# Peer Review File

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**Reviewer A**

**Comment 1:**

"A qualitative study of provider feedback on the feasibility and acceptability of virtual patient simulations for suicide prevention training" presents findings of a qualitative study in which feedback on a virtual suicide simulation tool was provided by stakeholders. This is an important area of inquiry, and ensuring that such a training option would fit the context of end users is key to eventual implementation. However, several weaknesses outlined below dampen enthusiasm for this manuscript. Overall, it is unclear how these findings fit into the overall literature on virtual simulation training and/or implementing such trainings, beyond the specific project outlined.

1. Line 135: Authors stated that they recruited to "achieve optimal group size (13),"- please provide what that optimal sample size was, and whether or not it was achieved.

**Reply 1:** Best practices in focus group research indicate that groups can range in size from as small as three to as many as fourteen. Size is determined by logistical considerations, existing acquaintance between participants, and the breadth of the topic being discussed. Smaller groups can have more limited, but more in-depth discussion, while larger groups benefit from broader perspective. For the purposes of our study, we opted for 13 leaders from diverse sectors.

**Changes in the text:** We added the above statement to original line 138 and replaced reference #13 with a more specific reference.

**Comment 2:**

2. It is unclear throughout the manuscript if the training was used by any of the stakeholders or members of stakeholders' institutions. For example, authors note "felt students were more confident" on line 179.

**Reply 2:** All stakeholders in the group used the VPS on their own, prior to participating in the focus group. They were invited to view the VPS for one hour. One participant had implemented the VPS at their place of work already and spoke from this perspective in the focus group.

**Changes in the text:** We added the above statement to original line 146.

**Comment 3:**

3. Line 195: Authors use the phrase "well-rounded:" Was this language used by the participants? If not, and this is the authors' phrasing, there is a need for specificity (i.e., what makes it well-rounded).

**Reply 3:** The term "well rounded" was our term for describing the breadth of the training. We deleted this term from the manuscript, as it is not based in participant phrasing.
**Changes in the text:** We deleted the term from original line 195.

**Comment 4:**

4. Line 219: Did focus group members describe any such issues regarding race/ethnicity in the program?

**Reply 4:** One participant noted there was a disconnect between a black actor discussing difficult content and a white actor in the corner of the screen smiling and giving a thumbs up.
**Changes in the text:** We added the above statement to original line 223.

**Comment 5:**

5. Line 227: Authors report the suggestion "Address issues of assessment up front." Please provide more information on what this means, as it was unclear to this reviewer.

**Reply 5:** Part of the VPS training program includes an assessment of performance. Participants suggested that the program should begin by clearly explaining to trainees what the assessment means including how it is conducted and scored, and by describing the program's general relative degree of difficulty, so that participants can avoid frustration and achieve optimal clinical growth by understanding the process from the outset.
**Changes in the text:** We edited to include the above statement starting on original line 227.

**Comment 6:**

6. Line 235: Unclear if VPS involves a crisis center set up by the institutions that would use the training. How is this different from national suicide hotlines?

**Reply 6:** The VPS system trains providers within existing institution structures to complete suicide prevention protocols with patients who screen positive for suicide. The VPS system does not encourage or require institutions to create or set up crisis centers or hotlines.
**Changes in the text:** We changed original line 235 to read, "*Cost.* When running a health care facility, crisis call center, or other 24-hour care system, agency leaders must cover patient time plus the cost of training."

**Comment 7:**

7. A weakness is also the types of individuals queried, as there was a lack of front line providers and other who would be the target end users of the program. This

may need to be discussed in the limitations section.

**Reply 7:** We have added this issue to the limitations section.

**Changes in the text:** We added to original line 289, "Another limitation is the lack of front-line providers and other who would be the target end users of the program."

**Reviewer B**

**Comment 8:**

This is a fairly straightforward description of a qualitative study regarding the potential usefulness of a simulation training for suicide risk assessments that was developed by the authors and could potentially become a commercial product. The disclosures about this potential conflict of interest are clear, so thank you for being transparent about that. I am not a qualitative researcher and therefore will not have much to say about the findings and their interpretation per se, but some other comments about the manuscript are:

- it would be helpful to clarify what the clinical backgrounds of the participants were. We know their current job titles, but it would be helpful to know also what their clinical experiences have been so that we know which kinds if disciplines and experience were represented.

**Reply 8:** The disciplines represented by the participants included social work, clinical psychology, psychiatry, and care management. Many are experts in their field and have ten or more years of practice experience. Several are involved with national suicide prevention organizations and have expertise in suicide prevention training and workflows.

**Changes in the text:** We have added this description to original line 142.

**Comment 9:**

- an important omission from this is that many (not all) institutions are being held to a specific standard for how they conduct suicide risk assessments by The Joint Commission. any organization that is accredited as a hospital system must now follow specific procedures for conducting suicide risk assessments, and although there is some flexibility for how this is being done, many are now using the C-SSRS (for adults) and the ASQ (for adolescents), often in combination with some version of the SAFE-T. Several (free) online trainings already exist for these resources, although that is not the same as providing simulation. The authors should acknowledge this and respond to the following:

1. Is this simulation training compatible with TJC's requirements?
2. Does it encourage the use of these other tools?
3. Would organizations that are relying on this training be prepared to meet TJC requirements (similar to #1 but slightly different)

Even if organizations are not yet held to TJC requirements, there is an increasing trend toward the use of these protocols, so it is important to acknowledge this and ideally ensure that training is compatible.

**Reply 9:** Regarding point 1, In 2019, The Joint Commission (TJC) released an updated National Patient Safety Goal (NPSG) 15.01.01. The NPSG was designed to improve the quality and safety of care for individuals being treated for behavioral health conditions and those who are identified as high risk for suicide. The NPSG addresses screening, risk assessment, and plans to mitigate risk, including policies and procedures to improve compliance with these practices. Regarding point 2, The simulated training picks up after an individual has screened positive for suicide by providing the skills and practice to do a thorough risk assessment and risk mitigation practices. The training does not explicitly name any tool for clinicians to use but the training is based on the C-SSRS. Regarding point 3, This simulation is compatible with TJC requirements. It offers health care providers a chance to gain confidence in risk assessment and best practices associated with mitigation of suicide risk. Organizations that use this training would be equipping their teams with the skills to meet these standards.

**Changes in the text:** We have addressed this by adding the following statement to original line 118: "In 2019, The Joint Commission (TJC) released an updated National Patient Safety Goal (NPSG) 15.01.01 which was designed to improve the quality and safety of care for individuals being treated for behavioral health conditions and those who are identified as high risk for suicide. The NPSG addresses screening, risk assessment, and plans to mitigate risk, including policies and procedures to improve compliance with these practices. The VPS training in this study picks up after an individual has screened positive for suicide by providing the skills and practice to do a thorough risk assessment and risk mitigation practices. The training does not explicitly name any tool for clinicians to use but the training is based on the Columbia Suicide Severity Rating Scale. As such, the VPS training in this study is compatible with TJC requirements and offers health care providers a chance to gain confidence in risk assessment and best practices associated with mitigation of suicide risk. Organizations that use this training would be equipping their teams with the skills to meet these standards."

**Comment 10:**

- finally, on p10, line 281--the manuscript discusses how an investment in suicide training can reduce costs by reducing suicide death and liability. This is still hypothetical when it comes to this particular product, unless you have a manuscript showing that the use of this training program actually improves suicide-related outcomes. So I would be much more careful about this claim and keep claims about cost-effectiveness limited to a comparison with traditional training rather than outcomes.

**Reply 10:** We have modified the manuscript to reflect this and further point to the importance of research on the impact of such training on suicide-related outcomes.
**Changes in the text:** We have added the following statement to original line 285: "Therefore, an investment in training for staff is likely to improve quality of care and outcomes for patients. However, research on the impact of training on suicide-related outcomes is needed to make this determination."

**Reviewer C**

**Comment 11:**
Aside from a missing period on page 9 line 266. Overall, I think the article is well written, concise, and provides an interesting contribution to the overall literature.
**Reply 11:** Period has been added.
**Changes in the text:** We have added a period to original line 266.