-NST)<br>(N=63) | 1–2 weekly sessions to incorporate both patient and parent sessions, delivered over 16 weeks | Age (SD): 14.87 years (1.68 years)<br>Female: 82.5%<br>Heterosexual: 79.4%<br>Lesbian/gay: 3.2%<br>Bisexual: 14.3%,<br>Questioning: 3.2%<br>American Indian: 3.2%<br>Asian: 1.6%<br>White: 25.4%<br>African American: 52.4%<br>Native Hawaiian/Pacific Islander: 1.6%<br>Biracial/multiracial: 6.3%<br>Hispanic: 14.3%<br>Other race/ethnicity: 9.5%<br>Physical abuse: 22.2%<br>Sexual abuse: 19%<br>Any mood disorder: 40.4%<br>Any anxiety disorder: 45.6%<br>Any substance disorder: 7.1%<br>ODD: 14%<br>Prior self-injurious behaviors: 67.6%<br>Prior suicidal attempt: 34.9% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Diamond, 2010**[25] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 03/2005–05/2007 | Inclusion: Adolescents scoring higher than 31 on the SIQ-JR and above 20 on the BDI-II and if these scores remained above the cut-off 2 days later; age 12-17; parent or guardian had to be willing to participate.<br><br>Exclusion: Patients who needed psychiatric hospitalization; were recently discharged from a psychiatric hospital; had current psychosis; had mental retardation or history of borderline intellectual functioning. | 6 months | Attachment-Based Family Therapy (ABFT)<br>(N=35) | 10 sessions over 3 months | Age (SD): 15.11 years (1.41 years)<br>Female: 91.4%<br>African American: 71.4%<br>Major depressive episode: 37.1%<br>Dysthymia: 8.6%<br>Any anxiety: 60%<br>Externalizing disorder (ADHD, ODD, CD): 65%<br>Prior suicidal attempt: 62.9% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Diamond, 2010[25] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 03/2005-05/2007 | Inclusion: Adolescents scoring higher than 31 on the SIQ-JR and above 20 on the BDI-II and if these scores remained above the cut-off 2 days later; age 12–17; parent or guardian had to be willing to participate.<br><br>Exclusion: Patients who needed psychiatric hospitalization; were recently discharged from a psychiatric hospital; had current psychosis; had mental retardation or history of borderline intellectual functioning. | 6 months | Enhanced Usual Care (EUC) (N=31) | The type and amount of treatment was determined independently by community providers. | Age (SD): 15.29 years (1.83 years)<br>Female: 74.2%<br>African American: 77.4%<br>Major depressive episode: 41.9%<br>Dysthymia: 6.5%<br>Any anxiety: 74.2%<br>Externalizing disorder (ADHD, ODD, CD): 48%<br>Prior suicidal attempt: 61.3% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Russon, 2021**[26] | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: NR | Inclusion: Adolescents/young adults had to self-identify as a sexual and/or gender minority, score 31 or higher on the SIQ-JR indicating serious suicide risk, and score 21 or higher on the BDI-II indicating moderate depression.<br><br>Exclusion: Significant impairment from psychosis Intellectual or developmental disabilities, urgent substance use trauma needs, and inability to speak or read English. | 4 months | Attachment-Based Family Therapy (ABFT)<br>(N=10) | Weekly sessions over 4 months | Age (SD years): 18.2 years<br>Transgender/gender diverse: 80%<br>LGBQ: 80%<br>Self-identified asexual= 10 %<br>Self-identified heterosexual= 10%<br>White: 50 %<br>Multiracial: 30 %<br>African American: 20 %<br>Prior suicidal attempt: 40 %<br>Depression (BDI-II): 35.4 (SD=11.92) |
| **Diamond, 2012**[27] | Country: United States, Israel<br>Study Design: Before–After study<br>Patient Enrollment Period: NR | Inclusion: Adolescents needed to report significant levels of suicidal ideation as evidenced by a score of 31 or greater on the SIQ-JR<br><br>Exclusion: had current psychosis or mental retardation | 3 months | Attachment-Based Family Therapy (ABFT)-Phase II<br>(N=10) | 60-minute weekly sessions delivered over 12 weeks per family (8–16 sessions) | Age (SD): 15.10 years (1.37 years)<br>Female: 80%<br>Exclusively gay: 10%<br>Exclusively lesbian: 20%<br>Primarily gay, but also attracted to females: 10%<br>Primarily lesbians, but also attracted to males: 60%<br>White: 20%<br>African American: 50%<br>Multiracial: 10%<br>Other race: 10%<br>Moderate to severe depressive symptoms: 80%<br>Prior suicidal attempt: 90% |

Abbreviations: ABFT = attachment-based family therapy; ADHD = attention-deficit/hyperactivity disorder; BDI-II = Beck's depression inventory; CD = conduct disorder; EUC = enhanced usual care; FE-NST = family-enhanced nondirective supportive therapy; LGBQ = lesbian, gay, bisexual, queer; NR = not reported; ODD = oppositional defiant disorder; RCT = randomized clinical trial; SD = standard deviation; SIQ-JR = suicidal ideation questionnaire—junior; PHQ = patient health questionnaire, C-SSRS: Columbia-suicide severity rating scale; ASQ = ages and stages questionnaires

**Table D.4. Characteristics of Included Studies for Family-Focused Therapy (FFT)**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Miklowitza, 2020**[28] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Participants aged 9–17 years who met DSM-IV or DSM-5 criteria for unspecified bipolar disorder or major depressive disorder, living with at least one parent who is available for assessments and intervention sessions, had at least one first- or second-degree relative with documentable bipolar I or II disorder, and had active mood symptoms (Young Mania Rating Scale scores >11 or Children's Depression Rating Scale, Revised scores >29) in the 1–2 weeks prior to intake.<br><br>Exclusion: Youth who are adopted and biological parents could not be interviewed, had comorbid neurological illnesses or autism spectrum disorder, or had concurrent substance/alcohol abuse or dependence disorder. Also, those already in family therapy unless they discontinued their existing trauma. | 48 months | Family-Focused Therapy (FFT) (N=61) | 12 sixty-minute sessions (8 weekly, 4 biweekly) for 4 months | Age (SD): 13.2 (2.7)<br>Female: 60.7%<br>Nonwhite 19.7%<br>Hispanic 24.6%<br>MDD: 60.7%<br>Bipolar disorder 39.3%<br>Hypomania, no or subthreshold depression 4.9%<br>Subthreshold depression and hypomania 11.5%<br>Prior suicidal attempt: 17% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Miklowitza, 2020[28] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Participants aged 9–17 years who met DSM-IV or DSM-5 criteria for unspecified bipolar disorder or major depressive disorder, living with at least one parent who is available for assessments and intervention sessions, had at least one first- or second-degree relative with documentable bipolar I or II disorder, and had active mood symptoms (Young Mania Rating Scale scores >11 or Children's Depression Rating Scale, Revised scores >29) in the 1–2 weeks prior to intake.<br><br>Exclusion: Youth who are adopted and biological parents could not be interviewed, had comorbid neurological illnesses or autism spectrum disorder, or had concurrent substance/alcohol abuse or dependence disorder. Also, those already in family therapy unless they discontinued their existing trauma. | 48 months | Enhanced Care (EC)<br>(N=66) | 3 weekly sixty-minute family sessions followed by 3 monthly individual sessions | Age (SD): 13.3 (2.5)<br>Female: 68.2%<br>Nonwhite 15.2%<br>Hispanic 12.1%<br>MDD: 60.7%<br>Bipolar disorder: 42.4%<br>Hypomania, no or subthreshold depression 6.1%<br>Subthreshold depression and hypomania: 7.6%<br>Prior suicidal attempt: 14% |

Abbreviations: EC = enhanced care; ED = emergency department; FFT = family-focused therapy; MDD = major depressive disorder; NR = not reported; SD = standard deviation; SIQ-JR = suicidal ideation questionnaire—junior; PHQ = patient health questionnaire, C-SSRS: Columbia-suicide severity rating scale; ASQ = ages and stages questionnaires

**Table D.5. Characteristics of Included Studies for Collaborative Assessment and Management of Suicidality (CAMS)**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Pistorello, 2021**[29] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: College students aged 18–25 years, who were seeking college counseling center (CCC), are new to CCC trauma (or not in trauma for 3 months prior) and endorsed a 2 or above on the question "I have thoughts of ending my life" on the Counseling Center Assessment of Psychological Symptoms (CCAPS-34).<br><br>Exclusion: NR | 2 months | Collaborative Assessment and Management of Suicidality (CAMS)<br>(N=33) | Average of 5.61 sessions over 4–8 weeks | Age (SD): 19.48 years (1.48 years)<br>Female: 63.6%<br>Heterosexual 48.5%<br>Bi-sexual/Gay: 36.4%<br>Unknown/ unsure sexual orientation: 15.2%<br>White 48.5%<br>Multiracial 18.2%<br>Hispanic: 9.1%<br>African American: 6.1%<br>Asian: 18.2%<br>Prior suicidal attempt: 27.3% |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: College students aged 18–25 years, who were seeking college counseling center (CCC), are new to CCC trauma (or not in trauma for 3 months prior) and endorsed a 2 or above on the question "I have thoughts of ending my life" on the Counseling Center Assessment of Psychological Symptoms (CCAPS-34).<br><br>Exclusion: NR | 2 months | Treatment as Usual (TAU)<br>(N=29) | Average of 5.61 sessions over 4–8 weeks | Age (SD): 20.52 years (2.31 years)<br>Female: 72.4%<br>Heterosexual 53.2%<br>Bi-sexual/Gay: 31%<br>Unknown/ unsure sexual orientation: 13.8%<br>White 48.3%<br>Multiracial: 31%<br>Hispanic: 6.9%<br>African American: 0%<br>Asian: 13.8%<br>Prior suicidal attempt: 34.5% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Adrian, 2023** [30] | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: 3/18/2019–1/24/2022 | Inclusion: Adolescents 10–20, referred to the Behavioral Health Crisis Care Clinic (CCC) due to past-week suicidal ideation or behavior and received at least two sessions in the Crisis Care Clinic<br><br>Exclusion: Severe cognitive impairment/developmental delay, no available caregiver or trusted adult to participate in trauma, primary presenting problem not related to SITB (self-injurious thoughts and behaviors). | 1 month | Behavioral Health Crisis Care Clinic (CCC) Team-Based Approach (N=189) | 4 sessions, weekly, first session was 90 minutes, the remaining were 50 minutes | Age (SD): 14.48 years (2.01 years)<br>Female: 62.4%<br>Self-identified males: 22.2%<br>Self-identified nonbinary/genderqueer: 15.4%<br>Multiple races: 15.3%<br>Asian American: 7.4%<br>African American: 4.2%<br>White: 57.6%<br>Hispanic: 14.1%<br>American Indian: 1%<br>Prior self-injurious behaviors: 78%<br>Prior suicidal attempt: 50%<br>Recent hospital discharge for mental health trauma: 27.6%<br>ASQ score: 2.52 (SD = 1.06) |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Adrian, 2021**[31] | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 13–17 years, exceeded the clinical cut-off (score ≥ 7) on the Suicidal Behavior Questionnaire-Revised (SBQ-R), and provided consent and parental permission to participate in study procedures.<br><br>Exclusion: Diagnoses of psychosis, life threatening eating disorder, or autism spectrum diagnosis/intellectual disability. Also, patients with limited English proficiency that would interfere with ability to completing assessments. | 6 months | Collaborative Assessment and Management of Suicide (CAMS) (N=22) | 60-minute sessions, scheduled one session/week for up to 16 sessions depending on response | Age (SD): 15.41 years (1.26 years)<br>Female: 68.2%<br>Self-identified male: 36.4%<br>Self-identified female: 59.1%<br>Self-identified transgender male: 4.5%<br>White: 81.82%<br>Native Hawaiian/Pacific Islander: 9%<br>Asian: 4.5%<br>Other race/ethnicity: 4.5%<br>Prior suicidal attempt: 31.8%<br>PHQ-9 score: 20.33 (SD=5.18)<br>SIQ score: 56.05 (SD=18.92) |

Abbreviations: ASQ = ages and stages questionnaires; CAMS = collaborative assessment and management of suicide; CCAPS = counseling center assessment of psychological symptoms; CCC = crisis care clinic; C-SSRS = Columbia-suicide severity rating scale; NR = not reported; PHQ = patient health questionnaire; PTSD = posttraumatic stress disorder; SBQ-R = suicidal behavior questionnaire-revised; SD = standard deviation; SIQ-JR = suicidal ideation questionnaire—junior; SITB = self-injurious thoughts and behaviors.

**Table D.6 Characteristics of Included Studies for Crisis Management**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Wharff, 2019**[32] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 1/2012–5/2014 | Inclusion: Adolescents aged 13–18 presenting to the ED with suicidality, defined as self-identification as suicidal, observation of suicidal behavior by a parent/responsible adult, or a recent suicide attempt. Must have a consenting parent or legal guardian with whom they reside.<br><br>Exclusion: Lack of fluency in English (adolescent or parent/guardian), medical instability (including intoxication), cognitive limitations prohibiting completion of research instruments, active psychosis, or need for physical or medication restraint in the ED. | 1 month | Family-Based Crisis Intervention (FBCI) (N=68) | One 60–90-minute session | Age (SD): 15.4 years (1.3 years)<br>Female: 74%<br>African American: 4%<br>White: 62%<br>Hispanic: 9%<br>Asian: 4%<br>Multiracial: 21%<br>Depression: 63%<br>Anxiety disorder: 18%<br>Other mood disorders: 7%<br>Other disorders: 12% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons<br><br>(N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Wharff, 2019[32] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 1/2012–5/2014 | Inclusion: Adolescents aged 13–18 presenting to the ED with suicidality, defined as self-identification as suicidal, observation of suicidal behavior by a parent/responsible adult, or a recent suicide attempt. Must have a consenting parent or legal guardian with whom they reside.<br><br>Exclusion: Lack of fluency in English (adolescent or parent/guardian), medical instability (including intoxication), cognitive limitations prohibiting completion of research instruments, active psychosis, or need for physical or medication restraint in the ED. | 1 month | Treatment as Usual (TAU)<br>(N=71) | NR | Age (SD): 15.6 years (1.5 years)<br>Female: 70%<br>African American: 8%<br>White: 70%<br>Hispanic: 10%<br>Asian: 1%<br>Multiracial: 15%<br>Depression: 71%<br>Anxiety disorder: 6%<br>Other mood disorders: 7%<br>Other disorder: 17% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Asarnow, 2011**[33] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 04/2003–08/2005 | Inclusion: Patients presenting to the ED for suicide attempts and/or ideation; age 10–18.<br><br>Exclusion: Acute psychosis/symptoms that impede consent/assessment; no parent/guardian to consent; youth not English-speaking; parents/guardians not English or Spanish-speaking. | 3 months | Family Intervention for Suicide Prevention (FISP)<br>(N=89) | One session in ED and phone call 48 hours after ED/hospital discharge, then as-needed at 1, 2, and 4 weeks | Age (SD): 14.8 years (2.1 years)<br>Female: 66%<br>White, non Hispanic: 35%<br>African American: 14%<br>Hispanic: 42%<br>Other race: 10%<br>Severe depression: 78%<br>PTSD: 53%<br>Substance abuse: 18%<br>Prior suicidal attempt: 66<br>Recent hospital discharge for mental health trauma: 23% |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 04/2003–08/2005 | Inclusion: Patients presenting to the ED for suicide attempts and/or ideation; age 10–18.<br><br>Exclusion: Acute psychosis/symptoms that impede consent/assessment; no parent/guardian to consent; youth not English-speaking; parents/guardians not English or Spanish-speaking. | 3 months | Enhanced Usual Care (EUC)<br>(N=92) | One session | Age (SD): 14.6 years (1.9 years)<br>Female: 72%<br>White, non Hispanic: 32%<br>African American: 12%<br>Hispanic: 49%<br>Other race: 8%<br>Severe depression: 78%<br>PTSD: 52%<br>Substance abuse: 17%<br>Prior suicidal attempt: 66<br>Recent hospital discharge for mental health trauma: 26% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons<br><br>(N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Wharff, 2012**[34] | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: 1/1/2001–6/30/2002 | Inclusion: Adolescents aged 13–18 years, presenting with symptoms of suicidality, accompanied by a family member, currently living with family, not intoxicated/sedated, and able to participate (not severely psychotic or significantly developmentally delayed).<br><br>Exclusion: not living with family, unaccompanied by family, intoxicated/sedated, severe psychosis, significant developmental delay, and presenting during certain hours when FBCI-trained staff were unavailable (overnight and weekends). | 3 months | Family-Based Crisis Intervention (FBCI) (N=100) | One session, followed by 5 followup assessments via telephone at 1-day, 1-week, 2-week, 1-month, and 3-month intervals | Age (SD): 15.60 years (1.45 years)<br>Female: 76.0%<br>Asian: 2%<br>African American: 16%<br>Hispanic: 11%<br>White: 65%<br>Biracial: 3%<br>Other race: 3%<br>Depressive disorders: 76%<br>Bipolar disorder: 5%<br>Other mood disorders: 1%<br>Anxiety disorders/PTSD 8%<br>Other conditions including eating disorder, psychosis, substance abuse, behavioral disorders, attention-deficit/hyperactivity disorder, and somatoform disorders: 11% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons<br><br>(N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Wharff, 2012[34] continued** | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: 1/1/2001–6/30/2002 | Inclusion: Adolescents aged 13–18 years, presenting with symptoms of suicidality, accompanied by a family member, currently living with family, not intoxicated/sedated, and able to participate (not severely psychotic or significantly developmentally delayed).<br><br>Exclusion: not living with family, unaccompanied by family, intoxicated/sedated, severe psychosis, significant developmental delay, and presenting during certain hours when FBCI-trained staff were unavailable (overnight and weekends). | 3 months | Retrospective Comparison Group (N=150) | NR | Age (SD): 15.50 years (1.47 years)<br>Female: 74%<br>Asian: 2.7%<br>African American: 17.3%<br>Hispanic: 11%<br>White: 64.7%<br>Biracial: 1.3%<br>Other race: 4.0%<br>Depressive disorders: 70%<br>Bipolar disorder: 6.7%<br>Other mood disorders: 1.3%<br>Anxiety disorders/PTSD: 6.6%<br>Other conditions: 15.3% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons<br><br>(N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Rotheram-Borus, 2000**[35] | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: 3/1991–2/1994 | Inclusion: Patients who have been admitted for a suicide attempt to the ER, aged 12–18 years, not psychiatrically hospitalized for more than 1 week, female, and not referred to hospitals outside of the New York City area.<br><br>Exclusion: Males, females identified only as suicidal ideators, females admitted for more than 1 week to a psychiatric ward following the suicide attempt, individuals ineligible due to low IQ, wrong age, no parent or family, or having moved immediately out of the area, and individuals referred to trauma programs closer to their residence. | 18 months | Specialized ER Care (N=65) | One session in the ER, followed by 6 outpatient sessions | Age (SD): 14.9 years (1.5 years)<br>Female: 100%<br>Hispanic: 89.2%<br>Depression: 90.76%<br>Prior suicidal attempt: 31.8% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons<br><br>(N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Rotheram-Borus, 2000[35] continued** | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: 3/1991–2/1994 | Inclusion: Patients who have been admitted for a suicide attempt to the ER, aged 12–18 years, not psychiatrically hospitalized for more than 1 week, female, and not referred to hospitals outside of the New York City area.<br><br>Exclusion: Males, females identified only as suicidal ideators, females admitted for more than 1 week to a psychiatric ward following the suicide attempt, individuals ineligible due to low IQ, wrong age, no parent or family, or having moved immediately out of the area, and individuals referred to trauma programs closer to their residence. | 18 months | Standard ER Care (N=75) | One session in the ER, followed by 6 outpatient sessions | Age (SD): 14.9 years (1.5 years)<br>Female: 100%<br>Hispanic: 85.3%<br>Depression: 80%<br>Prior suicidal attempt: 29.7% |

Abbreviations: ASQ = ages and stages questionnaires; ED = emergency department; ER = emergency room; EUC = enhanced usual care; FBCI = family-based crisis intervention; FISP = family intervention for suicide prevention; NR = not reported; PHQ = patient health questionnaire; PTSD = posttraumatic stress disorder; SD = standard deviation; SIQ-JR = suicidal ideation questionnaire—junior; TAU = treatment as usual

**Table D.7. Characteristics of Included Studies for Motivation Interviewing**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons<br><br>(N of Patients) | Dose/Frequency/Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Grupp-Phelan, 2019**[36] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period:4/2013–7/2015. | Inclusion: Adolescents aged 12–17 years presenting to the ED for nonpsychiatric concerns who screened positive on the Ask Suicide Screening Questions (ASQ) tool, lived within 100 miles of the hospital, had no contact with a mental health practitioner in the 90 days preceding the index ED visit, and were stable as determined by vital signs and triage criteria.<br><br>Exclusion: Presenting to the ED with a chief concern of suicidal behavior or a primary or secondary psychiatric concern or altered mental status attributable to illness or medication, lacked telephone access, were unable to understand the study process, or were unable to speak or read English adequately to participate in study procedures. | 6 months | Suicidal Teens Accessing Treatment After an Emergency Department Visit (STAT-ED)<br>(N=84) | 1–2 followup phone calls after ED discharge | Age (SD): 15.2 years (1.6 years)<br>Female: 78.8%<br>White 47.5%<br>African American: 42.5%<br>Multiracial 6.3%<br>Other race: 3.8%<br>Hispanic: 6.3%<br>Prior suicidal attempt: 36.7% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons<br><br>(N of Patients) | Dose/Frequency/Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Grupp-Phelan, 2019[36] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period:4/2013–7/2015. | Inclusion: Adolescents aged 12–17 years presenting to the ED for nonpsychiatric concerns who screened positive on the Ask Suicide Screening Questions (ASQ) tool, lived within 100 miles of the hospital, had no contact with a mental health practitioner in the 90 days preceding the index ED visit, and were stable as determined by vital signs and triage criteria.<br><br>Exclusion: Presenting to the ED with a chief concern of suicidal behavior or a primary or secondary psychiatric concern or altered mental status attributable to illness or medication, lacked telephone access, were unable to understand the study process, or were unable to speak or read English adequately to participate in study procedures. | 6 months | Enhanced Usual Care (EUC)<br>(N=84) | NR | Age (SD): 14.9 years (1.5 years)<br>Female: 79.7%<br>White: 53.8%<br>Black: 34.6%<br>Multiracial: 10.3:<br>Other race: 1.3%<br>Hispanic: 5.1%<br>Prior suicidal attempt: 45.5% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons<br><br>(N of Patients) | Dose/Frequency/Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **McManama O'Brien, 2018**[37] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 11/2014–1/2018 | Inclusion: Adolescents aged 14–17, psychiatrically hospitalized following a suicide plan or attempt, and endorsed alcohol use over the past month.<br><br>Exclusion: Participants were excluded from the study if they presented with active psychosis, could not comprehend written English, or were in the custody of the state. | 3 months | Alcohol and Suicide Intervention for Suicidal Teens (ASIST)<br>(N=25) | One 60- to 90-minute individual session and one 20- to 30-minute family session | Age (SD): 15.96 years (0.89 years)<br>Female: 84%<br>Transgender (FTM): 4%<br>Declined to state gender: 0%<br>Heterosexual: 72%<br>Gay/lesbian/homosexual: 0%<br>Bisexual: 24%<br>Unsure/declined race: 4%<br>African American: 4%<br>White: 76%<br>American Indian: 0%<br>Asian: 0%<br>Biracial: 8%<br>Other race: 12%<br>Hispanic: 20%<br>Non Hispanic: 80%<br>Illicit substance use:<br>Marijuana use: 72%<br>Cocaine use: 4%<br>Crystal meth: 0%<br>LSD: 0%<br>PCP: 0%<br>Inhalants: 0%<br>Opioids: 4%<br>Prescription: 20%<br>Tobacco use: 32%<br>Prior suicidal attempt: 64% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons<br><br>(N of Patients) | Dose/Frequency/Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **McManama O'Brien, 2018[37] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 11/2014–1/2018 | Inclusion: Adolescents aged 14–17, psychiatrically hospitalized following a suicide plan or attempt, and endorsed alcohol use over the past month.<br><br>Exclusion: Participants were excluded from the study if they presented with active psychosis, could not comprehend written English, or were in the custody of the state. | 3 months | Treatment as Usual (TAU) (N=25) | NR | Age (SD): 15.64 years (0.99 years)<br>Female: 76%<br>Transgender: 0%<br>Declined to state gender: 4%<br>Heterosexual: 64%<br>Gay/lesbian/homosexual: 0%<br>Bisexual: 28%<br>Unsure/declined race: 8%<br>African American: 4.17%<br>White: 58.33%<br>American Indian: 4.17%<br>Asian: 4.17%<br>Biracial: 8.33%<br>Other race: 20.83%<br>Hispanic: 24%<br>Non Hispanic: 76%<br>Illicit substance use:<br>Marijuana use: 92%<br>Cocaine use: 0%<br>Crystal meth: 4%<br>LSD: 12%<br>PCP: 0%<br>Inhalants: 4%<br>Opioids: 0%<br>Prescription: 16%<br>Tobacco use: 32%<br>Prior suicidal attempt: 40% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons<br><br>(N of Patients) | Dose/Frequency/Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **King, 2015**[38] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 2/2014–6/2014 | Inclusion: Adolescents aged 14–19 years, with a positive suicide risk screen (suicidal ideation, recent suicide attempt, or positive screens for both depression and alcohol or drug abuse), presenting with a non psychiatric chief complaint.<br><br>Exclusion: level one trauma (critically ill, medically unstable), significant cognitive impairment (unable to complete self-report screen), or disposition of psychiatric hospitalization. | 2 months | Teen Options for Change (TOC)<br>(N=27) | 35–45 minutes long interview, with telephone check-in 2–5 days after the ED visit | Age (SD): 17.7 years (1.7 years) (total population)<br>African American: 57% (total population)<br>White: 39%<br>American Indian or Alaska Native: 4%<br>Native Hawaiian/Pacific Islander: 2%<br>Hispanic: 2%<br>Other race/ethnicity: 2%<br>Depressive symptoms with alcohol/drug abuse: 53%<br>Prior suicidal attempt: 35% recent suicidal ideation or recent suicide attempt |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 2/2014–6/2014 | Inclusion: Adolescents aged 14–19 years, with a positive suicide risk screen (suicidal ideation, recent suicide attempt, or positive screens for both depression and alcohol or drug abuse), presenting with a non psychiatric chief complaint.<br><br>Exclusion: level one trauma (critically ill, medically unstable), significant cognitive impairment (unable to complete self-report screen), or disposition of psychiatric hospitalization. | 2 months | Enhanced Treatment as Usual (ETAU)<br>(N=22) | One time | Age (SD): 17.7 years (1.7 years) (total population)<br>African American: 57% (total population)<br>White: 39%<br>American Indian or Alaska Native: 4%<br>Native Hawaiian/Pacific Islander: 2%<br>Hispanic: 2%<br>Other race/ethnicity: 2%<br>Depressive symptoms with alcohol/drug abuse: 53%<br>Prior suicidal attempt: 35% (recent suicidal ideation or recent suicide attempt) |

Abbreviations: ASIST = alcohol and suicide intervention for suicidal teens; ASQ = ages and stages questionnaires; ED = emergency department; ETAU = enhanced treatment as usual; EUC = enhanced usual care; NR = not reported; PHQ = patient health questionnaire; RCT = randomized clinical trial; SD = standard deviation; SIQ-JR = suicidal ideation questionnaire—junior; STAT-ED = suicidal teens accessing treatment after an emergency department visit; TAU = treatment as usual; TOC = teen options for change

**Table D.8. Characteristics of Included Studies for Safety Planning**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Czyz, 2019**[39] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 1/2017–5/2017 | Inclusion: Adolescents aged 13–17 who were psychiatrically hospitalized due to suicide risk based on last-week suicidal ideation (with thoughts of method, intent, and/or plan) and/or last-month suicide attempt.<br><br>Exclusion: Severe cognitive impairment or altered mental status (e.g., psychosis or mania), transfer to residential placement, no availability of legal guardian (ward of state), or no access to a phone with texting capability. | 3 months | Motivational Interview-Enhanced Safety Planning + Treatment as Usual (MI-SafeCope + TAU)<br>(N=18) | 1 individual session, 1 family session, 1 phone call with adolescent and parent separately 2 weeks after discharge | Age (SD): 15.42 years (1.36 years)<br>Female: 78.8%<br>White: 86.1%<br>African American: 8.3%<br>Asian: 8.3%<br>Hispanic: 5.6%<br>American Indian: 2.8%<br>Native Hawaiian/Pacific Islander: 2.8%<br>Recent hospital discharge for mental health trauma: 100% |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 1/2017–5/2017 | Inclusion: Adolescents aged 13–17 who were psychiatrically hospitalized due to suicide risk based on last-week suicidal ideation (with thoughts of method, intent, and/or plan) and/or last-month suicide attempt.<br><br>Exclusion: Severe cognitive impairment or altered mental status (e.g., psychosis or mania), transfer to residential placement, no availability of legal guardian (ward of state), or no access to a phone with texting capability. | 3 months | Treatment as Usual (TAU)<br>(N=18) | RAP packet is completed during hospitalization, 1 or more individual sessions with nursing staff | NR |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Kennard, 2018**[40] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 12–18 presenting to psychiatric inpatient units with recent suicidal ideation with plan or intent, and/or a recent suicide attempt. Must have a consenting parent or legal guardian with whom they reside.<br><br>Exclusion: Need for residential trauma, active involvement of child protective services, mania, psychosis, autism, intellectual disability, and inability to complete baseline assessments due to discharge or refusal. | 6 months | As Safe as Possible (ASAP+TAU) (N=34) | 2.7 hours total, over a median of 3 sessions, followed by two phone call sessions and daily texts 1–2 weeks postdischarge | Age (SD): 14.9 years (1.6 years)<br>Female: 88.2<br>White: 79.4%<br>Hispanic: 2.9%<br>History of sexual or physical trauma: 41.2%<br>Depression: 91.2%<br>Alcohol/substance use: 23.5%<br>Anxiety disorder: 58.8%<br>ADHD: 26.5%<br>Bipolar disorder: 15.6 %<br>Other disorders: 14.7%<br>Prior self-injurious behaviors: 82.4%<br>Prior suicidal attempt: 82.4%<br>PHQ-9 score: 19 (4.8) |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Adolescents aged 12–18 presenting to psychiatric inpatient units with recent suicidal ideation with plan or intent, and/or a recent suicide attempt. Must have a consenting parent or legal guardian with whom they reside.<br><br>Exclusion: Need for residential trauma, active involvement of child protective services, mania, psychosis, autism, intellectual disability, and inability to complete baseline assessments due to discharge or refusal. | 6 months | Treatment as Usual (TAU) (N=32) | NR | Age (SD): 15.3 years (1.4 years)<br>Female: 90.6<br>White: 75%<br>Hispanic: 0%<br>History of sexual or physical trauma: 40%<br>Depression: 81.2%<br>Alcohol/substance use: 31.3%<br>Anxiety disorder: 56.2%<br>ADHD: 12.5%<br>Bipolar disorder: 8.8%<br>Other disorders: 21.9%<br>Prior self-injurious behaviors: 90.6%<br>Prior suicidal attempt: 78.1%<br>PHQ-9 score: 17.5 (5.8) |

Abbreviations: ADHD = attention-deficit/hyperactivity disorder; ASAP = as safe as possible; ASQ = ages and stages questionnaires; MI = motivational interview; NR = not reported; PHQ = patient health questionnaire; PTSD = posttraumatic stress disorder; RAP = recovery action plan; SD = standard deviation; SIQ-JR = suicidal ideation questionnaire—junior; SP = safety plan; TAU = treatment as usual

**Table D.9. Characteristics of Included Studies for Continuity of Care**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Czyz, 2021**[41] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 3/2019–1/2020 | Inclusion: Adolescents aged 13–17 years who are psychiatrically hospitalized and presenting with suicide risk concerns, including last-week suicidal ideation with thoughts of method, intent, or plan and/or last-month suicide attempt.<br><br>Exclusion: Cognitive impairment, altered mental status, residential placement, no availability of legal guardian, or no cell phone access. | 3 months | PHASE I Motivational Interview-Enhanced Safety Plan + Monitoring (MI-SP + Monitoring) (N=40) | One 60-minute individual session, one 30-minute family session | Age (SD): 15.08 years (1.40 years)<br>Female: 67.5%<br>White: 80.0%<br>African American: 7.5%<br>Asian: 5.0%<br>American Indian: 7.5%<br>Native Hawaiian/Pacific Islander: 0%<br>Other race/ethnicity: 2.5%<br>Depressive disorder: 80.0%<br>Anxiety disorder: 50.05%<br>Prior self-injurious behaviors: 77.5%<br>Prior suicidal attempt: 52.5%<br>C-SSRS score: 3.90 (0.90) |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 3/2019–1/2020 | Inclusion: Adolescents aged 13–17 years who are psychiatrically hospitalized and presenting with suicide risk concerns, including last-week suicidal ideation with thoughts of method, intent, or plan and/or last-month suicide attempt.<br><br>Exclusion: Cognitive impairment, altered mental status, residential placement, no availability of legal guardian, or no cell phone access. | 3 months | PHASE I Motivational Interview-Enhanced Safety Plan + Texts + Monitoring (MI-SP + Texts + Monitoring) (N=40) | 2 daily text messages for 4 weeks | Age (SD): 15.25 years (1.32 years)<br>Female: 67.5%<br>White: 87.5%<br>African American: 5%<br>Asian: 5%<br>American Indian: 2.5%<br>Native Hawaiian/Pacific Islander: 2.5%<br>Other race/ethnicity: 2.5%<br>Depressive disorder: 92.5%<br>Anxiety disorder: 57.5%<br>Prior self-injurious behaviors: 77.5%<br>Prior suicidal attempt: 47.5%<br>C-SSRS score: 3.93 (0.92) |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Czyz, 2021[41] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 3/2019–1/2020 | Inclusion: Adolescents aged 13–17 years who are psychiatrically hospitalized and presenting with suicide risk concerns, including last-week suicidal ideation with thoughts of method, intent, or plan and/or last-month suicide attempt.<br><br>Exclusion: Cognitive impairment, altered mental status, residential placement, no availability of legal guardian, or no cell phone access. | 3 months | PHASE II Booster Calls (N=36) | One call with adolescent and one with parent after MI-SP | Age (SD): 15.33 years (1.31 years)<br>Female: 67.5%<br>White: 86.1%<br>African American: 5.6%<br>Asian: 5.6%<br>American Indian: 5.6%<br>Native Hawaiian/Pacific Islander: 0%<br>Other race/ethnicity: 0%<br>Depressive disorder: 86.1%<br>Anxiety disorder: 63.9%<br>Prior self-injurious behaviors: 75%<br>Prior suicidal attempt: 44.4%<br>C-SSRS score: 3.92 (0.94) |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 3/2019–1/2020 | Inclusion: Adolescents aged 13–17 years who are psychiatrically hospitalized and presenting with suicide risk concerns, including last-week suicidal ideation with thoughts of method, intent, or plan and/or last-month suicide attempt.<br><br>Exclusion: Cognitive impairment, altered mental status, residential placement, no availability of legal guardian, or no cell phone access. | 3 months | PHASE II No Booster Calls (N=44) | NR | Age (SD): 15.02 years (1.39 years)<br>Female: 67.5%<br>White: 81.8%<br>African American: 6.8%<br>Asian: 4.5%<br>American Indian: 4.5%<br>Native Hawaiian/Pacific Islander: 2.3%<br>Other race/ethnicity: 4.5%<br>Depressive disorder: 86.4%<br>Anxiety disorder: 45.5%<br>Prior self-injurious behaviors: 79.5%<br>Prior suicidal attempt: 54.5%<br>C-SSRS score: 3.91 (0.88) |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Rengasamy, 2019**[42] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 9/8/2017–1/12/2018 | Inclusion: Adolescents aged 12–18 years who were admitted to inpatient psychiatric units for suicidal ideation or attempt<br><br>Exclusion: patients who were discharged to a longer-term care facility, transferred to another hospital or psychiatric unit, were placed exclusively under the care of child protective services, were readmitted within 12 hours of discharge, or lacked followup contact information | 3 months | Single Call Intervention (SCI)<br>(N=70) | One 10–20-minute phone call delivered 90 days after discharge | Age (SD): 15.1 years (1.6 years)<br>Female: 73%<br>Non White: 27%<br>History of sexual or physical trauma: (Physical abuse: 13%, Sexual abuse: 19%)<br>Other trauma: 9%<br>MDD: 64%<br>Depressive disorder: 21%<br>ADHD: 17%<br>ODD or CD: 9%<br>GAD: 13%<br>Anxiety disorder: 14%<br>Substance use disorder: 14%<br>Borderline personality disorder: 4%<br>PTSD: 13%<br>Prior suicidal attempt: 70% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Rengasamy, 2019[42] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 9/8/2017–1/12/2018 | Inclusion: Adolescents aged 12–18 years who were admitted to inpatient psychiatric units for suicidal ideation or attempt<br><br>Exclusion: patients who were discharged to a longer-term care facility, transferred to another hospital or psychiatric unit, were placed exclusively under the care of child protective services, were readmitted within 12 hours of discharge, or lacked followup contact information | 3 months | Multiple Calls Intervention (MCI)<br>(N=72) | Attempted 10–20-minute phone calls delivered on 1, 7, 14, 30, 60, at 90 days after discharge | Age (SD): 15 years (1.6 years)<br>Female: 67%<br>Non White: 25%<br>History of sexual or physical trauma: (Physical abuse: 10%, Sexual abuse: 25%)<br>Other trauma: 15%<br>MDD: 61%<br>Depressive disorder: 19%<br>ADHD: 25%<br>ODD or CD: 7%<br>GAD: 8%<br>Anxiety disorder: 22%<br>Substance use disorder: 10%<br>Borderline personality disorder: 6%<br>PTSD: 21%<br>Prior suicidal attempt: 58% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Greenfield, 2002**[43] | Country: Canada<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: 12/1996–10/1998 | Inclusion: Suicidal adolescents aged 12–17 years who presented at the ED with suicidal behavior and were deemed to require immediate psychiatric evaluation.<br><br>Exclusion: adolescents who were hospitalized for medical or surgical reasons, as determined by the pediatrician, and those who refused to participate in the study. | 6 months | Rapid-Response Outpatient (RRO) (N=158) | 10 telephone contacts over 18 weeks | Age (SD): 14 years (1.59 years)<br>Female: 72%<br>White: 70%<br>African American: 8%<br>Hispanic: 4%<br>Other race: 18%<br>Alcohol use: 47%<br>Illegal drug use: 48%<br>Depression: 46%<br>CD: 20%<br>Prior suicidal attempt: 33% |
| | Country: Canada<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: 12/1996–10/1998 | Inclusion: Suicidal adolescents aged 12–17 years who presented at the ED with suicidal behavior and were deemed to require immediate psychiatric evaluation.<br><br>Exclusion: adolescents who were hospitalized for medical or surgical reasons, as determined by the pediatrician, and those who refused to participate in the study. | 6 months | Control group (N=128) | NR | Age (SD): 14 years (1.46 years)<br>Female: 66%<br>White: 72%<br>African American: 4%<br>Hispanic: 4%<br>Other race: 20%.<br>Alcohol use: 52%<br>Illegal drug use: 59%<br>Depression: 50%<br>CD: 28%<br>Prior suicidal attempt: 29% |

Abbreviations: ADHD = attention-deficit/hyperactivity disorder; ASQ = ages and stages questionnaires; C-SSRS = Columbia-suicide severity rating scale; CD = conduct disorder; GAD = generalized anxiety disorder; MCI = multiple calls intervention; MDD = major depressive disorder; MI-SP = motivational interviewing-enhanced safety plan; NR = not reported; ODD = oppositional defiant disorder; PHQ = patient health questionnaire; PTSD = posttraumatic stress disorder; RCT = randomized clinical trial; RRO = rapid-response outpatient; SCI = single call intervention; SD = standard deviation; SIQ-JR = suicidal ideation questionnaire—junior; SP = safety planning

**Table D.10. Characteristics of Included Studies for Brief Adjunctive Treatments**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency /Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Dobias, 2021**[44] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 8/2020–9/2020 | Inclusion: Adolescents aged 13–16 years; comfortable reading and writing in English; no self-reported learning disability, visual impairment or other difficulty answering questions on a computer; had internet access; reported engaging in nonsuicidal self-injury (NSSI) within the previous month; reported disliking or hating themselves; did not exit the study prior to randomization<br><br>Exclusion: Participants whose responses included: copy/pasting from survey text, lack of English fluency, random text, or three words or fewer when asked for two sentences or more). Participants who self-disclosed that they had skipped through or not read entire portions of the survey or online program. | 3 months | Project SAVE (Stop Adolescent Violence Everywhere) (N=285) | One 30-minute online session | Age (SD): 14.92 years (0.98 years)<br>Female: 66.08%<br>Transgender: 7.69%<br>Transgender (female to male): 5.59%<br>Trans male: 5.59%<br>Trans masculine: 4.55%<br>Trans feminine: 0.35%<br>Genderqueer: 4.90%<br>Gender expansive: 2.10%<br>Intersex: 0.35%<br>Androgynous: 6.64%<br>Nonbinary: 21.33%<br>Two-spirited: 1.40%<br>Third gender: 1.05%<br>Agender: 4.55%<br>Not sure (gender identity): 11.89%<br>Other/Not Listed (gender identity): 5.94%<br>Missing: 2.10%<br>Heterosexual: 10.14%<br>Homosexual: 16.08%<br>Bisexual: 31.47%<br>Pansexual: 10.84%<br>Queer: 7.34%<br>Asexual: 4.90%<br>Other/Not Listed (sexual orientation): 4.20%<br>Unsure/Questioning (sexual orientation): 10.49%<br>Does not use a label: 4.55%<br>American Indian: 4.20%<br>Asian (including Asian Desi): 5.59%<br>African American: 8.74%<br>Hispanic: 20.63%<br>Native Hawaiian/Pacific Islander: 1.05%<br>White: 76.92%<br>Prefer not to answer: 0.35%<br>Other/not listed: 1.40% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency /Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Dobias, 2021[44] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 8/2020–9/2020 | Inclusion: Adolescents aged 13–16 years; comfortable reading and writing in English; no self-reported learning disability, visual impairment or other difficulty answering questions on a computer; had internet access; reported engaging in nonsuicidal self-injury (NSSI) within the previous month; reported disliking or hating themselves; did not exit the study prior to randomization<br><br>Exclusion: Participants whose responses included: copy/pasting from survey text, lack of English fluency, random text, or three words or fewer when asked for two sentences or more). Participants who self-disclosed that they had skipped through or not read entire portions of the survey or online program. | 3 months | Supportive Therapy ("Share Your Feelings") (N=293) | One 30-minute online session | Age (SD): 14.97 years (0.99 years)<br>Female: 66.67%<br>Transgender: 8.24%<br>Transgender (female to male): 6.45%<br>Trans male: 5.38%<br>Trans masculine: 6.45%<br>Trans feminine: 0.36%<br>Genderqueer: 6.81%<br>Gender expansive: 2.51%<br>Intersex: 0.36%<br>Androgynous: 7.17%<br>Nonbinary: 17.20%<br>Two-spirited: 0.72%<br>Third gender: 0.36%<br>Agender: 3.58%<br>Not sure (gender identity): 9.32%<br>Other/Not Listed (gender identity): 3.23%<br>Missing: 2.87%<br>Heterosexual: 13.62%<br>Homosexual: 13.98%<br>Bisexual: 38.35%<br>Pansexual: 9.32%<br>Queer: 3.58%<br>Asexual: 2.51%<br>Other/Not Listed (sexual orientation): 5.38%<br>Unsure/Questioning (sexual orientation): 7.17%<br>Does not use a label: 5.02%<br>American Indian: 6.81%<br>Asian (including Asian Desi): 8.96<br>African American: 10.75%<br>Hispanic: 21.50%<br>Native Hawaiian/Pacific Islander: 2.15%<br>White: 73.12%<br>Prefer not to answer: 1.43%<br>Other/not listed: 2.87% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency /Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Fitzpatrick, 2005**[45] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Participants with suicidal ideation were selected for participation based on a screening with the Beck Suicide Scale (score of 6 or greater as well as endorsing active ideation.)<br><br>Exclusion: NR | 1 month | Brief Problem-Orientation Treatment group (N=110) | 35-minute video, followup evaluations at 1 week, 2 weeks, and 1 month | Age (SD): 19.02 years (1.21 years)<br>Female: 54.54%<br>American Indian: 1%<br>Hispanic: 2%<br>Identified as Asian/Pacific Islander: 14%<br>White: 75%<br>African American: 4%<br>Other or mixed ancestry: 3% |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Participants with suicidal ideation were selected for participation based on a screening with the Beck Suicide Scale (score of 6 or greater as well as endorsing active ideation.)<br><br>Exclusion: NR | 1 month | Treatment as Usual (TAU) (N=NR) | 35-minute video, followup evaluations at 1 week, 2 weeks, and 1 month | |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency /Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Yen, 2020[46]** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 3/2015–1/2016 | Inclusion: Adolescents aged 12–18, living at home, English speaking, and access to text messaging.<br><br>Exclusion: Diagnosed with a psychotic disorder or exhibited cognitive or intellectual disabilities, or a ward of the state. | 6 months | Skills to Enhance Positivity (STEP) (N=26) | 3 individual in-person sessions, 1 family in-person session, 1 month of daily text messages and weekly phone calls postdischarge | Age (SD): 15.69 years (1.72 years)<br>Female: 53.8%<br>African American: 3.8%<br>White: 73.1%<br>Other race 23.1%<br>Any past abuse (sexual, physical and/or emotional): 38.5%<br>Childhood sexual abuse: 19.2%<br>Any mood disorder: 92.3%<br>Any anxiety disorder: 46.2%<br>Any trauma disorder: 3.8%<br>Substance use disorder: 23.1%<br>Prior self-injurious behaviors: 100.0%<br>Prior suicidal attempt: 57.7%<br>Recent hospital discharge for mental health trauma: 53.8% |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 3/2015–1/2016 | Inclusion: Adolescents aged 12–18, living at home, English speaking, and access to text messaging.<br><br>Exclusion: Diagnosed with a psychotic disorder or exhibited cognitive or intellectual disabilities, or a ward of the state. | 6 months | Enhanced Treatment as Usual (ETAU) (N=26) | Daily text messages for 1 month postdischarge | Age (SD): 15.58 years (1.21 years)<br>Female: 65.4%<br>African American: 3.8%<br>White: 80.8%<br>Other race 15.4%<br>Any past abuse (sexual, physical and/or emotional): 73.1%<br>Childhood sexual abuse: 15.4%<br>Any mood disorder: 92.3%<br>Any anxiety disorder: 42.3%<br>Any trauma disorder: 3.8%<br>Substance use disorder: 7.7%<br>Prior self-injurious behaviors: 92.3%<br>Prior suicidal attempt: 46.2%<br>Recent hospital discharge for mental health trauma: 42.3% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency /Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Ahmadi, 2022**[47] | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: 2018–2020 | Inclusion: Youth aged 9–18 years with comorbid PTSD and suicidality (C-SSRS score ≥3) admitted to the Olive View-UCLA Psychiatric Emergency Room (OV-PER) on a Monday or Wednesday, who did not have other major psychiatric disorders or prior suicide attempts, and who received developmental age-appropriate, clinically indicated RFPP-S.<br><br>Exclusion: Youth who had major psychiatric disorders, or prior suicide attempts. | 6 months | Reminder-Focused Positive Psychiatry and Suicide Prevention (RFPP-S)<br>(N=50) | 10 minutes twice daily for 2 consecutive days | Age (SD): 13 years (2 years)<br>Female: 56%<br>Recent hospital discharge for mental health trauma: 72%<br>PHQ-9 score: 20±1<br>C-SSRS score: suicidal ideation 4±1, suicidal behavior 0±0 |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency /Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Ahmadi, 2022[47] continued** | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: 2018–2020 | Inclusion: Youth aged 9–18 years with comorbid PTSD and suicidality (C-SSRS score ≥3) admitted to the Olive View-UCLA Psychiatric Emergency Room (OV-PER) on a Monday or Wednesday, who did not have other major psychiatric disorders or prior suicide attempts, and who received developmental age-appropriate, clinically indicated RFPP-S.<br><br>Exclusion: Youth who had major psychiatric disorders, or prior suicide attempts. | 6 months | Treatment as Usual (TAU) (N=150) | One session within 2 weeks after discharge | Age (SD): 13 years (2 years)<br>Female: 58%<br>Recent hospital discharge for mental health trauma: 72%<br>PHQ-9 score: 20±2<br>C-SSRS score: suicidal ideation 4±1, suicidal behavior 0±0 |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency /Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Yen, 2019**[48] | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: 03/2014–01/2015 | Inclusion: Adolescents aged 12–18 admitted for suicide risk, proficient in English<br><br>Exclusion: Active psychotic disorder, autism, cognitive deficits, wards of the state | 6 months | Skills to Enhance Positivity (STEP treatment)<br>(N=20) | In-person phase: 4 sessions (30-45 minutes each), on different consecutive weekdays<br><br>Remote-delivery phase: daily text messaging and weekly phone calls for one month | Age (SD): 15.9 years (1.5 years) (total population)<br>Female: 75% (total population)<br>Non Hispanic White: 80% (total population)<br>History of sexual or physical trauma: Past abuse (physical, sexual, emotional, neglect) 40% (total population)<br>MDD: 55%<br>Depressive disorder: 20%<br>Mood disorder: 25%<br>Substance use disorder: 15%<br>Anxiety disorder: 30% (total population)<br>Prior suicidal attempt: 65% (total population) |
| **Hill, 2023**[49] | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: 02/2019–07/2020 | Inclusion: Adolescents aged 12–17, endorsement of bereavement, thwarted belongingness score ≥21.<br><br>Exclusion: Not 12–17 years of age, Not bereaved, Thwarted belongingness < 21, Did not receive services at clinic. | 1 months | Supporting Grieving Teens (SGT)<br>(N=32) | Two sessions, one week apart, 30–40 min each | Age (SD): 14.44 years (1.56 years)<br>Female: 87.5%<br>Transgender/do not identify as male or female: 3.1%<br>Heterosexual/straight: 56.3%<br>Bisexual: 25.0%<br>Gay/lesbian: 3.1%<br>Not sure (sexual orientation): 12.5%<br>Participant declined to provide their sexual orientation: 3.1%<br>Hispanic: 31.3%<br>African American: 31.3%<br>White: 25.0%<br>Mixed/biracial/other: 12.5% |

Abbreviations: ASQ = ages and stages questionnaires; C-SSRS = Columbia-suicide severity rating scale; ETAU = enhanced treatment as usual; MDD = major depressive disorder; NR = not reported; NSSI = nonsuicidal self-injury; PHQ = patient health questionnaire; PTSD = posttraumatic stress disorder; RFPP-S = reminder-focused positive psychiatry and suicide prevention; SAVE = stop adolescent violence everywhere; SD = standard deviation; SGT = supportive grieving teens; SIQ-JR = suicidal ideation questionnaire—junior; STEP = skills to enhance positivity; TAU = treatment as usual

**Table D.11. Characteristics of Included Studies for Social Network Interventions**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **King, 2019**[50, 51] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 11/10/ 2002– 10/26/2005 | Inclusion: Adolescents aged 13–17 years who were patients on a psychiatric unit at a university or private hospital were eligible if they reported serious thoughts about killing themselves within the past 4 weeks (many times or with a plan) or a suicide attempt within the past month, defined by parent or adolescent report on the DISC-IV.<br><br>Exclusion: Severe cognitive impairment, direct transfer to a medical unit or residential placement, and residence outside geographic area. | 168 months | Youth-Nominated Support Team + Treatment as Usual (YST + TAU)<br>(N=223) | 1 educational session for support people weekly phone calls between support persons and youth for 3 months | Age (SD): 15.6 years (1.2 years)<br>Female: 71.3%<br>White: 83.4%<br>African American: 6.3%<br>Hispanic: 1.8%<br>Other or missing race/ethnicity: 8.5%<br>Prior suicide attempt: 34.5%<br>Depressive disorder: 87.9% (total population)<br>PTSD: 25.2% (total population)<br>Physical abuse: 17.8% (total population)<br>Sexual abuse: 19.4% (total population) |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 11/10/ 2002– 10/26/2005 | Inclusion: Adolescents aged 13–17 years who were patients on a psychiatric unit at a university or private hospital were eligible if they reported serious thoughts about killing themselves within the past 4 weeks (many times or with a plan) or a suicide attempt within the past month, defined by parent or adolescent report on the DISC-IV.<br><br>Exclusion: Severe cognitive impairment, direct transfer to a medical unit or residential placement, and residence outside geographic area. | 168 months | Treatment as Usual (TAU)<br>(N=225) | NR | Age (SD): 15.6 years (1.4 years)<br>Female: 71.1%<br>White: 84%<br>African American: 6.7%<br>Hispanic: 1.8%<br>Other or missing race/ethnicity: 7.5:<br>Single suicide attempt: 33.8% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons<br><br>(N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **King, 2006**[52] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Youth aged 12–17 years, suicide attempt or significant suicidal ideation/intent during the past month, a score of 20 or 30 on the Self-Harm subscale of the Child and Adolescent Functional Assessment Scale, and at least one completed baseline measure.<br><br>Exclusion: severely or profoundly mentally retarded (special education certification) or presented with incapacitating psychosis. | 6 months | Youth Nominated Support Team-Version 1 + Treatment as Usual (YST-1 + TAU)<br>(N=151) | 1.5–2-hour psychoeducation sessions then maintain weekly contact with adolescents over 6 months | Age (SD): 15.4 years (1.5 years)<br>Female: 68.9%<br>White: 85%<br>African American: 7.5%<br>Other race: 7.5%<br>Prior suicidal attempt: 45.3 % |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: NR | Inclusion: Youth aged 12–17 years, suicide attempt or significant suicidal ideation/intent during the past month, a score of 20 or 30 on the Self-Harm subscale of the Child and Adolescent Functional Assessment Scale, and at least one completed baseline measure.<br><br>Exclusion: severely or profoundly mentally retarded (special education certification) or presented with incapacitating psychosis. | 6 months | Treatment as Usual (TAU)<br>(N=138) | 6 months | Age (SD): 15.2 years (1.4 years)<br>Female: 67.4%<br>White: 79.6%<br>African American: 13.1%<br>Other race: 7.3%<br>Prior suicidal attempt: 47.8 % |

Abbreviations: ASQ = ages and stages questionnaires; DISC = diagnostic interview schedule for children; NR = not reported; PHQ = patient health questionnaire; PTSD = posttraumatic stress disorder; SD = standard deviation; SIQ-JR = suicidal ideation questionnaire—junior; SOS = signs of suicide; TAU = treatment as usual; YST = youth-nominated support team

**Table D.12. Characteristics of Included Studies for School-based Skills Interventions**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Robinson, 2024**[53] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 2014–2015 | Inclusion: Public high schools in a large midwestern city; on-site school-based health centers and served predominantly African American and multiracial students (>92%) who resided in low-resourced neighborhoods. Participants, recruited during their ninth-grade year (i.e., academic year 2014–2015)<br><br>Exclusion: Students with elevated suicide risk were excluded from this study if they were not cleared to participate by the school-based health center (SBHC) | 12 months | Adapted-Coping with Stress course (A-CWS) (N=190) | 15 sessions, weekly, 45 minutes each, over 4 months, 8 to 10 students per group | Age (SD): 14.5 years (5.9 years)<br>Female: 56%<br>African American: 79.718%<br>Multiracial: 12.4% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Robinson, 2024[53] continued** | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 2014–2015 | Inclusion: Public high schools in a large midwestern city; on-site school-based health centers and served predominantly African American and multiracial students (>92%) who resided in low-resourced neighborhoods. Participants, recruited during their ninth-grade year (i.e., academic year 2014–2015)<br><br>Exclusion: Students with elevated suicide risk were excluded from this study if they were not cleared to participate by the school-based health center (SBHC) | 12 months | Standard care (N=190) | Weekly, one-on-one or group sessions, depending on the student's needs | Age (SD): 14.5 years (5.9 years)<br>Female: 56%<br>African American: 79.718%<br>Multiracial: 12.4% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Randell, 2001**[54] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 1995–1998 | Inclusion: Students in grades 9–12 from seven urban high schools who were potential high school dropouts. Selected based on being below expected credits, high absenteeism, a GPA of 2.3 or lower, and/or slipping grades. Those with prior dropout status or those referred by school staff for high-risk status were included if they met one or more of these criteria.<br><br>Exclusion: NR | 2.5 months | Counselors CARE + Coping and Support Training (C-CARE + CAST) (N=103) | 1.5–2-hour interview 12-session over 6 weeks twice weekly | Female: 48–59%<br>White: 40%<br>Mixed ethnicity: 13%<br>African American: 12%<br>Asian/Pacific Islander: 13%<br>Hispanic: 7%<br>American Indian: 2%<br>Other race: 4%<br>Unknown race: 9% |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 1995–1998 | Inclusion: Potential high school dropouts were identified as being at suicide risk and were assigned to study conditions.<br><br>Exclusion: NR | 2.5 months | Counselors CARE (C-CARE) (N=117) | 1.5–2-hour interview 6-weeks | Female: 48–59%<br>White: 40%<br>Mixed ethnicity: 13%<br>African American: 12%<br>Asian/Pacific Islander: 13%<br>Hispanic: 7%<br>American Indian: 2%<br>Other race: 4%<br>Unknown race: 9% |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 1995–1998 | Inclusion: Potential high school dropouts were identified as being at suicide risk and were assigned to study conditions.<br><br>Exclusion: NR | 2.5 months | Intervention as Usual (N=121) | 15–30-minute weekly | Female: 48–59%<br>White: 40%<br>Mixed ethnicity: 13%<br>African American: 12%<br>Asian/Pacific Islander: 13%<br>Hispanic: 7%<br>American Indian: 2%<br>Other race: 4%<br>Unknown race: 9% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Silverstone, 2015**[55] | Country: Canada<br>Study Design: Before–After study<br>Patient Enrollment Period: 2/2014–6/2014 | Inclusion: Students in grades 6–12, voluntary participation, written parental and student consent for additional intervention.<br><br>Exclusion: NR | 3 months | Empowering a Multimodal Pathway Towards Healthy Youth (EMPATHY) (N=3244) | 8 sessions over 12 weeks for CBT resiliency programs<br>Guided internet CBT program NR | Age (SD): 14.31 years (1.97 years)<br>Female: 48.3% |

Abbreviations: A-CWS = adapted-coping with stress course; ASQ = ages and stages questionnaires; CAST = coping and support training; C-CARE = counselors CARE; EMPATHY = empowering a multimodal pathway towards healthy youth; NR = not reported; PHQ = patient health questionnaire; RCT = randomized clinical trial; SBHC = school-based health center; SD = standard deviation; SIQ-JR = suicidal ideation questionnaire—junior

**Table D.13. Characteristics of Included Studies for Suicide Awareness/Gatekeeper Programs**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Aseltine, 2004**[56] | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 10/2001–11/2002 | Inclusion: Public school students in 3 schools in Hartford and 2 high schools in Columbus.<br><br>Exclusion: Subjects who had missing values on any variable in a particular analysis. | 3 months | Signs of Suicide (SOS)<br>(N=1027) | 2-day program | Female: 51.4% (total population)<br>Non Hispanic White: 16.6% (total population)<br>Non Hispanic African American: 25.4% (total population)<br>Hispanic: 42.4% (total population)<br>Multiethnic: 10% (total population)<br>Other race: 5.6% (total population)<br>Prior suicidal attempt: 3.6% |
| | Country: United States<br>Study Design: RCT<br>Patient Enrollment Period: 10/2001–11/2002 | Inclusion: Public school students in 3 schools in Hartford and 2 high schools in Columbus.<br><br>Exclusion: Subjects who had missing values on any variable in a particular analysis. | 3 months | Control group<br>(N=1073) | NR | Female: 51.4% (total population)<br>Non Hispanic White: 16.6% (total population)<br>Non Hispanic African American: 25.4% (total population)<br>Hispanic: 42.4% (total population)<br>Multiethnic: 10% (total population)<br>Other race: 5.6% (total population)<br>Prior suicidal attempt: 5.4% |
| **Hermosillo-de-la-Torre, 2023**[57] | Country: Mexico<br>Study Design: Before–After study<br>Patient Enrollment Period: 2017–2019 | Inclusion: Female adolescents aged 11–14 years, originally from a municipality in the northwestern region of Jalisco, Mexico, belonging to a medium-low socioeconomic stratum. The participants were in the first year of primary and secondary education in Mexican public system schools, all from the same school and class<br><br>Exclusion: NA | 24 months | Dialectical Behavior Therapy Skills Training Program (DBT-PAHSE)<br>(N=34) | 25 sessions, each session lasted 120 min and was implemented by psychology professionals trained in DBT | Age (SD): 13.78 years (0.428 years)<br>Female: 100% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Sale, 2022**[58] | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: NR | Inclusion: Youth <25 years old, have experienced recent suicide attempts or suicidal ideation, residing in five counties in the Kansas City, Missouri area, who are eligible and enrolled in the continuity-of-care program, which involves identification in hospitals, schools, community organizations, and provider settings.<br><br>Exclusion: NR | 6 months | Continuity-of-Care Model (N=983) | Weekly sessions over 3–7 months | Female: 62.7%<br>White: 75.4%<br>African American: 6.1%<br>Asian: 1.6%<br>American Indian: 0.5%<br>Other race: 4.8%<br>Multiracial: 10.8%<br>Hispanic: 11.4%<br>Non Hispanic: 87.6%<br>Transgender: 5.6%<br>Nonconforming: 0.8%<br>Heterosexual: 68%<br>Bisexual: 11.4%<br>Homosexual: 4.2%<br>Other gender identity: 3.7%<br>History of sexual or physical trauma: 47.3% |
| **Rivero, 2014**[59] | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: 9/2004–3/2011 | Inclusion: Undergraduate students living in residence at a large public university in the northeastern US who exhibited signs indicative of risk of suicide as defined by the following indices: 1. student threatened suicide verbally or in writing, 2. student had made overt plans and preparations for suicide, 3. student has engaged in serious self-injury.<br><br>Exclusion: NR | 1.5 months | Consultation and Resource Evaluation Program (CARE Net) (N=108) | 2-hour 1–2 sessions, with followup as needed | Female: 59%<br>White: 42%<br>African American: 12%<br>Asian or Asian American: 8%<br>Hispanic: 7%<br>Multiracial: 5%<br>Unavailable race/ethnicity: 24%<br>Prior self-injurious behaviors: 34% |

Abbreviations: ASQ = ages and stages questionnaires; CARE Net = consultation and resource evaluation program; DBT-PAHSE = dialectical behavior therapy skills training program; NR = not reported; PHQ = patient health questionnaire; RCT = randomized clinical trial; SD = standard deviation; SIQ-JR = suicidal ideation questionnaire—junior; SOS = signs of suicide

**Table D.14. Characteristics of Included Studies for Community-based, Culturally Tailored Adjunct Programs**

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Allen, 2018**[60] | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: NR | Inclusion: Youth aged 12–18 in Alaska Native.<br><br>Exclusion: NR | 12 months | *Qungasvik* Cultural Intervention. Treatment Arm Community (Community 1) (N=61) | 26 modules, each is delivered in one or more 1–3-hour sessions. Average 7 modules over 12 months | Age (SD): 14.24 years (1.72 years)<br>Female: 57.4% |
| | Country: United States<br>Study Design: Comparative Observational study<br>Patient Enrollment Period: NR | Inclusion: Youth aged 12–18 in Alaska Native.<br><br>Exclusion: NR | 12 months | Comparison Arm Community (Community 2) (N=77) | 26 modules, each is delivered in one or more 1–3-hour sessions. Average 2 modules over 12 months | Age (SD): 14.62 years (1.82 years)<br>Female: 27% |

| Author, Year | Country, Study Design, Patient Enrollment Period | Inclusion and Exclusion Criteria | Length of Followup | Intervention and Comparisons (N of Patients) | Dose/Frequency/ Duration | Patient Characteristics |
|---|---|---|---|---|---|---|
| **Humensky, 2017**[61] | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: NR | Inclusion: Hispanic adolescents aged 11–18, experienced suicidal ideation or attempts prior to referral, continue to experience suicidal ideation at the time of referral, receiving mental health trauma either at Comunilife or another clinic.<br><br>Exclusion: Not explicitly stated, but the program primarily targets Latina adolescents meeting the inclusion criteria. | 24 months | Life is Precious (LIP) (N=107) | 3–7pm weekdays, Saturday mornings | Age (SD): 14.9 years (2.3 years)<br>Female: 100%<br>Hispanic: 100%<br>Puerto Rican: 29%<br>Dominican: 24%<br>Mexican: 24%<br>Ecuadorian: 5%<br>Other or two or more races: 4%<br>Two or more races: 15%<br>History of sexual or physical trauma: ever sexually abused: 25%<br>Tobacco use in 30 days before program entry: 6%<br>Alcohol use in 30 days before program entry: 9%<br>Marijuana use in 30 days before program entry: 7%<br>Depression: 45%<br>Bipolar Disorder: 6%<br>Prior suicidal attempt: 17% |
| **Cwik, 2016**[62] | Country: United States<br>Study Design: Before–After study<br>Patient Enrollment Period: 4/2009–6/2011 | Inclusion: Apaches aged 10–19 years, who attempted suicide in the past 90 days.<br><br>Exclusion: NR | 3 months | New Hope (N=13) | 1–2 visits (2–4 hours total intervention time) | Age (SD): 14.3 years (2.2 years)<br>Female: 92%<br>Lifetime alcohol use: 62%<br>Lifetime marijuana use: 69% |

Abbreviations: ASQ = ages and stages questionnaires; LIP = life is precious; NR = not reported; PHQ = patient health questionnaire; SD = standard deviation; SIQ-JR = suicidal ideation questionnaire—junior

# Appendix E. Description of the Interventions

**Table E.1. Description of Interventions for Cognitive-Behavioral Therapy (CBT)**

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Duarté-Vélez, 2022**[1] **RCT** | Socio-Cognitive-Behavioral Therapy Protocol for Suicidal Behaviors (SCBT-SB) (N=24) | SCBT-SB protocol includes two main phases consisting of a crisis module and subsequent modules individualized to the adolescent. The goal of the crisis module is understanding and managing the suicidal crisis and teaching core skills including cognitive restructuring, problem solving and communication skills. The subsequent modules are individualized for the adolescent and include more in-depth skills in communication, cognitive restructuring, emotion regulation, social interaction, trauma management and substance use control. | 1.5–3 hours/week+ collateral case management support as needed, home-based services usually lasted from 6–14 weeks | Clinic | Addressing suicidal ideation and suicide attempts |
| | Treatment as Usual (TAU) (N=22) | Eclectic individual therapy including CBT techniques, emphasizing psychoeducation, and providing support, with conjoint and individual caregiver sessions as needed | 1.5–3 hours/week+ collateral case management support as needed, home-based services usually lasted from 6–14 weeks | Clinic | Addressing suicidal ideation and suicide attempts |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Sinyor, 2020**[2] **RCT** | Brief Cognitive Behavioral Therapy (BCBT) (N=12) | BCBT is designed to target and prevent suicidal behavior by strengthening emotion regulation and cognitive flexibility. It includes safety planning along with components of emotion regulation (e.g., relaxation, mindfulness, reasons for living), cognitive flexibility (e.g., cognitive reappraisal, activity planning) and relapse prevention. | 10 weekly 45 min sessions occurring over the first 15 weeks of enrollment with 3 booster sessions occurring at 6, 9 and 12-months after enrollment | Inpatient and outpatient | Addressing suicidal behaviors |
| | Minimal-directive supportive psychotherapy (MDSP) (N=12) | MDSP is an enhanced usual care attentional control treatment consisting of minimally-directive supportive therapy. Therapists were instructed to provide support through active listening and validation, but not make directive suggestions or provide techniques or skills training. | 10 weekly 45 min sessions occurring over the first 15 weeks of enrollment with 3 booster sessions occurring at 6, 9 and 12-months after enrollment | Inpatient and outpatient | Addressing suicidal behaviors |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Esposito-Smythers, 2019[3]** **RCT** | Family-focused Cognitive Behavioral Therapy (F-CBT) (N=74) | F-CBT is a modified version of the I-CBT protocol, integrating cognitive and behavioral techniques to address adolescent suicidality, substance abuse, and other co-occurring conditions. It includes motivational enhancement, adolescent parent training, and family modules, focusing on managing acute suicidality with skills including problem-solving, cognitive restructuring, behavioral activation, affect regulation, and a menu of supplemental skills including emotion regulation (distress tolerance), physical health (healthy lifestyle), trauma (trauma narrative), and anxiety (exposure), parental "self-care" sessions, and a parent training emotion coaching session to improve parent-child interactions. | Weekly sessions in the initial 6 months, then biweekly, and then monthly sessions for both adolescents and parents in the later stages of the 12-month period | Clinic | Addressing suicidal behaviors and ideation |
| | Enhanced treatment as usual (E-TAU) (N=73) | Those assigned to the E-TAU condition were referred for treatment by their inpatient or partial hospitalization treatment team. The frequency and type of outpatient care provided was at the discretion of the individual provider. | Provided at the discretion of the individual provider. | Clinic | Addressing suicidal behaviors and ideation |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Asarnow, 2017**[4] **RCT** | Safe Alternatives for Teens and Youths (SAFETY) (N=20) | The SAFETY program is a family-centered cognitive-behavioral treatment designed to address the unique challenges in treating self-harming youths. The program involves two therapists working with each family (i.e., one working primarily with the youth and one with the caregivers), with sessions beginning with individual youth and parent components and concluding with all participants coming together. Treatment is structured using a cognitive-behavioral fit analysis to identify risk and protective processes, resulting in an individually tailored approach. The program was organized around safety planning emphasizing means restriction, strengthening interactions with positive supports, cognitive restructuring and coping skills, followed by relapse prevention and linkage to needed services, including primary care and other mental health, school-based, or community services. | Weekly/bi-weekly sessions over 3 months duration | In-home, and clinic | Crisis care |
| | Enhanced Treatment as Usual (E-TAU) (N=22) | E-TAU included an in-clinic parent session, followed by < 3 telephone calls aimed at supporting motivation/actions to obtain followup treatment. Therapists educated parents about the risk of repeat SA/SH behavior, steps to reduce risk (restrict access to dangerous SA/SH methods, protective monitoring/support, danger associated with disinhibiting effects of alcohol/drug use), and importance of followup care, and worked with parents to develop plans for maintaining youth safety and establishing followup treatment. Calls included a check on youth's mood, safety, outpatient treatment attendance, barriers to beginning/continuing treatment, and work to enhance motivation and address treatment-attendance barriers. Calls were scheduled for roughly one week after the in-person session, two weeks after the first call, and four weeks after the second call, with calls stopping when youths were attending treatment regularly. | 1 parents session followed by 3 telephone calls | Clinic and telehealth | Crisis care |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Spirito, 2015**[5] **RCT** | Parent-Adolescent Cognitive Behavioral Therapy (PA-CBT) (N=16) | In PA-CBT, adolescents and parents were each assigned their own therapist. Treatment included individual sessions for parents and adolescents as well as conjoint family sessions. Parents and adolescents met with the study psychiatrist for medication management. Core CBT skills were taught to both parents and adolescents including problem solving ,cognitive restructuring, affect regulation, behavioral activation and relapse prevention. Based on adolescents needs, skills were repeated or additional modules were added (e.g., distress tolerance). Conjoint sessions focused on family problem-solving and communication. Homework provided after each session to reinforce CBT skills. | Weekly sessions for 12 weeks, followed by a maintenance phase of biweekly sessions for another 12 weeks | Clinic | Addressing suicidal behaviors |
| | Adolescent Only Cognitive Behavioral Therapy (AO-CBT) (N=8) | Adolescents were offered the same CBT treatment modules as PA-CBT but the treatment consisted primarily of individual sessions. Parents participated in end-of-session check-ins for most sessions and were involved when safety concerns were discussed. | Weekly sessions for 12 weeks, followed by a maintenance phase of biweekly sessions for another 12 weeks | Clinic | Addressing suicidal behaviors |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Esposito-Smythers, 2011**[6] **RCT** | Integrated Cognitive Behavioral Therapy (I-CBT) (N=20) | I-CBT was grounded in social learning theory and integrated CBT techniques to remediate maladaptive cognitions underlying suicidality and alcohol/drug use. It included individual adolescent CBT sessions (e.g., problem-solving, refusal skills), family sessions (e.g. communication, behavioral contracting), parent training sessions (e.g. monitoring, emotion regulation), one motivational interview session each for the adolescent and parents, and case management calls as needed. The adolescent and parent sessions could be repeated and practiced throughout the protocol. | Acute phase: weekly/biweekly sessions with parents for 6 months Continuation phase: biweekly sessions with parents for 3 months Maintenance phase: as needed monthly sessions with parents for 3 months | Clinic | Addressing suicidal ideation |
| | Enhanced Treatment as Usual (E-TAU) (N=20) | The outpatient treatment schedule and therapeutic approach in E-TAU was determined independently by community providers. E-TAU was enhanced by providing a diagnostic evaluation report to community providers and medication management by the study psychiatrist. Families in E-TAU could call the study to obtain information about resources availability in their community. | NR | Clinic | Addressing suicidal ideation |
| **Donaldson, 2005**[7] **RCT** | Skills-Based Treatment (SBT) (N=15) | SBT focused on teaching problem-solving, cognitive restructuring, affect management skills (e.g., relaxation). Each session involved assessment of suicidality, skill education, and skill practice (in-session and homework). | Active phase: 6 individual sessions and 1 family the first 3 months Maintenance phase: 3 monthly sessions | Clinic | Addressing suicidal behaviors and ideation |
| | Supportive-Relationship Treatment (SRT) (N=16) | SRT was non directive and supportive, exploring the adolescent's mood, behavior and factors contributing to suicidal actions. Techniques included exploratory questions, connecting affect to events, and providing feedback without providing skills training or homework. The same therapists delivered SRT. | Active phase: 6 individual sessions and 1 family the first 3 months Maintenance phase: 3 monthly sessions | Clinic | Addressing suicidal behaviors and ideation |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Slesnick, 2019[8]** **RCT** | Cognitive Therapy for Suicide Prevention + Treatment as Usual (CTSP + TAU) (N=75) | CTSP is a manualized cognitive therapy intervention developed specifically for suicide prevention, delivered by licensed master's level counselors/social workers. A crisis plan is developed in the first session. Automatic thoughts, core beliefs, and key life events associated with suicidal behaviors are identified. Middle sessions focus on cognitive restructuring, problem-solving, and behavior change techniques to address suicide-specific risk factors like hopelessness, poor problem-solving, and impaired impulse control. Later sessions aim to prevent relapse through practicing newly acquired skills. | 10 session (50-min each) including weekly/bi-weekly meetings; followed by optional 9 maintenance sessions | Drop-in center for homeless youth | Addressing suicidal behaviors and ideation |
| | Treatment as Usual (TAU) (N=75) | TAU was provided at a local drop-in center for homeless youth, where youth can access services to meet basic needs like food, laundry, showers, and recreational activities. Youth are also linked to community resources like psychiatric evaluation and psychological services as needed by on-site licensed therapists. However, these TAU sessions are unsystematic and not manualized. | 50 min sessions | Drop-in center for homeless youth | Addressing suicidal behaviors and ideation |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Zullo, 2021[9]** **Comparative Observational study** | Suicide Prevention and Resilience (SPARC) + Intensive outpatient program (IOP) (N=62) | SPARC is a CBT intervention that addresses distorted cognitions around perceived burdensomeness and thwarted belonging that precedes suicide attempts and helps to modify these conditions by increasing supportive interactions with the environment and addressing cognitive distortions around key relationships. Treatment included communication training and coaching caregivers to be more aware of subtle messages being conveyed to the adolescent, scheduling activities, and mapping aspects of the adolescent's self-image in proportion to each other. | Twice a week for the teen therapy group sessions; once a week for individual therapy sessions; once a week for parent skills group sessions and multifamily groups Delivered for 4 to 6 weeks | Clinic | Addressing suicidal ideation and behaviors |
| | Standard intensive outpatient program (IOP) (N=61) | Participants received standard care at an intensive outpatient program (IOP) based on Cognitive Behavioral Therapy for Suicide Prevention (e.g., components of problem solving, cognitive restructuring, relaxation). The standard care provided in the control arm aims to enhance coping skills and decrease depressive cognitions through various treatment modules. | Twice a week for the teen therapy group sessions; once a week for individual therapy sessions; once a week for parent skills group sessions and multifamily groups Delivered for 4 to 6 weeks | Clinic | Addressing suicidal ideation and behaviors |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Vitiello, 2009[10]** **Comparative Observational study** | Cognitive Behavioral Therapy with focus on Suicide Prevention (CBT-SP) (N=17) | CBT-SP was specifically aimed at modifying known risk factors for suicide, such as depression, with the goal of preventing recurrence of suicidal behavior. Sessions including both individual and parent-youth sessions, and incorporated five key elements: chain analysis of the index suicide attempt, safety planning to reduce current suicide risk, case conceptualization (i.e., formulation of the patient's specific cognitive, behavioral, affective, and contextual problems), skill acquisition and enhancement (e.g., behavioral activation, cognitive restructuring, and problem solving), and relapse prevention. | 22 sessions over 6 months | Clinic | Ongoing treatment following crisis |
| | Medications (N=14) | Antidepressant pharmacotherapy after an adaptation of the Texas Medication Algorithm for adolescent depression: first step, monotherapy with an SSRI, followed, in case of nonresponse, by a different SSRI as step 2 and an alternate class (venlafaxine, duloxetine, mirtazapine, or bupropion) as step 3, with the option of augmenting with lithium or other antidepressant in case of partial response | NR | Clinic | Ongoing treatment following crisis |
| | Combination of both CBT and antidepressant pharmacotherapy (Comb) (N=93) | Combination of the two modalities (CBT/Med) | NR | Clinic | Ongoing treatment following crisis |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Kennard, 2018[11]** **Before–After study** | Suicide Prevention and Resilience at Children's (SPARC) Intensive Outpatient Program (IOP) (N=364) | The SPARC IOP included group therapy along with individual and family therapy, medication management as needed, and a weekly skills-based parent psychoeducation group. Groups were conducted by licensed psychologists, licensed master's level clinicians, or postdoctoral fellows trained on the intervention. The IOP was primarily Cognitive Behavioral Therapy and consisted of chain analysis and safety planning, behavioral activation, problem solving, emotion regulation, distress tolerance, interpersonal effectiveness, family communication, enhancing positive emotions, and relapse prevention. | 3 hours of group therapy twice weekly for 4–6 weeks, 1-hour weekly for parents' group | Clinic and telehealth | Addressing suicidal ideation and behaviors |
| **Duarté-Vélez, 2016[12]** **Before–After study** | The Socio-Cognitive Behavioral Treatment for Suicidal Behavior (SCBT-SB) (N=11) | SCBT-SB integrates socio-cognitive and behavioral strategies within a cultural and familial context to address the heightened risk of suicide in this population. It includes safety planning as well as components of cognitive restructuring, emotional regulation, behavioral activation, enhancing social interactions and family communication, and trauma processing. Delivered through individual and family sessions, SCBT-SB emphasizes cultural sensitivity, focusing on the specific values, norms, and stressors relevant to Puerto Rican adolescents. | Weekly, for 6 months, followup biweekly booster sessions provided, when necessary, individual sessions were 60 minutes and family sessions were 60 to 120 minutes | Clinic | Ongoing treatment following crisis care |

Abbreviations: AO-CBT = adolescent only cognitive behavioral therapy; ASQ = ages and stages questionnaires; BCBT = brief cognitive behavioral therapy; CBT = cognitive-behavioral therapy; CTSP = cognitive therapy for suicide prevention; E-TAU = enhanced trauma-as-usual; F-CBT = family-focused cognitive behavioral therapy; I-CBT = integrated outpatient cognitive-behavioral therapy; IOP = intensive outpatient program; MDSP = minimally-directive supportive psychotherapy control; NR = not reported; PA-CBT = parent-adolescent cognitive behavioral therapy; PHQ = patient health questionnaire; PTSD = posttraumatic stress disorder; RCT = randomized clinical trial; SAFETY = safe alternatives for teens and youths; SA = suicide attempt; SBT = skills-based treatment; SCBT-SB = socio-cognitive behavioral trauma for suicidal behavior; SCBT-SB = socio-cognitive-behavioral therapy protocol for suicidal behaviors; SD = standard deviation; SH = self-harm; SRT = supportive-relationship treatment; SPARC = suicide prevention and resilience; TAU = treatment as usual

**Table E.2. Description of Interventions for Dialectical Behavior Therapy (DBT)**

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **McCauley, 2018**[13] **RCT** | Dialectical Behavior Therapy (DBT) (N=86) | DBT has four components; weekly individual psychotherapy, multifamily group skills training, youth and parent telephone coaching, and weekly therapist team consultation that focuses on increasing validation in parent-teen interactions. Parent participation in treatment was in family sessions. Treatment focuses on skills to enhance emotion regulation, distress tolerance, interpersonal effectiveness, and mindfulness. | Weekly individual and group therapy for 6 months | Clinic | Addressing suicidal behaviors (suicide attempts and nonsuicidal self-injury) |
| | Individual and Group Supportive Therapy (IGST) (N=87) | IGST emphasized acceptance, validation, and feelings of connectedness and belonging. Individual and group supportive therapy included individual sessions, adolescent supportive group therapy. | Weekly individual and group therapy for 6 months | Clinic | Addressing suicidal behaviors (suicide attempts and nonsuicidal self-injury) |
| **Pistorello, 2012**[14] **RCT** | Dialectical Behavior Therapy (DBT) (N=31) | DBT included individual therapy sessions, group skills training, skills coaching between sessions as needed via telephone, email, or texting, group supervision for therapists, and as-needed family interventions. Treatment focuses on skills to enhance emotion regulation, distress tolerance, interpersonal effectiveness, and mindfulness. The DBT skills modules each lasted 8 weeks (6 weeks of skills training plus 2 weeks of mindfulness) and were taught in a semester-based schedule. Four modifications were made to standard DBT for adults-shortening the distress tolerance module, allowing flexibility for missed sessions during breaks, shortening skills groups to 1.5 hours, and changing when modules were taught based on the academic calendar. | Weekly 50-minute individual session; weekly 90-min group session; skills coaching as needed via telephone, email, or texting between sessions; weekly 90-min group supervision/consultation for therapists; as-needed family interventions, for 7–12 months | Clinic and telehealth | Addressing suicidal ideation |
| | Optimized Treatment as Usual (O-TAU) (N=32) | O-TAU included individual therapy, group therapy, supervision for therapists, as-needed between-session consultation, and as-needed family interventions. The specific treatment approach was based on the supervisor's psychodynamic orientation integrating developmental and object relations perspectives. | Weekly 50-minute individual session; weekly, 90-min group supervision/consultation for therapists; as-needed family interventions, for 7–12 months | Clinic | Addressing suicidal ideation |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Swart, 2014**[15]<br><br>**Comparative Observational study** | Mode Deactivation Therapy (MDT)<br>(N=20) | MDT is a 'third wave CBT" based on contextual behavioral methodology that combines mindfulness, acceptance, emotional and cognitive defusion, cognitive redirection in a structured format including a therapeutic technique of Validation, Clarification, and Redirection (VCR) to help the adolescent adopt functional alternative beliefs. | 8–11 months | Clinic | Addressing suicidal behaviors |
| | Treatment as Usual (TAU)<br>(N=20) | The TAU protocol was based on standard Cognitive Behavioral Therapy (CBT) with relapse prevention strategy. It focused on relapse prevention, trigger identification, and cognitive distortions. | 8–11 months | Clinic | Addressing suicidal behaviors |
| **Tebbett-Mock, 2020**[16]<br><br>**Comparative Observational study** | Dialectical Behavior Therapy (DBT)<br>(N=425) | Patients in a residential program received 9 skills training groups per week within all five adolescent DBT modules including Mindfulness, Distress Tolerance, Emotion Regulation, Interpersonal Effectiveness, and Middle Path. Patients also received DBT individual and family therapy sessions. Team members met weekly for consultation, training and supervision. | 9 skills groups per week, 3 individual sessions per week, 1 to 2 family/collateral sessions per week | Inpatient | Addressing suicidal ideation |
| | Treatment as Usual (TAU)<br>(N=376) | Patients received 3–4 cognitive behavioral group sessions per week and 10 activity groups focused on general coping strategies, along with 3 individual and 1–2 family sessions per week that were cognitive behavioral, family systems and supportive in nature. | 3 to 4 skills groups per week, 10 activity groups per week, 3 individual sessions per week, 1 to 2 family/collateral sessions per week | Inpatient | Addressing suicidal ideation |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Katz, 2004**[17]<br><br>**Comparative Observational study** | Dialectical Behavior Therapy (DBT)<br>(N=26) | A 2-week inpatient DBT program adapted from the 12-week adolescent outpatient DBT model. It included 10 daily manualized DBT skills training sessions under modules of emotion regulation, interpersonal effectiveness, mindfulness and distress tolerance. It also includes twice weekly individual DBT therapy sessions to review diary cards and conduct behavioral analysis, and a DBT milieu with DBT-trained nursing staff to facilitate skills generalization. Treatment was delivered by a psychiatrist with 2 years of adolescent DBT training and supervision. The DBT team met regularly for consultation. | Daily group therapy, twice-weekly individual session for 2 weeks | Inpatient | Addressing suicidal behaviors and ideation |
| | Treatment as Usual (TAU)<br>(N=27) | TAU consisted of daily psychodynamic psychotherapy groups, individual psychodynamic psychotherapy at least once per week, and a psychodynamically-oriented milieu, without any formal behavior therapy. It was delivered by a psychiatrist with 2 years training in adolescent psychodynamic psychiatry and 9 years' experience on the inpatient unit. | Daily group therapy, once-weekly individual session for 2 weeks | Inpatient | Addressing suicidal behaviors and ideation |
| **Rathus, 2002**[18]<br><br>**Comparative Observational study** | Dialectical Behavior Therapy (DBT)<br>(N=29) | DBT included individual therapy and multifamily skills training groups, individual sessions focused on suicidal behaviors, therapy-interfering behaviors, and increasing behavioral skills. The skills training group taught modules on mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance, and included parents to enhance generalization of skills. DBT was delivered by doctoral level psychologists or predoctoral psychology interns who received DBT training. | Twice weekly sessions for 3 months | Clinic | Addressing suicidal behaviors |
| | Treatment as Usual (TAU)<br>(N=82) | Individual and family sessions, with therapists employing short-term psychodynamic or supportive approaches aimed toward resolving acute problems. Treatment addressed issues of identity formation, separation/individuation, intra-psychic conflicts that emerged as relevant to the adolescent's presenting problems and coping with daily life stressors. Family therapy sessions generally employed a family systems orientation and aided the family in resolving their acute conflicts. This modality also provided psychoeducation regarding adolescent depression and addressed issues regarding acculturation and blended families as relevant. | Twice weekly sessions for 3 months | Clinic | Addressing suicidal behaviors |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Sunseri, 2004**[19] **Before–After study** | Dialectical Behavior Therapy (DBT) (N=68) | DBT was provided in a residential setting and included skills groups focusing on mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness) DBT skills were also posted on poster boards, within eyesight in the milieu. Clients were also given access to their therapists through a pager after hours only for skills coaching as needed. They also received weekly individual therapy working from a weekly diary card and behavior chain analysis and following a treatment hierarchy to decrease suicidal behaviors and therapy and quality of life interfering behaviors and increasing behavioral skills. | Weekly individual sessions, twice per week 90-minute group sessions, telephone as needed, for 1 year | Residential care | Addressing suicidal behaviors |
| **Darrow, 2022**[20] **Before–After study** | Dialectical Behavior Therapy-Adolescent (N=132) | DBT A involved weekly individual therapy, multi-family, family therapy as needed and skills coaching as needed. Skills modules included emotion regulation, distress tolerance, interpersonal effectiveness and mindfulness. Rather than ending after modules are completed at 6 months, youth stayed in DBT-A until they reached their individual goals related to decreasing life-threatening behavior. | Weekly individual, multifamily skills groups, family therapy and phone coaching as needed for 6 months plus extra weeks if necessary. | Clinic | Addressing suicidal thoughts and behaviors |
| **Cloutier, 2022**[21] **Before–After study** | Building Resilience and Attachment in Vulnerable Adolescents (BRAVA) (N=46) | BRAVA is a novel brief group treatment to decrease suicidal behavior and increase family cohesion for youth presenting with mild-to-moderate SI. Adolescent groups focused on developing effective coping strategies, distress tolerance, and interpersonal effectiveness skills. Caregiver groups focus on developing effective parenting and attachment relationships. | Six, concurrent (parent, adolescent), 90-minute, group sessions weekly for 6 weeks | Clinic | Addressing suicidal behavior and family cohesion |
| **Berk, 2020**[22] **Before–After study** | Dialectical Behavior Therapy (DBT) (N=24) | DBT consisted of individual therapy sessions, multi-family skills group sessions, telephone coaching, and a consultation team for therapists. The multi-family skills groups covered mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness, and the "Walking the Middle Path" module focused on applying skills to the parent-child relationship. Individual therapy used a diary card and used standard DBT treatment hierarchy to set the session agenda. DBT therapists provided 24/7 coaching availability or other approaches to facilitate skills generalization. The therapists attended a weekly consultation team meeting. | Weekly individual sessions, 75-minute, weekly multi-family group sessions over 6 months | Clinic | Addressing suicidal behaviors |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Courtney, 2015**[23]<br><br>**Before–After study** | Adapted Dialectical Behavior Therapy for Adolescents (A-DBT-A)<br>(N=61) | A-DBT-A consisted of group sessions and incorporated modules on mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness, and "walking the middle path" (a family intervention); adolescents attended 14 group sessions and weekly individual sessions over 14 weeks where they discussed application of skills learned in group to their daily lives; behavioral chain analyses and diary cards were used in individual sessions; A-DBT-A was an adaptation of DBT in that parents were only included in 4 group sessions instead of all of them and telephone coaching only was during business hours. | 15 weekly group sessions, 14 weekly individual sessions | Clinic and telehealth | Addressing suicidal ideation and behaviors |

Abbreviations: A-DBT-A = adapted dialectical behavior therapy for adolescents; BRAVA = building resilience and attachment in vulnerable adolescents; DBT = dialectical behavior therapy; IGST = individual and group supportive therapy; MDT = mode deactivation therapy; O-TAU = optimized treatment as usual; SD = standard deviation; SI = suicide ideation; TAU = treatment as usual; VCR = validation clarification and redirection

**Table E.3. Description of Interventions for Attachment-Based Family Therapy (ABFT)**

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Diamond, 2019**[24]<br>**RCT** | Attachment-Based Family Therapy (ABFT) (N=66) | ABFT is a process-oriented, emotion focused treatment that aims to strengthen parent-adolescent attachment bonds to create a protective and secure base for adolescent development. In early sessions the therapist works individually with the child to understand how ruptures contribute to suicidal behavior and compromise the adolescent's ability to use parents as a coping resource. They also work individually with the parent to understand how stressors and attachment history inhibit emotionally supportive parenting. Later, in conjoint sessions, the adolescent is supported to express their perceived emotional disappointments while the parents are coached to acknowledge and validate the adolescent's feelings. As trust improves, treatment shifts to promoting adolescent autonomy. | 1–2 weekly sessions to incorporate both patient and parent sessions, delivered over 16 weeks | Clinic | Addressing suicidal ideation |
| | Family-Enhanced Nondirective Supportive Therapy (FE-NST) (N=63) | FE-NST augments the adolescent's access to supportive adult relationships through the adolescent's relationship with the therapist. Therapists implement NST by focusing on reflective listening, empathizing with the adolescent's experiences of stress, and supporting the adolescent in articulating and exploring thoughts and feelings. A 5-session parent psychoeducation program was added to the NST condition to control for parent involvement in ABFT (FE-NST). At least 1 primary caregiver was required to participate in assessments and treatments | 1–2 weekly sessions to incorporate both patient and parent sessions, delivered over 16 weeks | Clinic | Addressing suicidal ideation |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Diamond, 2010**[25]<br>**RCT** | Attachment-Based Family Therapy (ABFT) (N=35) | ABFT is a process-oriented, emotion focused treatment that aims to strengthen parent-adolescent attachment bonds to create a protective and secure base for adolescent development. In early sessions the therapist works individually with the child to understand how ruptures contribute to suicidal behavior and compromise the adolescent's ability to use parents as a coping resource. They also work individually with the parent to understand how stressors and attachment history inhibit emotionally supportive parenting. Later, in conjoint sessions, the adolescent is supported to express their perceived emotional disappointments while the parents are coached to acknowledge and validate the adolescents' feelings. As trust improves, treatment shifts to promoting adolescent autonomy. | 10 sessions over 3 months | Clinic | Addressing suicidal ideation |
| | Enhanced Usual Care (EUC)<br>(N=31) | EUC was a facilitated referral process with ongoing clinical monitoring. Providers were found for the participants, initial appointments were set up, and treatment attendance was encouraged. The type and amount of treatment was determined independently by community providers. | The type and amount of treatment was determined independently by community providers. | Clinic | Addressing suicidal ideation |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Russon, 2021**[26]<br><br>**Before–After study** | Attachment-Based Family Therapy (ABFT) (N=10) | ABFT focuses on strengthening parent-adolescent attachment bonds to create a protective and secure base for adolescent development. In early sessions the therapist works individually with the child to understand how ruptures contribute to suicidal behavior and compromise the adolescent's ability to use parents as a coping resource. They also work individually with the parent to understand how stressors and attachment history inhibit emotionally supportive parenting. Later, in conjoint sessions, the adolescent is supported to express their perceived emotional disappointments while the parents are coached to acknowledge and validate the adolescent's feelings. As trust improves, treatment shifts to promoting adolescent autonomy.<br><br>The treatment was adapted for use with LGBTQ+ youth including: 1) adding more individual sessions to build alliance and increase sensitivity to who should be involved in treatment. 2) increasing the number of meetings with caregivers showing rejecting behaviors 3) therapists actively educated external systems of care (e.g., schools, psychiatry, and hospitals) regarding the needs of LGBTQ+ young people. 4) helped parents empathize with their child's experience of discrimination for their minoritized identity. | Weekly sessions over 4 months | Clinic | Addressing suicidal ideation |
| **Diamond, 2012**[27]<br><br>**Before–After study** | Attachment-Based Family Therapy (ABFT)-Phase II<br>(N=10) | ABFT-LGB is a process-oriented, emotion focused psychotherapy composed of 5 treatment tasks delivered sequentially: 1) Relational Reframe to reduce criticism/hostility and focus on attachment, 2) Alliance Building with the Adolescent to prepare them to discuss family conflicts, 3) Alliance Building with Parents to process their feelings about the adolescent's sexual orientation and improve parenting practices, 4) Reattachment Task conducted with parent and child to facilitate corrective attachment episodes, and 5) Competency Promoting Task conducted with the parent and child to build adolescent self-esteem and autonomy while maintaining family connection. Specific adaptations of this treatment for LGB adolescents included more time processing parental feelings about sexual orientation, addressing acceptance and invalidation related to sexual orientation, and promoting access to LGB-affirming resources. | 60-minute weekly sessions delivered over 12 weeks per family (8–16 sessions) | Clinic | Addressing suicidal ideation |

Abbreviations: ABFT = attachment-based family therapy; EUC = enhanced usual care; FE-NST = family-enhanced nondirective supportive therapy; LGBQ = lesbian, gay, bisexual, queer; NST = nondirective supportive therapy; RCT = randomized clinical trial

**Table E.4. Description of Interventions for Family-Focused Therapy (FFT)**

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Miklowitza, 2020**[28]<br>**RCT** | Family-Focused Therapy (FFT) (N=61) | FFT consisted of family sessions including the child, parents, and siblings that focused on reducing family expressed emotion and included psychoeducation about mood disorders, communication enhancement training, and problem-solving skills training. | 12 sixty-minute sessions (8 weekly, 4 biweekly) for 4 months | Clinic | Addressing suicidal ideation and behaviors |
| | Enhanced Care (EC) (N=66) | EC consisted of family psychoeducation sessions followed by individual psychoeducation sessions focused on implementing a mood management plan. | 3 weekly sixty-minute family sessions followed by 3 monthly individual sessions | Clinic | Addressing suicidal ideation and behaviors |

Abbreviations: EC = enhanced care; FFT = family-focused therapy

**Table E.5. Description of Interventions for Collaborative Assessment and Management of Suicidality (CAMS)**

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Pistorello, 2021**[29]<br>**RCT** | Collaborative Assessment and Management of Suicidality (CAMS) (N=33) | CAMS focused on identifying and managing "suicidal drivers" or problems that make adolescents suicidal and help them to develop a plan when encountering these problems. Sessions started with the collaborative completion of suicide status form (SSF) by client/therapist and ended with a reconsideration of the CAMS Stabilization Plan and the driver-focused treatment plan. | Average of 5.61 sessions over 4–8 weeks | College counseling center | Addressing suicidal ideation and other suicide-related outcomes |
| | Treatment as Usual (TAU) (N=29) | TAU was defined as the treatment a study counselor would ordinarily use in their routine clinical work, based on their theoretical orientation. The only attempt to control the type of intervention provided as part of TAU treatment was to ensure that therapists not use any CAMS or DBT strategies | Average of 5.61 sessions over 4–8 weeks | College counseling center | Addressing suicidal ideation and other suicide-related outcomes |
| **Adrian, 2023**[30]<br>**Before–After study** | Behavioral Health Crisis Care Clinic (CCC) Team-Based Approach (N=189) | The Behavioral Health Crisis Care Clinic (CCC) intervention includes CAMS-based psychotherapy, a treatment that uses skills training to address problems that drive suicide for teens, as well as psychoeducation, lethal means restriction, and parent skills training for caregivers. The CCC intervention also includes a team-based approach with a case manager and two clinicians (one for the youth, one for the caregiver) involved in the care of each family. | 4 sessions, weekly, first session was 90 minutes, the remaining were 50 minutes | Clinic (77%), telehealth (23%) | Addressing suicidal behaviors |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Adrian, 2021**[31]<br><br>**Before–After study** | Collaborative Assessment and Management of Suicide (CAMS)<br>(N=22) | CAMS is a suicide-focused intervention framework that helps clinicians effectively engage, assess, and treat suicidal risk through the use of the Suicide Status Form (SSF). CAMS aims to enhance therapeutic alliance and increase patient motivation to collaboratively target and treat patient-defined "drivers" of suicidality. Treatment strategies are flexible and allow clinicians to use their own theoretical orientation. The intervention included stabilization planning and a focus on problems that make suicide appealing to the patient. Parent participation in treatment is encouraged, with parents involved in at least the first and last sessions. | 60-minute sessions, scheduled one session/week for up to 16 sessions depending on response | Clinic | Addressing suicidal thoughts and behaviors |

Abbreviations: CAMS = collaborative assessment and management of suicide; TAU = treatment as usual; CCC = crisis care clinic; SSF = suicide status form; DBT = dialectical behavior therapy

**Table E.6. Description of Interventions for Crisis Management**

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Wharff, 2019**[32] **RCT** | Family-Based Crisis Intervention (FBCI) (N=68) | FBCI is a single-session intervention that incorporates principles from cognitive-behavioral, narrative, and family systems therapies. delivered to the suicidal adolescent and their parent(s)/guardian(s) in the ED. FBCI aims to stabilize the adolescents and to empower the family to manage the adolescent safely at home. The clinician works with the adolescent and family to deliver concreate tools and safety planning skills while utilizing nonjudgmental collaboration to foster rapport between caregivers and the adolescents. Modules include1) psychoeducation, 2) cognitive behavioral skill building, 3) therapeutic readiness, 4) safety planning, 5) unified crisis narrative. | One 60–90-minute session | Emergency department | Addressing suicidal behaviors |
| | Treatment as Usual (TAU) (N=71) | Standard psychiatric evaluation and clinical/discharge recommendations delivered in the ED. Delivered by licensed psychiatric social workers. | NR | Emergency department | Addressing suicidal behaviors |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Asarnow, 2011**[33]<br>**RCT** | Family Intervention for Suicide Prevention (FISP)<br>(N=89) | FISP includes a brief youth and family crisis-therapy delivered in the ED focused on 1) reframing the suicide attempt as a problem requiring action, 2) educating families regarding the importance of outpatient mental health treatment and restricting access to dangerous attempt methods, 3) obtaining a commitment from the youth to use a safety plan in future crises; 4) strengthening family support by encouraging youths and parents to identify positive attributes in the youth and family; 5) developing a hierarchy of potential suicidality triggers using an "emotional thermometer" to identify feelings and physical, cognitive, and behavioral reactions to these triggers; 6) developing and practice using a "safety plan" for reducing "emotional temperature" and attempt-risk; and creating a "Safety Plan Card" (often supplemented by a "Hope Box") to provide a concrete tool that youths could use at times of acute stress/suicide attempt-risk to cue reminders of reasons for living and safe/adaptive coping. Structured telephone contacts focused on motivating and supporting outpatient treatment attendance were made within the first 48 hours after ED/hospital discharge with additional contacts as needed. | One session in ED and phone call 48 hours after ED/hospital discharge, then as-needed at 1, 2, and 4-weeks | Emergency department and telehealth | Crisis care |
| | Enhanced Usual Care (EUC)<br>(N=92) | Usual care enhanced by a one-session training for ED staff. Training emphasized the importance of linking suicidal patients to outpatient mental health treatment, restricting access to dangerous/lethal attempt methods, and increased risk associated with substance use. | One session | Emergency department | Crisis care |
| **Wharff, 2012**[34]<br>**Comparative Observational study** | Family-Based Crisis Intervention (FBCI)<br>(N=67) | FBCI is a single-session ED intervention that incorporates principles from cognitive-behavioral, narrative, and family systems therapies. The social worker meets separately with the adolescent and family to assess their perceptions of the suicidal crisis, then meets with the whole family together to construct a unified narrative, improve communication, and collaboratively develop a safety plan. The goal is to stabilize the patient and provide tools for the family to manage the crisis at home. | One session, followed by 5 followup assessments via telephone at 1-day, 1-week, 2-week, 1-month, and 3-month intervals | Emergency department and telehealth | Crisis care |
| | Retrospective Comparison Group<br>(N=150) | This group received standard psychiatric assessment and care as per ER protocol at that time. | NR | Emergency department | Crisis care |

| Author, Year, Study Design | Intervention Name (N of Patients) | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Rotheram-Borus, 2000**[35]<br><br>**Comparative Observational study** | Specialized ER Care (N=65) | The specialized ER care program included trainings to primary ER staff to enhance positive patient interactions, reinforce the importance of outpatient treatment, and recognize the seriousness of suicide attempts. Second, a 20-min "soap opera" videotape was shown to adolescents and their mothers in the ER to instill realistic expectations regarding treatment. The video reviewed the stories of two adolescents one of whom had repeated her suicide attempt after not following up on outpatient treatment. After the video, a bilingual crisis therapist met with the adolescent and their mother to discuss the videotape, conduct a therapy session, and contract for followup outpatient treatment. In the therapy session in the ER, the therapist conducted a behavioral assessment of behavioral risk for imminent danger of suicide, asked the SA and the mothers to identify positive attributes of themselves and their family, and made a plan for the SA on coping with future suicidal feelings. Following discharge the adolescent received 6 sessions of Successful Negotiation Acting Positively (SNAP), a followup family cognitive behavioral treatment to support positive coping strategies and enhance family support for problem solving. In the 6 sessions, a therapist worked with the families to establish a supportive family climate, recognize feelings, solve family problems, negotiate, and enjoy pleasant activities. Through exercises and role-playing, family members identified, analyzed, negotiated, and solved important family problems. The same clinicians continued providing therapy to families who requested or needed additional treatment after completing the sessions, using similar principles and techniques as the SNAP program. | One session in the ER, followed by 6 outpatient sessions | Emergency department and clinic | Addressing suicidal behaviors and ongoing treatment following crisis |
| | Standard ER Care (N=75) | This included standard ER procedures of evaluation by a pediatrician and psychiatrist to determine need for hospitalization and medical procedures. Referral was made to the SNAP outpatient treatment that was part of the specialized ER (described above). | One session in the ER, followed by 6 outpatient sessions | Emergency department | Addressing suicidal behaviors and ongoing treatment following crisis |

Abbreviations: ED = emergency department; ER = emergency room; EUC = enhanced usual care; FBCI = family-based crisis intervention; FISP = family intervention for suicide prevention; NR = not reported; RCT = randomized clinical trial; SNAP = successful negotiation acting positively; TAU = treatment as usual

**Table E.7. Description of Interventions for Motivation Interviewing**

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Grupp-Phelan, 2019[36]**<br>**RCT** | Suicidal Teens Accessing Treatment After an Emergency Department Visit (STAT-ED)<br>(N=84) | STAT-ED used motivational interviewing (MI) to target mental health care seeing, barrier reduction discussion and referral. Patients also received limited case management during the transition from the ED to outpatient care to reinforce the principles of suicide risk reduction and review the actionable plan for initiating and sustaining mental health treatment. The case management protocol included 1–2 follow up calls after discharge. | 1–2 followup phone calls after ED discharge | Emergency department, telehealth | Addressing suicidal behaviors |
| | Enhanced Usual Care (EUC)<br>(N=84) | The enhanced usual care (EUC) intervention consisted of brief mental health care consultation and referral. | NR | Emergency department | Addressing suicidal behaviors |
| **McManama O'Brien, 2018[37]**<br>**RCT** | Alcohol and Suicide Intervention for Suicidal Teens (ASIST)<br>(N=25) | In addition to TAU, adolescents received the ASIST intervention, consisting of an individual session and a family session. The individual session included: building rapport, assessing motivation for change, enhancing motivation for change, envisioning the future, establishing goals, and completing worksheets. The session addresses alcohol use and suicidal thoughts in an integrated manner, exploring the connections between them. Personalized feedback is provided to increase motivation to alter alcohol use by recognizing the potential link with suicidal thoughts and behaviors. The family session involved a clinician facilitated discussion of the adolescent's goals, strategies, and change plan to gain parental support in the change process. | One 60 to 90-minute individual session and one 20 to 30-minute family session | Inpatient | Addressing suicidal ideation |
| | Treatment as Usual (TAU)<br>(N=25) | Participants who received TAU were assigned a psychiatrist and social worker who coordinated evaluation and treatment to address the adolescents' most acute presenting problems. TAU typically includes medication evaluation, individual and family sessions, and psychoeducational groups on a variety of topics. In addition, TAU involves creating a six-point safety and coping plan that connects feelings-thoughts-actions. Alcohol and other drug use was addressed on an individual basis at the discretion of the adolescent's clinical team. When alcohol and other drug use was discussed, psychoeducation was provided to both the adolescent and family, particularly around safety planning in the community and recommendations for substance use treatment upon discharge when appropriate. | NR | Inpatient | Addressing suicidal ideation |

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **King, 2015**[38] **RCT** | Teen Options for Change (TOC) (N=27) | The TOC intervention included 35–45 minute adapted motivational interview with a mental health professional. where the therapist reviewed personalized feedback including normative data for depression and suicidal ideation, risk level for alcohol use, and functional impairment. The therapist used a culturally tailored goals and values clarification guide to facilitate the adolescent's identification of behavioral goals. Using MI techniques, they facilitated the adolescent's development of a personalized action plan consisting of an objective goal and a list of up to 3 steps to take to forward this goal. Adolescents also received a handwritten follow up note and a telephone check in from their therapist 2–5 days after discharge to support and facilitate action plan implementation. Adolescents in TOC also received E-TAU consisting of a crisis card with suicide emergency phone numbers in addition to written information about depression, suicide risk, firearm safety and local mental health services, | 35–45 minutes long interview, with telephone check-in 2–5 days after the ED visit | Emergency department and telehealth | Crisis care |
| | Enhanced Treatment as Usual (ETAU) (N=22) | Adolescents in the ETAU group were given a crisis card with phone numbers for suicidal emergency support, along with written information about depression, suicide risk, firearm safety, and local mental health services. | One time | Emergency department | Crisis care |

Abbreviations: ASIST = alcohol and suicide intervention for suicidal teens; ED = emergency department; ETAU = enhanced treatment as usual; EUC = enhanced usual care; MI = motivational interviewing; NR = not reported; STAT-ED = suicidal teens accessing treatment after an emergency department visit; TAU = treatment as usual; TOC = teen options for change

**Table E. 8. Description of Interventions for Safety Planning**

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Czyz, 2019**[39]<br>**RCT** | Motivational Interview-Enhanced Safety Planning + Treatment as Usual (MI-SafeCope + TAU)<br>(N=18) | MI-Safe cope incorporates motivational interviewing (MI) to enhance adolescents' motivation and self efficacy to use their safety plans and engage in adaptive coping following discharge. It also aims to enlist parents support in encouraging safety plan use. A four-phase MI framework which includes engaging, focusing, evoking, and planning is used to guide the safety planning session. More broadly, MI-consistent strategies (such as reflective listening, rolling with resistance/sustain talk, eliciting self-motivational statements or "change talk," enhancing self-efficacy, affirming, etc.) are used to elicit internal motivation toward behavioral change (adhere to safety plan), resolve ambivalence about change, and support self-efficacy for change. Family session includes a focus on sharing the safety plan and preparing parents, with input from the adolescent, for how they may support the adolescent in implementing the individualized safety plan after discharge and on strengthening parents' motivation, commitment, and self-efficacy to follow through with these recommendations. In person components are followed with a booster phone call, separately with the adolescent and the parent. The purpose of the call is to adjust the safety plan to better meet postdischarge needs. | 1 individual session, 1 family session, 1 phone call with adolescent and parent separately 2 weeks after discharge | Inpatient and telehealth | Ongoing treatment following crisis |
| | Treatment as Usual (TAU)<br>(N=18) | Usual care during hospitalization, including the Recovery Action Plan (RAP). The RAP includes a section on crisis management strategies and safety planning, including warning signs, important crisis and emergency phone numbers, and a list of healthy support persons. It also includes a brief needs assessment, identifying the circumstances and stressors leading up the hospitalization, and a section focusing on identifying factors and activities that contribute to wellness; communication with family; and plans for discharge, including healthy coping skills. | RAP packet is completed during hospitalization, 1 or more individual sessions with nursing staff | Inpatient | Ongoing treatment following crisis |

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Kennard, 2018**[40]<br>**RCT** | As Safe as Possible (ASAP+TAU)<br>(N=34) | ASAP included in person modules delivered on the inpatient unit including 1) treatment adherence and safety planning; 2) affect protection including reasons for living, mood monitoring and pleasant events scheduling; 3) affect regulation strategies; 4) skills review. Therapists delivering these modules used motivational interviewing skills. At discharge, adolescents in ASAP were given an App that included their safety plan and sent daily texts to prompt adolescents to rate their level of emotional distress (1-5, 5=most upsetting). Based on their level of distress, participants were offered a range of distress tolerance and emotion regulation skills, with the ability to upload support materials (videos, websites, photos). For participants at the highest level of distress, the app presented the safety plan, including interpersonal support, clinical contact options. Patients in this ASAP also received bridging therapist calls to review use of safety plan, ASAP components, app use and adherence to care. | 2.7 hours total, over a median of 3 sessions, followed by two phone call sessions and daily texts 1–2 weeks postdischarge | Inpatient and telehealth | Ongoing treatment following crisis |
| | Treatment as Usual (TAU)<br>(N=32) | Inpatient care across sites focused on diagnosis, safety assessment, stabilization, pharmacotherapy, psychoeducation, and disposition. Referrals for outpatient treatment were provided prior to discharge. Unit therapists developed a safety plan with the patient and family, although no standard protocol was followed. | NR | Inpatient and telehealth | Ongoing treatment following crisis |

Abbreviations: ASAP = as safe as possible; MI = motivational interview; NR = not reported; RAP = recovery action plan; RCT = randomized clinical trial; TAU = treatment as usual

**Table E.9. Description of Interventions for Continuity of Care**

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Czyz, 2021**[41]<br><br>**RCT** | PHASE I<br><br>Motivational Interview-Enhanced Safety Plan + Monitoring (MI-SP + Monitoring)<br><br>(N=40) | MI-SP uses MI strategies to increase adolescents' motivation to adhere to safety plan and coping, resolve, ambivalence, and support self-efficacy after discharge; The individual session ends with developing a personalized safety plan followed by family session for the adolescent to share the safety plan and discuss the parents' role in implementing the safety plan In addition to MI-SAFE Cope, participants received usual are during hospitalization (e.g., stabilization, safety planning, referrals) | One 60-minute individual session, one 30-minute family session | Inpatient | Addressing suicidal ideation and behaviors after being hospitalized for suicide risk concerns |
| | PHASE I<br><br>Motivational Interview-Enhanced Safety Plan + Texts + Monitoring (MI-SP + Texts + Monitoring)<br><br>(N=40) | In addition to receiving MI-SP (described above), adolescents randomized to support texts in Phase I received 2 automated text messages daily for 4 weeks; texts included MI-consistent strategies and language and included content focused on: self-efficacy to cope with suicidal urges, motivation to maintain safety, tailored messages referencing personal reasons for living and coping strategies, coping tips, reminders about crisis resources, encouragement to use personal safety plan, affirmations, and strengthening social connectedness.<br><br>In addition to MI-SAFE Cope with texts, participants received usual are during hospitalization (e.g., stabilization, safety planning, referrals) | 2 daily text messages for 4 weeks | Telehealth | Addressing suicidal ideation and behaviors after being hospitalized for suicide risk concerns |

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Rengasamy, 2019**[42] **RCT** | Single Call Intervention (SCI) (N=70) | SCI consisted of a single attempted telephone call delivered 90 days postintervention to participants and guardians; phone calls with guardians consisted of review of parental concerns of suicidality and concerns related to treatment followup; phone calls with adolescents consisted of reviewing the suicidality assessment and safety plan, assessing a their confidence in the safety plan, and elicitation of reasons for living; both guardian and participant interventions included assessment of global well-being, medication, and weapon safety, perceived helpfulness of the intervention, and problem solving related to logistical of medical concerns, safety education, and referral information; if participants were not reached a voice mail was left and recontacted the following week | One 10–20-minute phone call delivered 90 days after discharge | Telehealth | Addressing suicidal behaviors |
| | Multiple Calls Intervention (MCI) (N=72) | MCI consisted of six attempted telephone calls participants and guardians; phone calls with guardians consisted of review of parental concerns of suicidality and concerns related to treatment followup; phone calls with adolescents consisted of reviewing the suicidality assessment and safety plan, assessing a their confidence in the safety plan, and elicitation of reasons for living; both guardian and participant interventions included assessment of global well-being, medication, and weapon safety, perceived helpfulness of the intervention, and problem solving related to logistical of medical concerns, safety education, and referral information; if participants were not reached a voice mail was left and recontacted the following week | Attempted 10–20-minute phone calls delivered on 1, 7, 14, 30, 60, at 90 days after discharge | Telehealth | Addressing suicidal behaviors |

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Greenfield, 2002**[43]<br>**Comparative Observational study** | Rapid-Response Outpatient (RRO)<br>(N=158) | RRO involved immediate followup care from a specialized outpatient team after assessment in the emergency department. This team consisted of a part-time psychiatrist and a psychiatric nurse who initiated telephone contact with the patient and their family to plan a followup appointment. The intervention aimed to assess the crisis nature, identify precipitating events, and evaluate the support system of the adolescent. Interventions included reframing misconceptions, addressing maladaptive behaviors and communication patterns, medication management if appropriate, and utilization of community resources. The outpatient team-maintained contact with the patient until long-term followup was arranged in the community and was available in case of future crises. | 10 telephone contacts over 18 weeks | Emergency department and outpatient | Ongoing treatments following crisis care |
| | Control group<br>(N=128) | To continue the treatment initiated in the emergency department, psychiatrists of patients in the control group could either hospitalize the patient, follow the patient as an outpatient, or refer the patient to a variety of community resources, such as a hospital-based outpatient psychiatric clinic, a nonhospital-based community health facility, or a private mental health worker. | NR | Emergency department, inpatient or outpatient | Ongoing treatments following crisis care |

Abbreviations: MCI = multiple calls intervention; MI = motivational interviewing; MI-SP = motivational interview-enhanced safety plan; NR = not reported; RCT = randomized clinical trial; RRO = Rapid-Response Outpatient; SCI = single call intervention; SP = safety planning

**Table E. 10. Description of Interventions for Brief Adjunctive Treatments**

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Dobias, 2021**[44]<br>**RCT** | Project SAVE (Stop Adolescent Violence Everywhere)<br>(N=285) | Project SAVE is a ~30-min, self-administered, web-based program that draws on components of cognitive behavior therapy (e.g. psychoeducation about relationships between thoughts, feelings, and behaviors; secondary coping skills such as distress tolerance) designed to decrease self-injurious behaviors in youth. The Project SAVE SSI has 4 general content sections: 1) explaining the science behind how changing actions (i.e., decreasing self-injurious behaviors) can positively impact thoughts and emotions over time; 2) detailing scientific evidence and testimonials from other teens that have decreased their self-injurious behaviors and noticed positive change as a result; 3) providing evidence-based tips and alternative coping mechanisms to replace self-harming behavior; 4) offering an opportunity for youth to share their own thoughts and advice on what they have learned with other teenagers who are facing similar challenges. These content areas are reinforced by intervention design features intended to maximize persuasiveness and memorability. Adolescents had the option to select 2 of the most commonly endorsed reasons for self harm and then were provided with additional psychoeducation and coping strategies specific to their barriers of choice. | One 30-minute online session | Online program | Addressing suicidal behaviors |
| | Supportive Therapy ("Share Your Feelings")<br>(N=293) | Supportive Therapy ("Share Your Feelings") is a ~30-min, self-administered, web-based program that uses components of supportive therapy to encourage participants in the control group to identify and express their feelings by first, explaining why sharing feelings is natural, important, and helpful; second, including testimonials from teens who have shared their feelings with close others. | One 30-minute online session | Online program | Addressing suicidal behaviors |

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Fitzpatrick, 2005**[45]<br><br>**RCT** | Brief Problem-Orientation Treatment group (N=110) | Problem Orientation Treatment included a 35-minute video focused on problem-solving and coping styles. The initial 20 minutes provided information about identifying problems, as well as the cognitive, behavioral, and affective reactions that most people have toward problems. This psychoeducational module aimed to explain/ define problems, solutions, emotions, and stress and provided definitions as well as examples of each category. The initial segment focused on four main points: (a) increasing sensitivity to problems and to encourage an active coping model, (b) focusing attention on positive problem-solving thoughts versus rumination and worry; (c) maximizing effort and persistence in the face of setbacks and emotional distress; and (d) minimizing emotional distress while maximizing positive emotions. Following this presentation, an additional 10-minute segment encouraged participants to elicit problems and their reactions to these problems. Participants completed the Problem-Solving Self-Monitoring Form (PSSM; D'Zurilla & Nezu,1999) to assist them in identifying thoughts, feelings, and reactions to problem situations. The final 10-minute segment encouraged participants to apply the skills learned in the video to their personal problem situation. A multifaceted case example was presented to demonstrate application of skills. | 35-minute video, followup evaluations at 1 week, 2 weeks, and 1 month | Clinic | Addressing suicidal ideation |
| | Treatment as Usual (TAU) (N=110) | The control group watched a 35-minute video on health issues like diet, exercise, and sleep, with no coping skills content. | 35-minute video, followup evaluations at 1 week, 2 weeks, and 1 month | Clinic | Addressing suicidal ideation |

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Yen, 2020[46]**<br>**RCT** | Skills to Enhance Positivity (STEP) (N=26) | STEP consists of two phases: 1) in-person phase consisting of three individual sessions and one family session delivered while patient is admitted to the inpatient unit or shortly after discharge, 2) remote-delivery phase, consisting of one month of daily text messaging and weekly phone calls to facilitate practice of mood monitoring and positive affect exercises. STEP provides psychoeducation on the function of positive emotions and 3 sets of exercises to increase attention to positive affect including mindfulness meditation, gratitude and savoring. All adolescents also received usual care on the inpatient unit consisting of individual sessions with psychiatrist and therapy groups throughout the day and were referred to follow up psychiatric care. | 3 individual in-person sessions, 1 family in-person session, 1 month of daily text messages and weekly phone calls postdischarge | Inpatient, and telehealth | Ongoing treatment following crisis |
| | Enhanced Treatment as Usual (ETAU) (N=26) | ETAU participants received usual inpatient care and were referred to followup psychiatric care after discharge. They also received daily text messages for one month about health habits to control for attention, but did not receive mood monitoring, in-person sessions, family session, or phone calls. | Daily text messages for 1 month postdischarge | Inpatient, and telehealth | Ongoing treatment following crisis |

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Ahmadi, 2022**[47]<br><br>**Comparative Observational study** | Reminder-Focused Positive Psychiatry and Suicide Prevention (RFPP-S)<br>(N=50) | RFPP-S is a developmental age-appropriate, trauma-informed safety prevention intervention derived from RFPP. It consists of two RFPP components (trauma reminders and avoidance/negative cognitions), as well as safety planning and distress tolerance skill sets for youths with PTSD and their families.<br>The youth component included exercises in self-compassion, treatment engagement, tolerating trauma reminders, managing reactivity and suicidality through distress tolerance and contextual differentiation between current reminders and the original trauma. The avoidance/negative cognitions component involved flexible thinking exercises, expressing negative thoughts/emotions, promoting posttraumatic growth, treatment adherence, positive attention to self, enhancing relationships, and problem-solving skills. The parent component involved a psychoeducation session on the RFPP-S modules. After discharge, RFPP-S groups received reminders about followup mental health visits via text or phone calls twice weekly. | 10 minutes twice daily for 2 consecutive days | Psychiatric emergency department | Addressing suicidal ideation |
| | Treatment as Usual (TAU)<br>(N=150) | Youths experiencing suicidal ideation or behaviors were evaluated and protected in a supervised private room without access to dangerous objects during psychiatric emergency room visits. They engaged in a respectful, collaborative milieu, conversed with the mental health team to remain calm, received suicide risk assessment and screening to determine appropriate level of care, and interventions to develop skills for recognizing and coping with suicidal thoughts and PTSD. This included safety planning, identifying sources of help, and making the environment safer. Psychiatric hospitalization was typical for those in acute crisis with PTSD and moderate-to-high suicide risk. | One session within 2 weeks after discharge | Psychiatric emergency department. | Addressing suicidal ideation |

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Yen, 2019**[48]<br>**Before–After study** | Skills to Enhance Positivity (STEP treatment)<br>(N=20) | STEP focuses on providing psychoeducation on the function of positive emotions and three sets of skills: mindfulness meditation, gratitude, and savoring, with an in-person phase consisting of three individual sessions and one family session delivered on the inpatient unit or shortly after discharge, followed by a remote-delivery phase which consisted of one month of daily text messaging and weekly phone calls to facilitate practice of mood monitoring and positive affect skills. The STEP program was adjunctive so all participants received the usual care on the inpatient unit which includes individual sessions with the psychiatrist and therapy groups during the day. | In-person phase: 4 sessions (30–45 minutes each), on different consecutive weekdays<br>Remote-delivery phase: daily text messaging and weekly phone calls for one month | Inpatient and telehealth | Ongoing treatment following crisis |
| **Hill, 2023**[49]<br>**Before–After study** | Supporting Grieving Teens (SGT)<br>(N=32) | SGT consists of two sessions administered via a web- based platform, in which a series of animated videos introduce the session content and text- based prompts allow youth to provide personalized responses. of the first session of SGT consists of helping the adolescent to identify a type of social support they want or need and develop a plan to seek support from an appropriate person. In addition, adolescents identify ways to maintain and strengthen existing relationships. The second session consists of the same elements with the primary goal to reinforce the skills learned from the first session. During both sessions, a clinical team member is present to provide guidance and support as needed. | Two sessions, one week apart, 30–40 min each | Telehealth | Addressing suicidal ideation |

Abbreviations: CBT = cognitive behavior therapy; ETAU = enhanced treatment as usual; PTSD: posttraumatic stress disorder; RFPP-S = reminder-focused positive psychiatry and suicide prevention; RCT = randomized clinical trial; SAVE = stop adolescent violence everywhere; SGT = supportive grieving teens; SSI = self-injurious behavior; STEP = skills to enhance positivity; TAU = treatment as usual

**Table E.11. Description of Interventions for Social Network Interventions**

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **King, 2019**[50, 51] **RCT** | Youth-Nominated Support Team + Treatment as Usual (YST + TAU) (N=223) | YST is a psychoeducational, social support intervention designed to supplement routine care for suicidal adolescents after psychiatric hospitalization. Adolescents nominated "caring adults" (3–4 individuals) to serve as support persons. Support persons attended a psychoeducational session led by YST intervention specialists to learn about the youth's treatment plan, suicide warning signs, and how to be supportive. Support persons were encouraged to maintain weekly contact with the youth. The intervention specialists regularly contact the support persons. As this treatment was considered adjunctive, adolescents in YST also received usual care that included psychotherapy, medication, alcohol/drug treatment, partial hospitalization, and/or community services. | 1 educational session for support persons, weekly phone calls between support persons and youth for 3 months | Community | Addressing suicidal ideation and behaviors |
| | Treatment as Usual (TAU) (N=225) | Routine care that included psychotherapy, medication, alcohol/drug treatment, partial hospitalization, and/or community services. | NR | Community | Addressing suicidal ideation and behaviors |
| **King, 2006**[52] **RCT** | Youth Nominated Support Team-Version 1 + Treatment as Usual (YST-1 + TAU) (N=151) | YST is a psychoeducational, social support intervention designed to supplement routine care for suicidal adolescents after psychiatric hospitalization. Adolescents nominated "caring adults" (3–4 individuals) to serve as support persons. Support persons attended a psychoeducational session led by YST intervention specialists to learn about the youth's treatment plan, suicide warning signs, and how to be supportive. Support persons were encouraged to maintain weekly contact with the youth. As this treatment was considered adjunctive, adolescents in YST also received usual care that included psychotherapy, medication, alcohol/drug treatment, partial hospitalization, and/or community services. The intervention specialists regularly contact the support persons. As this treatment was considered adjunctive, adolescents in YST also received usual care that included psychotherapy, medication, alcohol/drug treatment, partial hospitalization, and/or community services. | 1.5–2-hour psychoeducation sessions then maintain weekly contact with adolescents over 6 months | Community | Addressing suicidal behaviors and ideation |
| | Treatment as Usual (TAU) (N=138) | Routine care that included psychotherapy (100%), medication (96.8%), alcohol/drug treatment (13.4%), partial hospitalization (18.0%), and community services (8.5%). | 6 months | Community | Addressing suicidal behaviors and ideation |

Abbreviations: NR = Not Reported; RCT = Randomized Controlled Trial; TAU = Treatment as Usual; YST + TAU = Youth-Nominated Support Team + Treatment as Usual; YST-1 + TAU = Youth Nominated Support Team-Version 1 + Treatment as Usual

**Table E.12. Description of Interventions for School-based Skills Interventions**

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Robinson, 2024**[53] **RCT** | Adapted-Coping with Stress course (A-CWS) (N=190) | Adapted-Coping with Stress course (A-CWS) intervention aims to increase skills for adaptively coping with individual and contextual stressors. It is a culturally grounded, cognitive-behavioral group protocol specifically designed for African American adolescents. Sessions focused on building group cohesion, identifying stressors and outcomes, learning, and practicing culturally relevant coping strategies. The intervention incorporated material reflecting African American culture, heritage and values and emphasized techniques for adaptively coping with salient socioecological stressors like racial discrimination and community violence exposure. | 15 sessions, weekly, 45 minutes each, over 4 months, 8 to 10 students per group | School | Addressing suicidal ideation |
| | Standard care (N=190) | The standard care control condition reflects services students would typically receive if A-CWS did not exist. It includes comprehensive intake assessment and a range of services based on student need, from brief behavioral interventions to one-on-one or group sessions. | Weekly, one-on-one or group sessions, depending on the student's needs | School | Addressing suicidal ideation |
| **Randell, 2001**[54] **RCT** | Counselors CARE + Coping and Support Training (C-CARE + CAST) (N=103) | Adolescents in C-CARE plus CAST received C-CARE, a computer-assisted assessment of risk and protective factors and a counseling session to summarize results and reinforce coping, and facilitation of connections with school personnel and a parent. They also received CAST, 12-session small-group life skills training program. The group sessions occur over 6 weeks, twice weekly for 1 hour each, with 6–7 students per group. Sessions target mood management, drug use control and school performance through skills training. Delivered by specially trained group leaders. | C-CARE plus 12 one-hour group sessions over 6 weeks | School | Addressing suicidal behaviors |
| | Counselors CARE (C-CARE) (N=117) | A computer-assisted assessment of risk and protective factors and a counseling session to summarize results and reinforce coping, and facilitation of connections with school personnel and a parent, adolescents. | 3.5–4-hour session | School | Addressing suicidal behaviors |
| | Intervention as Usual (N=121) | An individually administered assessment using suicide scales, followed by facilitating connections with school and parents as per school policy. Simulates usual school response. | 15–30-minute session | School | Addressing suicidal behaviors |

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Silverstone, 2015**[55]<br><br>**Before–After study** | Empowering a Multimodal Pathway Towards Healthy Youth (EMPATHY) (N=3244) | The EMPATHY program is a pioneering, school-based initiative aimed at mitigating depression and suicidality among youth. It encompasses a holistic approach that begins with extensive screening of students using electronic tablets to identify those at risk for mental health challenges, including depression, suicidality, and anxiety. Key components include rapid interventions for students identified as actively suicidal, such as the implementation of cognitive-behavioral therapy (CBT) resiliency program specifically for all students in Grades 7 and 8 to enhance mental resilience, and a guided internet-based CBT for students screening as high risk to offer further support. The internet-based CBT was guided by a resiliency coach rather than a mental health professional and key CBT components were not reported. | 8 sessions over 12 weeks for CBT resiliency programs<br>Guided internet CBT program NR | School | Addressing suicidal ideation and behaviors |

Abbreviations: A-CWS = adapted-coping with stress course; CAST = coping and support training; CBT = cognitive-behavioral therapy; C-CARE = counselors CARE; EMPATHY = empowering a multimodal pathway towards healthy youth

**Table E.13. Description of Interventions for Suicide Awareness/Gatekeeper Programs**

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Aseltine, 2004**[56] **RCT** | Signs of Suicide (SOS) (N=1027) | SOS incorporates two prominent suicide prevention strategies - raising awareness about suicide and depression, and a brief screening for depression and other suicide risk factors. The program teaches students to recognize signs of suicide and depression in themselves and others, and the specific action steps needed to respond to those signs. The main teaching components are a video and discussion guide. Students also complete a depression screening form that they score themselves. The program is designed to be implemented on a school-wide basis by health educators. | 2-day program | School | Addressing suicidal behaviors |
| | Control group (N=1073) | Control group did not participate in the Signs of Suicide (SOS) program until after the evaluation was completed at the 3-month followup. | NR | NR | Addressing suicidal behaviors |
| **Hermosillo-de-la-Torre, 2023**[57] **Before–After study** | Dialectical Behavior Therapy Skills Training Program (DBT-PAHSE) (N=34) | DBT-PAHSE consisted of 25 sessions corresponding to five interconnected modules: Mindfulness, Distress Tolerance, Emotional Regulation, Interpersonal Effectiveness, and an additional module on self-knowledge and self-assessment. The skills were presented using a metaphor of an enchanted forest and each skill was presented as a power to use to win the game. The program was applied by psychology professionals trained in DBT. | 25 sessions, each session lasted 120 min and was implemented by psychology professionals trained in DBT. | School | Addressing suicidal behavior, associated risk factors (emotional dysregulation, depression), and protective factors |

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Sale, 2022**[58] **Before–After study** | Continuity-of-Care Model (N=983) | Continuity-of-care model approach involves suicide prevention specialists identifying youth at risk for suicide across various settings like hospitals, schools, community organizations, and provider settings. It includes rapid followup and eligibility assessment using the Columbia Suicide Severity Rating Scale (C-SSRS) and semi-structured interviews. Eligible youth are immediately linked to in-person mental health services within Certified Community Behavioral Health Clinics (CCBHCs). Tailored suicide prevention psychotherapy and case management services are provided based on each youth's needs. Care continues until the youth is no longer suicidal or requires longer-term services, with additional support such as transportation, employment, and housing assistance if needed. Ongoing engagement is maintained through postcards, emails, texts, and networking with other community providers to build an enhanced safety net around the youth. | Weekly sessions over 3–7 months | Community, school, and clinic | Addressing suicidal thoughts and behaviors |
| **Rivero, 2014**[59] **Before–After study** | Consultation and Resource Evaluation Program (CARE Net) (N=108) | CARE Net intervention was designed to provide a mechanism for staff members within a college counseling center to intervene with students who threaten or attempt suicide, as well as their parents and as appropriate their roommates. Residential life will refer the student who then participates in 1) an assessment of current suicide risk. 2) an evaluation of the student's willingness and ability to refrain from self-harm. 3) consultation on needed psychiatric, psychological, and support services is provided. 4) parents or guardians are informed of the incident and the aims of CARE Net. 5) a supportive educational intervention is offered for the student's roommates or suitemates. 6), a "CARE Plan" is developed, listing support sources and healthy alternatives to risk behaviors. | 2-hour 1–2 sessions, with followup as needed | College counseling center | Crisis care |

Abbreviations: CARE Net = consultation and resource evaluation program; CCBHCs = certified community behavioral health clinics; C-SSRS = Columbia suicide severity rating scale; DBT-PAHSE = dialectical behavior therapy skills training program; NR = not reported; RCT = randomized controlled trial; SOS = signs of suicide

**Table E.14. Description of Interventions for Community-based, Culturally Tailored Adjunct Programs**

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Allen, 2018[60]**<br><br>**Comparative Observational study** | *Qungasvik* Cultural Intervention. Treatment Arm Community (Community 1) (N=68) | Community 1 was intervention development community for the Qungasvik intervention; our research team was invited to co-develop the intervention here by community leadership and tribal resolution. The Qungasvik intervention is a multi-level, community-driven, cultural intervention for rural Yup'ik Alaska Native youth focused on preventing suicide and alcohol misuse. It takes a strengths-based approach, using engagement in local Yup'ik cultural practices and teachings as the primary mechanism for promoting protective factors. The intervention involves implementing a series of adaptable modules, such as seal hunting or storytelling, which are designed to experientially teach Yup'ik values, skills, and ways of being that prior research has linked to resilience against suicide and alcohol risk. The modules are planned and delivered by community members recognized as cultural experts, especially Elders, following the traditional Qasgiq model of social organization. This model guides a collaborative process of coming together to plan activities, identify those best suited to lead them, carry out the activities, and then regroup to debrief and prepare for the next step. While the specific components are adaptable, maintaining fidelity to this community-driven process and ensuring modules map onto researched protective factors are seen as core to the intervention's integrity within the cultural context. | 26 modules, each is delivered in one or more 1–3-hour sessions. Average 7 modules over 12 months | Community | Addressing suicidal ideation |
| | Comparison Arm Community (Community 2) (N=77) | Community 2 was enrolled into the larger dynamic wait listed design (DWLD) outcomes study which approached ‘larger’ population communities to maximize sample size in one area in Southwestern Alaska. | 26 modules, each is delivered in one or more 1–3-hour sessions. Average 2 modules over 12 months | Community | Addressing suicidal ideation |

| Author, Year, Study Design | Intervention Name | Description of the Intervention | Dose/Frequency/ Duration | Delivery Settings | Intervention Objectives |
|---|---|---|---|---|---|
| **Humensky, 2017**[61]<br><br>**Before–After study** | Life is Precious (LIP)<br>(N=107) | LIP is an afterschool program designed to promote family relationships, academic support, creative expression, and wellness. Participants come on a drop-in basis and can take advantage of any or all of the services. The program includes: 1) therapeutic services to build communication skills, allowing participants to learn how to communicate with their families to overcome acculturation gaps. 2) supported education services including resources for tutoring and assistance with homework and applications to competitive high school or college; 3) creative expression services including art, music, and dance therapists to help participants express their feelings; 4) wellness support activities support adolescents in positive body image, cooking and exercise. | 3–7pm weekdays, Saturday mornings | Community | Addressing suicidal ideation and behaviors |
| **Cwik, 2016**[62]<br><br>**Before–After study** | New Hope<br>(N=13) | The New Hope intervention is a brief, culturally adapted intervention for American Indian adolescents who have recently attempted suicide. Developed through a community-driven participatory approach in partnership with the White Mountain Apache Tribe, New Hope is delivered by trained Apache paraprofessional Community Mental Health Workers over 1–2 home visits after the adolescent is discharged from the emergency department. The intervention emphasizes the seriousness of the attempt, teaches coping skills to reduce risk (emotion regulation, cognitive restructuring, social support, self-efficacy, safety planning), helps overcome barriers to treatment motivation and adherence, and links the adolescent to outpatient mental health services. It incorporates familiar Apache characters, environments, and cultural practices into the materials. Key innovations include having the intervention delivered by local paraprofessionals and producing a new culturally relevant video with Native actors and Apache Elders to increase participant engagement. | 1–2 visits (2–4 hours total intervention time) | Community | Ongoing treatment following crisis care |

Abbreviations: DWLD = dynamic wait listed design; LIP = life is precious

# Appendix F. Risk of Bias

**Table F.1.1. Risk of Bias for Cognitive-Behavioral Therapy (CBT): Randomized Clinical Trials**

| Author, Year | Overall ROB | ROB from Randomization Process | ROB due to Deviations From Intended Interventions | ROB due to Missing Outcome Data | ROB in Measurement of Outcomes | ROB in Selection of the Reported Results |
|---|---|---|---|---|---|---|
| **Duarté-Vélez, 2022**[1] | High risk | Moderate risk | Moderate risk | High risk | Low risk | Low risk |
| **Sinyor, 2020**[2] | Moderate risk | Low risk | Moderate risk | Low risk | Low risk | Moderate risk |
| **Esposito-Smythers, 2019**[3] | High risk | Low risk | Moderate risk | High risk | Low risk | High risk |
| **Asarnow, 2017**[4] | High risk | Low risk | Moderate risk | Low risk | High risk | Low risk |
| **Spirito, 2015**[5] | High risk | High risk | Moderate risk | High risk | Low risk | Moderate risk |
| **Esposito-Smythers, 2011**[6] | Moderate risk | Low risk | Moderate risk | Low risk | Low risk | Low risk |
| **Donaldson, 2005**[7] | Moderate risk | Low risk | Moderate risk | Moderate risk | Low risk | Low risk |
| **Slesnick, 2019**[8] | Moderate risk | Low risk | Moderate risk | Low risk | Low risk | Low risk |

Abbreviation: ROB = risk of bias

**Table F.1.2. Risk of Bias for Cognitive-Behavioral Therapy (CBT): Comparative Observational Studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome Not Present Before the Exposure | Comparability Between Groups | Outcome Data Source | Independent Blind Assessment of Outcome | Loss During Followup |
|---|---|---|---|---|---|---|---|---|
| **Zullo, 2021**[9] | High risk | High risk | Low risk | High risk | Moderate risk | Low risk | High risk | Low risk |
| **Vitiello, 2009**[10] | High risk | High risk | Low risk | High risk | Moderate risk | Low risk | Low risk | High risk |

Abbreviation: ROB = risk of bias

**Table F.1.3. Risk of Bias for Cognitive-Behavioral Therapy (CBT): Before–After Studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome Not Present Before the Exposure | Alternative Causes for Outcomes | Adequate Length of Followup |
|---|---|---|---|---|---|---|
| **Kennard, 2018**[11] | High risk | Low risk | Low risk | High risk | High risk | Low risk |
| **Duarté-Vélez, 2016**[12] | High risk | High risk | Low risk | High risk | High risk | Low risk |
| **Silverstone, 2015**[55] | High risk | Low risk | Low risk | High risk | High risk | High risk |

Abbreviation: ROB = risk of bias

**Table F.2.1. Risk of Bias for Dialectical Behavior Therapy (DBT): Randomized Clinical Trials**

| Author, Year | Overall ROB | ROB From Randomization Process | ROB due to Deviations From Intended Interventions | ROB due to Missing Outcome Data | ROB in Measurement of Outcomes | ROB in Selection of the Reported Results |
|---|---|---|---|---|---|---|
| **McCauley, 2018**[13] | Moderate risk | Low risk | Moderate risk | Low risk | Low risk | Low risk |
| **Pistorello, 2012**[14] | Moderate risk | Low risk | Moderate risk | Low risk | Low risk | Low risk |

Abbreviation: ROB = risk of bias

**Table F.2.2. Risk of Bias for Dialectical Behavior Therapy (DBT): Comparative Observational Studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome not Present Before the Exposure | Comparability Between Groups | Outcome Data Source | Independent Blind Assessment of Outcome | Loss During Followup |
|---|---|---|---|---|---|---|---|---|
| **Tebbett-Mock, 2020**[16] | High risk | High risk | Low risk | High risk | Moderate risk | Low risk | High risk | Low risk |
| **Katz, 2004**[17] | High risk | Low risk | Low risk | Low risk | High risk | Low risk | High risk | High risk |
| **Rathus, 2002**[18] | High risk | High risk | Low risk | High risk | High risk | Low risk | High risk | High risk |
| **Swart, 2014**[15] | High risk | High risk | Low risk | Low risk | Moderate risk | Low risk | High risk | High risk |
| **Sunseri, 2004**[19] | High risk | Low risk | Low risk | High risk | High risk | Low risk | High risk | Low risk |

Abbreviation: ROB = risk of bias

**Table F.2.3. Risk of Bias for Dialectical Behavior Therapy (DBT): Before–After Studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome not Present Before the Exposure | Alternative Causes for Outcomes | Adequate Length of Followup |
|---|---|---|---|---|---|---|
| **Darrow, 2022**[20] | High risk | Low risk | Low risk | Low risk | High risk | Low risk |
| **Cloutier, 2022**[21] | High risk | High risk | Low risk | Low risk | High risk | High risk |
| **Berk, 2020**[22] | High risk | Low risk | Low risk | Low risk | High risk | Low risk |
| **Courtney, 2015**[23] | High risk | Low risk | Low risk | High risk | High risk | High risk |

Abbreviation: ROB = risk of bias

**Table F.3.1. Risk of Bias for Attachment-Based Family Therapy (ABFT): Randomized Clinical Trials**

| Author, Year | Overall ROB | ROB from Randomization Process | ROB due to Deviations From Intended Interventions | ROB due to Missing Outcome Data | ROB in Measurement of Outcomes | ROB in Selection of the Reported Results |
|---|---|---|---|---|---|---|
| **Diamond, 2019**[24] | High risk | Low risk | Moderate risk | High risk | Low risk | Low risk |
| **Diamond, 2010**[25] | High risk | Low risk | Moderate risk | Low risk | High risk | Low risk |

Abbreviation: ROB = risk of bias

**Table F.3.2. Risk of Bias for Attachment-Based Family Therapy (ABFT): Before–After Studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome not Present Before the Exposure | Alternative Causes for Outcomes | Adequate Length of Followup |
|---|---|---|---|---|---|---|
| **Russon, 2021**[26] | High risk | High risk | Low risk | High risk | High risk | High risk |
| **Diamond, 2012**[27] | High risk | High risk | Low risk | Low risk | High risk | High risk |

Abbreviation: ROB = risk of bias

**Table F.4.1. Risk of Bias for Family-Focused Therapy (FFT): Randomized Clinical Trials**

| Author, Year | Overall ROB | ROB from Randomization Process | ROB due to Deviations From Intended Interventions | ROB due to Missing Outcome Data | ROB in Measurement of Outcomes | ROB in Selection of the Reported Results |
|---|---|---|---|---|---|---|
| **Miklowitza, 2020[28]** | High risk | Moderate risk | High risk | High risk | Low risk | Moderate risk |

Abbreviation: ROB = risk of bias

**Table F.5.1. Risk of Bias for Collaborative Assessment and Management of Suicidality (CAMS): Randomized Clinical Trials**

| Author, Year | Overall ROB | ROB from Randomization Process | ROB due to Deviations From Intended Interventions | ROB due to Missing Outcome Data | ROB in Measurement of Outcomes | ROB in Selection of the Reported Results |
|---|---|---|---|---|---|---|
| **Pistorello, 2021**[29] | Moderate risk | Moderate risk | Moderate risk | Low risk | Low risk | Moderate risk |

Abbreviation: ROB = risk of bias

**Table F.5.2. Risk of Bias for Collaborative Assessment and Management of Suicidality (CAMS): Before–After Studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome not Present Before the Exposure | Alternative Causes for Outcomes | Adequate Length of Followup |
|---|---|---|---|---|---|---|
| **Adrian, 2023**[30] | High risk | Moderate risk | Low risk | High risk | High risk | High risk |
| **Adrian, 2021**[31] | High risk | Low risk | Low risk | High risk | High risk | Low risk |

Abbreviation: ROB = risk of bias

**Table F.6.1. Risk of Bias for Crisis Management: Randomized Clinical Trials**

| Author, Year | Overall ROB | ROB from Randomization Process | ROB due to Deviations From Intended Interventions | ROB due to Missing Outcome Data | ROB in Measurement of Outcomes | ROB in Selection of the Reported Results |
|---|---|---|---|---|---|---|
| **Wharff, 2019**[32] | Moderate risk | Moderate risk | Moderate risk | Moderate risk | Low risk | Low risk |
| **Asarnow, 2011**[33] | Moderate risk | Low risk | Moderate risk | Low risk | Low risk | Low risk |

Abbreviation: ROB = risk of bias

**Table F.6.2. Risk of Bias for Crisis Management: Comparative Observational Studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome not Present Before the Exposure | Comparability Between Groups | Outcome Data Source | Independent Blind Assessment of Outcome | Loss during Followup |
|---|---|---|---|---|---|---|---|---|
| **Wharff, 2012**[34] | High risk | Low risk | Low risk | High risk | High risk | Low risk | High risk | High risk |
| **Rotheram-Borus, 2000**[35] | High risk | High risk | Low risk | Low risk | Moderate risk | Low risk | High risk | Low risk |

Abbreviation: ROB = risk of bias

**Table F.7.1. Risk of Bias for Motivation Interviewing: Randomized Clinical Trials**

| Author, Year | Overall ROB | ROB from Randomization Process | ROB due to Deviations from Intended Interventions | ROB due to Missing Outcome Data | ROB in Measurement of Outcomes | ROB in Selection of the Reported Results |
|---|---|---|---|---|---|---|
| **Grupp-Phelan, 2019**[36] | Moderate risk | Low risk | Moderate risk | Low risk | Low risk | Low risk |
| **O'Brien, 2018**[37] | Moderate risk | Low risk | Moderate risk | Moderate risk | Low risk | Moderate risk |
| **King, 2015**[38] | Moderate risk | Low risk | Moderate risk | Low risk | Low risk | Low risk |

Abbreviation: ROB = risk of bias

**Table F.8.1. Risk of Bias for Safety Planning: Randomized Clinical Trials**

| Author, Year | Overall ROB | ROB from Randomization Process | ROB due to Deviations From Intended Interventions | ROB due to Missing Outcome Data | ROB in Measurement of Outcomes | ROB in Selection of the Reported Results |
|---|---|---|---|---|---|---|
| **Czyz, 2019**[39] | Moderate risk | Moderate risk | Moderate risk | Moderate risk | Low risk | Moderate risk |
| **Kennard, 2018**[40] | Moderate risk | Moderate risk | Moderate risk | Low risk | Low risk | Low risk |

Abbreviation: ROB = risk of bias

**Table F.9.1. Risk of Bias for Continuity of Care: Randomized Clinical Trials**

| Author, Year | Overall ROB | ROB from Randomization Process | ROB due to Deviations From Intended Interventions | ROB due to Missing Outcome Data | ROB in Measurement of Outcomes | ROB in Selection of the Reported Results |
|---|---|---|---|---|---|---|
| **Czyz, 2021[41]** | High risk | Low risk | Moderate risk | High risk | Low risk | Moderate risk |
| **Rengasamy, 2019[42]** | High risk | High risk | Moderate risk | Low risk | Low risk | Moderate risk |

Abbreviation: ROB = risk of bias

**Table F.9.2. Risk of Bias for Continuity of Care: Comparative Observational Studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome not Present Before the Exposure | Comparability Between Groups | Outcome Data Source | Independent Blind Assessment of Outcome | Loss During Followup |
|---|---|---|---|---|---|---|---|---|
| **Greenfield, 2002[43]** | High risk | Low risk | Low risk | High risk | Low risk | Low risk | High risk | Low risk |

Abbreviation: ROB = risk of bias

**Table F.10.1. Risk of Bias for Brief Adjunctive Treatments: Randomized Clinical Trials**

| Author, Year | Overall ROB | ROB from Randomization Process | ROB due to Deviations From Intended Interventions | ROB due to Missing Outcome Data | ROB in Measurement of Outcomes | ROB in Selection of the Reported Results |
|---|---|---|---|---|---|---|
| **Dobias, 2021**[44] | Moderate risk | Low risk | Moderate risk | Low risk | Low risk | Low risk |
| **Fitzpatrick, 2005**[45] | Moderate risk | Low risk | Moderate risk | Low risk | Low risk | Low risk |
| **Yen, 2020**[46] | High risk | Moderate risk | High risk | Moderate risk | Low risk | Moderate risk |

Abbreviation: ROB = risk of bias

**Table F.10.2. Risk of Bias for Brief Adjunctive Treatments: Comparative Observational Studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome not Present Before the Exposure | Comparability Between Groups | Outcome Data Source | Independent Blind Assessment of Outcome | Loss During Followup |
|---|---|---|---|---|---|---|---|---|
| **Ahmadi, 2022**[47] | High risk | High risk | Low risk | High risk | Moderate risk | Low risk | High risk | High risk |

Abbreviation: ROB = risk of bias

**Table F.10.3. Risk of Bias for Brief Adjunctive Treatments: Before–After Studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome not Present Before the Exposure | Alternative Causes for Outcomes | Adequate Length of Followup |
|---|---|---|---|---|---|---|
| **Yen, 2019**[48] | High risk | High risk | Low risk | High risk | High risk | Low risk |
| **Hill, 2023**[49] | High risk | Low risk | Low risk | High risk | High risk | High risk |

Abbreviation: ROB = risk of bias

**Table F.11.1. Risk of Bias for Social Network Interventions: Randomized Clinical Trials**

| Author, Year | Overall ROB | ROB from Randomization Process | ROB due to Deviations From Intended Interventions | ROB due to Missing Outcome Data | ROB in Measurement of Outcomes | ROB in Selection of the Reported Results |
|---|---|---|---|---|---|---|
| **King, 2019**[50, 51] | Moderate risk | Low risk | Moderate risk | Moderate risk | Low risk | Low risk |
| **King, 2006**[52] | High risk | Low risk | Moderate risk | Moderate risk | High risk | Low risk |

Abbreviation: ROB = risk of bias

**Table F.12.1. Risk of Bias for School-based Skills Interventions: Randomized Clinical Trials**

| Author, Year | Overall ROB | ROB from Randomization Process | ROB due to Deviations From Intended Interventions | ROB due to Missing Outcome Data | ROB in Measurement of Outcomes | ROB in Selection of the Reported Results |
|---|---|---|---|---|---|---|
| **Robinson, 2024**[53] | High risk | Moderate risk | Moderate risk | Low risk | High risk | Moderate risk |
| **Randell, 2001**[54] | High risk | Moderate risk | High risk | Low risk | Low risk | Moderate risk |

Abbreviation: ROB = risk of bias

**Table F.12.2. Risk of Bias for School-based Skills Interventions: Before–After studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome not Present Before the Exposure | Alternative Causes for Outcomes | Adequate Length of Followup |
|---|---|---|---|---|---|---|
| **Silverstone, 2015**[55] | High risk | Low risk | Low risk | High risk | High risk | High risk |

Abbreviation: ROB = risk of bias

**Table F.13.1. Risk of Bias for Suicide Awareness/Gatekeeper Programs: Randomized Clinical Trials**

| Author, Year | Overall ROB | ROB from Randomization Process | ROB due to Deviations From Intended Interventions | ROB due to Missing Outcome Data | ROB in Measurement of Outcomes | ROB in Selection of the Reported Results |
|---|---|---|---|---|---|---|
| **Aseltine, 2004**[56] | Moderate risk | Low risk | Moderate risk | Low risk | Low risk | Low risk |

Abbreviation: ROB = risk of bias

**Table F.13.2. Risk of Bias for Suicide Awareness/Gatekeeper Programs: Before–After Studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome not Present Before the Exposure | Alternative Causes for Outcomes | Adequate Length of Followup |
|---|---|---|---|---|---|---|
| **Hermosillo-de-la-Torre, 2023**[57] | High risk | High risk | Low risk | High risk | High risk | Low risk |
| **Sale, 2022**[58] | High risk | High risk | Low risk | High risk | High risk | Low risk |
| **Rivero, 2014**[59] | High risk | High risk | Low risk | High risk | High risk | High risk |

Abbreviation: ROB = risk of bias

**Table F.14.1. Risk of Bias for Community-based, Culturally Tailored Adjunct Programs: Comparative Observational Studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome not Present Before the Exposure | Comparability Between Groups | Outcome Data Source | Independent Blind Assessment of Outcome | Loss during Followup |
|---|---|---|---|---|---|---|---|---|
| **Allen, 2018[60]** | High risk | High risk | Low risk | Low risk | Moderate risk | Low risk | High risk | Low risk |

Abbreviation: ROB = risk of bias

**Table F.14.2. Risk of Bias for Community-based, Culturally Tailored Adjunct Programs: Before–After Studies**

| Author, Year | Overall ROB | Representativeness of Study Cohort | Ascertainment of Exposure | Outcome not Present Before the Exposure | Alternative Causes for Outcomes | Adequate Length of Followup |
|---|---|---|---|---|---|---|
| **Humensky, 2017[61]** | High risk | High risk | Low risk | High risk | High risk | Low risk |
| **Cwik, 2016[62]** | High risk | Low risk | Low risk | High risk | High risk | High risk |

Abbreviation: ROB = risk of bias

# Appendix G. References


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