APPENDIX A. DATA COLLECTION FORMS
Article ID:_______

Reviewer: 

Date: 

Population (check all that apply)

- Men
- Women
- Veterans
- Military

Age (complete all that are reported)

Mean: _____________
Median: ___________
Range: ____________

Setting (check all)

- Primary Care
- Hospital
- Psychiatric
- Population Based
- Other
- Not stated / Not reported / Not applicable

Country (check one)

- US
- UK/New Zealand/Canada/Australia
- Other

Interventions (check all that apply)

- Physician
- Patient
- Population Based
- Organizational
- Not stated / Not reported / Not applicable

Outcome (check all)

- Attempters
- Completers
- SI

Design (check one)

- Experimental
- Observational

Intervention Codes

References to Retrieve: _____ _____ _____ _____

Study Design: _____________
VA-ESP Suicide Prevention
Detail Intervention & Quality Review Form

Article ID
Reviewer: Steven Bagley Assigned on:

1. Was the study:
   (Check all that apply)
   - Outpatient
   - Inpatient
   - Emergency Dept/ Crisis Services
   - Not reported/Not applicable

2. What was the sample size: (NR for not reported)

<table>
<thead>
<tr>
<th>F/Up Duration</th>
<th>Units</th>
<th>Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>F/Up 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F/Up 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F/Up 2</td>
<td></td>
<td></td>
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<tr>
<td>F/Up 3</td>
<td></td>
<td></td>
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<tr>
<td>F/Up 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Eligibility Criteria

4. The intervention consisted of:

Quality Measurement (only interventions)

1. Was the study described as randomized?
   - Yes
   - No
   - Don’t know

2. Treatment Allocation
   a. Was a method of randomization performed?
      - Yes
      - No
      - Don’t know
   b. Was the treatment allocation concealed?
      - Yes
      - No
      - Don’t know

3. Were the groups similar at baseline regarding the most important prognostic indicators?
   - Yes
   - No
   - Don’t know

4. Were the eligibility criteria specified?
   - Yes
   - No
   - Don’t know

5. Was the outcome assessor blinded?
   - Yes
   - No
   - Don’t know

6. Was the care provider blinded?
   - Yes
   - No
   - Don’t know

7. Were subjects blinded?
   - Yes
   - No
   - Don’t know

8. Were point estimates and measures of variability presented for the primary outcome measures?
   - Yes
   - No
   - Don’t know

9. Were all randomized participants analyzed in the group to which they were allocated?
   - Yes
   - No
   - Don’t know

10. Were co-interventions avoided or similar?
    - Yes
    - No
    - Don’t know

11. Was the compliance acceptable in all groups?
    - Yes
    - No
    - Don’t know

12. Was the drop-out rate described and acceptable?
    - Yes
    - No
    - Don’t know

13. Was the timing of the outcome assessment in all groups similar?
    - Yes
    - No
    - Don’t know
APPENDIX B. EXCLUDED STUDIES

EXCLUDED AFTER INITIAL REVIEW

No Intervention


Foreign Language


Duplicate Data


Review or Meta-analysis


Lester, D. The effectiveness of suicide prevention centers: a review. Suicide Life Threat Behav. 1997 Fall; 27(3):304-10.


No Outcome of Interest or Usable Outcome


Bateman, D. N.; Bain, M.; Gorman, D., and Murphy, D. Changes in paracetamol, antidepressants and opioid poisoning in Scotland during the 1990s. QJM. 2003 Feb; 96(2):125-32.


Sheen, C. and Dillon, J. The effect on toxicity and healthcare costs on reducing the size of available acetaminophen pack sizes in the Tayside region of Scotland. Gastroenterology. 2001; 120(Suppl. 1):A-228.


Stuart, H. Fighting stigma and discrimination is fighting for mental health. Canadian Public Policy. 2005; S21-S28.


**adolescent**

Design- Other


EXCLUDED AT FURTHER REVIEW (N=49)

Country


Bradvik, L. and Berglund, M. Long-term treatment and suicidal behavior in severe depression: ECT and antidepressant pharmacotherapy may have different effects on the occurrence and seriousness of suicide attempts. Depress Anxiety. 2006; 23(1):34-41.


Pharmacotherapy


Psychotherapy


Bradvik, L. and Berglund, M. Long-term treatment and suicidal behavior in severe depression: ECT and antidepressant pharmacotherapy may have different effects on the occurrence and seriousness of suicide attempts. Depress Anxiety. 2006; 23(1):34-41.


**Suicidal Ideation**


### Evidence Table 1. Studies Describing Suicide Prevention Interventions in Military Personnel and Veterans

<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Study Design</th>
<th>Country / Setting</th>
<th>Veteran / Military</th>
<th>Outcome</th>
<th>Intervention</th>
<th>Detailed Intervention</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>James LC et al 1996</td>
<td>Cohort</td>
<td>US / Population &amp; Other</td>
<td>No / Yes</td>
<td>Completers</td>
<td>Population / Organizational</td>
<td>25th Infantry Division (Light) Suicide Prevention Program implementation beginning in 1992. This program incorporated warning signs and risk factors along with community education.</td>
<td>In the two years following complete implementation (1994) the suicide rate decreased to 3.</td>
</tr>
<tr>
<td>McDaniel WW et al. 1990</td>
<td>Cohort</td>
<td>US / Other</td>
<td>No / Yes</td>
<td>Attempters &amp; SI</td>
<td>Organizational</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knox KL et al. 2003</td>
<td>Interrupted Time Series</td>
<td>US / Population</td>
<td>No / Yes</td>
<td>Completers</td>
<td>Population / Organizational</td>
<td>To assess the impact of the US Air Force suicide prevention program implemented in 1996, this study looked at 5,260,292 air force personnel. The program aimed to reduce risk factors for suicide and enhance protective factors as well as increasing understanding of mental health and policies while decreasing the stigma of seeking mental health assistance.</td>
<td>The relative risk for suicide when comparing the pre-implementation population and post-implementation population was 0.67 (95% CI: 0.57, 0.80). There was a 33% relative risk reduction for those in the post implementation group.</td>
</tr>
<tr>
<td>Jones DE et al. 2001</td>
<td>Observational</td>
<td>US / Population</td>
<td>No / Yes</td>
<td>Completers</td>
<td>Population</td>
<td>Existing resources (education in suicide awareness and life skills training, counseling, post-suicide interventions, and suicide incident reporting) were augmented with new training video using positive role models to increase detection and referral.</td>
<td>For Navy, suicide rate dropped to 9.2/100000, the lowest rate in 10 years. For the Marine Corps, the rate was 15.6/100000.</td>
</tr>
<tr>
<td>Kennedy CH et al. 2005</td>
<td>Cohort</td>
<td>US / Other</td>
<td>No / Yes</td>
<td>Attempters</td>
<td>Patient</td>
<td>This is a one year follow up on a gambling treatment program implemented in January 2003 as a part of the Substance Abuse Rehabilitation Program at the US Naval Hospital in Okinawa, Japan. There was 35 participants.</td>
<td>Prior to treatment participants expressed suicidal ideation and 3 (8.5%) made suicide attempts related to their gambling. Post-implementation, no participants expressed suicidal ideation or attempted suicide.</td>
</tr>
<tr>
<td>Rozanov VA et al. 2002</td>
<td>Cohort</td>
<td>Ukraine / Population</td>
<td>No / Yes</td>
<td>Completers</td>
<td>Population / Organizational</td>
<td>This two year suicide prevention program, implemented in 2000, used training seminars for soldiers, professional officers, and commanders that spanned the course of one year. Brochures on suicide prevention were distributed to more than 2000 soldiers.</td>
<td>The average number of suicides per year between 1998 and 1999 was 32.6 per 100,000. In 1999 the suicide rate was 74.7 per 100,000. During the first year of the program there was no reported suicides and in the 2nd year there were 16.7 per 100,000 reported suicides.</td>
</tr>
<tr>
<td>Gordana DJ et al. 2007</td>
<td>Cohort</td>
<td>Serbia &amp; Montenegro / Other</td>
<td>No / Yes</td>
<td>Completers</td>
<td>Organizational</td>
<td>Two year follow up on a Suicide Prevention Program, based on the U.S. Air Force suicide prevention program, that was implemented in 2003. The program focused on early prevention and identification of those at increased risk of committing suicide. The long-term objective was modifying military-specific risk factors for suicide. The program was applied by selection, education, and motivation.</td>
<td>Suicides decreased from 15 in 2003 (pre-implementation) to 9 in 2004 and 7 in 2005. After one year of implementation, suicides decreased from 13 per 100,000 of military personnel to 5 per 100,000 military personnel.</td>
</tr>
<tr>
<td>Koons CR et al. 2001</td>
<td>RCT</td>
<td>UC / Psychiatric</td>
<td>Yes / No</td>
<td>Attempters &amp; SI</td>
<td>Patient</td>
<td>Dialectical behavior therapy (DBT) in with borderline personality disorder. 28 women veterans were randomized to DBT or usual care groups. 20 patients (10 in each group) completed the treatment.</td>
<td>Patients in the DBT reported significantly greater decrease in depression (as measured by the BDI), suicidal ideation, and hopelessness than usual care patients.</td>
</tr>
<tr>
<td>Gibbons RD et al. 2007</td>
<td>Observational</td>
<td>US / Primary Care &amp; Psychiatric</td>
<td>Yes / No</td>
<td>Attempters</td>
<td>Patient</td>
<td>Comparison of 226,866 patients in a VHA data set who were diagnosed with depression and had one of the following treatments: no antidepressant, SSRI, non-SSRI, tricylic or combinations.</td>
<td>Odds ratio for comparing the SSRI treatment to the no antidepressant, non-SSRI and tricyclic categories was 0.34 (95% CI: 0.31 to 0.38, p&lt;0.0001).</td>
</tr>
<tr>
<td>IJgen MA et al. 2007</td>
<td>Observational</td>
<td>US / Psychiatric</td>
<td>Yes / No</td>
<td>Attempters</td>
<td>Patient</td>
<td>This study followed 3733 veterans entering either a residential or outpatient substance abuse program. Data on suicide attempts were collected for 12 months prior to entry, during treatment and 12 months after entry.</td>
<td>During treatment, residential treatment was associated with a lower rate of suicide attempts than outpatient treatment. Predicting suicide attempts after drug abuse treatment was not significant for either setting.</td>
</tr>
<tr>
<td>Author, Year</td>
<td>Study Design / Setting</td>
<td>Sample Size Enrolled</td>
<td>Follow Up Time Points / Follow Up</td>
<td>Veterans / Military</td>
<td>Country / Mean Age</td>
<td>Eligibility Criteria</td>
<td>Quality Measurements</td>
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<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Koons CJ et al. 2001</td>
<td>RCT / Psychiatric</td>
<td>28</td>
<td>3 mths / NR 6 mths / 20</td>
<td>Yes / No</td>
<td>US / 35</td>
<td>Female veterans with borderline personality disorder</td>
<td>Described as Randomized</td>
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<td></td>
<td>Eligibility Criteria Specified</td>
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<td>Outcome Assessor Blinded</td>
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<td>Randomized patients analyzed in group they were allocated to</td>
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<td>Drop-out rate described</td>
</tr>
<tr>
<td>Welu T 1977</td>
<td>RCT / Psychiatric</td>
<td>120</td>
<td>4 mths / 119</td>
<td>No / No</td>
<td>US / 29</td>
<td>ED contact for suicide attempt</td>
<td>Similarity at Baseline between groups</td>
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<tr>
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<td></td>
<td>Patients Blinded</td>
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<td></td>
<td>Timing of Outcome Assessment Similar</td>
</tr>
<tr>
<td>Termansen PE et al. 1975</td>
<td>CCT / Psychiatric</td>
<td>202</td>
<td>3 mths / 128</td>
<td>No / No</td>
<td>Canada / NR</td>
<td>ER presentation for suicide attempt</td>
<td>Similarity at Baseline between groups</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Patients Blinded</td>
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<td></td>
<td></td>
<td>Timing of Outcome Assessment Similar</td>
</tr>
<tr>
<td>Allard R et al. 1992</td>
<td>RCT / Psychiatric</td>
<td>150</td>
<td>12 mths/ NR 18 mths/ NR 24 mths / 126</td>
<td>No / No</td>
<td>Canada / NR</td>
<td>Seen in ED after suicide attempt</td>
<td>Similarity at Baseline between groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>Patients Blinded</td>
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<td></td>
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<td></td>
<td></td>
<td>Timing of Outcome Assessment Similar</td>
</tr>
</tbody>
</table>

Evidence Table 2. RCT and CCTs Describing Suicide Interventions
<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Study Design / Setting</th>
<th>Sample Size Enrolled</th>
<th>Follow Up Time Points / Follow Up</th>
<th>Veterans / Military</th>
<th>Country / Mean Age</th>
<th>Eligibility Criteria</th>
<th>Quality Measurements</th>
<th>Interventions</th>
<th>Duration of Treatment</th>
<th>Outcome</th>
<th>Adverse Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chowdhury N et al. 1973(^2)</td>
<td>CCT / Psychiatric</td>
<td>155</td>
<td>6 mths/ NR</td>
<td>No / No</td>
<td>UK / NR</td>
<td>Hospital contact for deliberate self harm for repeat patients</td>
<td>Described as Randomized: No, Eligibility Criteria Specified: No, Outcome Assessor Blinded: Don't Know, Randomized patients: Don't Know, Similarity at Baseline between groups: No, Patients Blinded: Yes.</td>
<td>Attempters</td>
<td>6 months from discharge</td>
<td>Attempters</td>
<td>24% acts of parasuicide in treatment &amp; 23% in control</td>
</tr>
<tr>
<td>Gardner R et al. 1977(^2)</td>
<td>RCT / Hospital</td>
<td>312</td>
<td>1 yr / 273</td>
<td>No / No</td>
<td>UK / NR</td>
<td>Patient admitted to hospital for self poisoning</td>
<td>Described as Randomized: Don't Know, Eligibility Criteria Specified: No, Outcome Assessor Blinded: Yes, Randomized patients: No, Similarity at Baseline between groups: Yes, Patients Blinded: Yes.</td>
<td>Inpatient assessment by medical vs. psychiatric team</td>
<td>Not reported. Assessment during following year.</td>
<td>Attempters &amp; Completers</td>
<td>10% repeat attempts for medical team, 13% repeat attempts for psychiatrist. 0% suicide for medical team, 0.4% for psychiatrist.</td>
</tr>
<tr>
<td>Gibbons JS et al. 1978(^2)</td>
<td>RCT / Psychiatric &amp; Other</td>
<td>400</td>
<td>1 yr / 400</td>
<td>No / No</td>
<td>UK / NR</td>
<td>ED contact for deliberate self poisoning, not requiring immediate psychiatric treatment</td>
<td>Described as Randomized: Don't Know, Eligibility Criteria Specified: No, Outcome Assessor Blinded: Yes, Randomized patients: No, Similarity at Baseline between groups: Yes, Patients Blinded: Yes.</td>
<td>Social worker to assist with task oriented problem solving</td>
<td>Not reported. Assessment at one year.</td>
<td>Attempters</td>
<td>13.5 repeated self poisoning in treatment group &amp; 14.5 in control</td>
</tr>
<tr>
<td>Hawton K et al. 1981(^2)</td>
<td>RCT / Psychiatric</td>
<td>96</td>
<td>1 yr / 96</td>
<td>No / No</td>
<td>UK / 25.2</td>
<td>Hospitalization for deliberate self poisoning</td>
<td>Described as Randomized: Yes, Eligibility Criteria Specified: Yes, Outcome Assessor Blinded: Yes, Randomized patients: Yes, Similarity at Baseline between groups: Yes, Patients Blinded: Yes.</td>
<td>Maximum of 3 months, 1st 2 as frequent as needed</td>
<td>Outpatient vs. home based therapy</td>
<td>Attempters &amp; SI</td>
<td>10% repeated attempts in home-based, 15% in outpatients</td>
</tr>
<tr>
<td>Author, Year</td>
<td>Study Design / Setting</td>
<td>Sample Size Enrolled</td>
<td>Follow Up Time Points / Follow Up</td>
<td>Veterans / Military</td>
<td>Country / Mean Age</td>
<td>Eligibility Criteria</td>
<td>Quality Measurements</td>
<td>Intervention</td>
<td>Duration of Treatment</td>
<td>Outcome</td>
<td>Adverse Events</td>
</tr>
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</tr>
<tr>
<td>Hawton K et al. 1987&lt;sup&gt;22&lt;/sup&gt;</td>
<td>RCT / Psychiatric &amp; Primary Care</td>
<td>80</td>
<td>9 mths / 65</td>
<td>No / No</td>
<td>UK / 29.3</td>
<td>Hospitalized for overdose, not in need of formal psychiatric care</td>
<td>Yes</td>
<td>Yes</td>
<td>Don’t Know</td>
<td>1 patient in counseling group committed suicide, 15.4% in general practitioner group repeated, 7.3% in counseling repeated</td>
<td></td>
</tr>
<tr>
<td>Guthrie E et al. 2001&lt;sup&gt;33&lt;/sup&gt;</td>
<td>RCT / Psychiatric</td>
<td>119</td>
<td>6 mths / 95</td>
<td>No / No</td>
<td>UK / 31.2</td>
<td>ED contact for deliberate self poisoning</td>
<td>Yes</td>
<td>Yes</td>
<td>Don’t Know</td>
<td>four sessions of psychodynamic interpersonal therapy in patient’s home</td>
<td></td>
</tr>
<tr>
<td>Bennewith O et al. 2002&lt;sup&gt;44&lt;/sup&gt;</td>
<td>RCT / Primary Care</td>
<td>1932</td>
<td>12 mths / 1932</td>
<td>No / No</td>
<td>UK / 32.6</td>
<td>Seen in ED for deliberate self harm</td>
<td>Yes</td>
<td>Yes</td>
<td>Don’t Know</td>
<td>letter from GP, use of guidelines for GP to use</td>
<td></td>
</tr>
<tr>
<td>Clarke T et al. 2002&lt;sup&gt;35&lt;/sup&gt;</td>
<td>RCT / Other</td>
<td>526</td>
<td>12 mths / 467</td>
<td>No / No</td>
<td>UK / 33</td>
<td>ED contact for deliberate self harm</td>
<td>Yes</td>
<td>Yes</td>
<td>Don’t Know</td>
<td>1 year after first self harm episode</td>
<td></td>
</tr>
</tbody>
</table>

Note: The table provides details of randomized controlled trials (RCTs) and controlled clinical trials (CCTs) describing suicide interventions. The table includes information on the study design, setting, sample size, follow-up time points, country, mean age, eligibility criteria, quality measurements, method of randomization, outcome assessment, compliance acceptability, similarity at baseline between groups, patients blinded, randomization patients analyzed in group they were allocated to, timing of outcome assessment similar, intervention, duration of treatment, and outcome with adverse events.
<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Study Design / Setting</th>
<th>Sample Size Enrolled</th>
<th>Follow Up Time Points / Follow Up</th>
<th>Veterans / Military</th>
<th>Country / Mean Age</th>
<th>Eligibility Criteria</th>
<th>Quality Measurements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motto JA et al. 2001</td>
<td>RCT / Psychiatric</td>
<td>843</td>
<td>1 yr/ 843 5 yrs/ 843 15 yrs/ 843</td>
<td>No / No</td>
<td>US / NR</td>
<td>Hospitalized for depression or suicidality</td>
<td>Don’t Know  Don’t Know  Yes  Don’t Know</td>
</tr>
<tr>
<td>Morgan HG et al. 1993</td>
<td>RCT / Psychiatric</td>
<td>212</td>
<td>1 yr/ 212</td>
<td>No / No</td>
<td>UK / 30.1</td>
<td>Admission follow up episode of deliberate self harm</td>
<td>Don’t Know  Don’t Know  Yes  Don’t Know</td>
</tr>
<tr>
<td>Evans MO et al. 1999</td>
<td>RCT / Other</td>
<td>827</td>
<td>6 mths/ 827</td>
<td>No / No</td>
<td>UK / 33.3</td>
<td>Hospitalization for deliberate self harm</td>
<td>Don’t Know  Don’t Know  Yes  Don’t Know</td>
</tr>
<tr>
<td>Carter GL et al. 2005</td>
<td>RCT / Psychiatric</td>
<td>772</td>
<td>12 mths/ 772</td>
<td>No / No</td>
<td>Australia / NR</td>
<td>ED contact for deliberate self poisoning</td>
<td>Don’t Know  Don’t Know  Yes  Yes</td>
</tr>
</tbody>
</table>

**Evidence Table 2. RCT and CCTs Describing Suicide Interventions Continued**

<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Study Design / Setting</th>
<th>Sample Size Enrolled</th>
<th>Follow Up Time Points / Follow Up</th>
<th>Veterans / Military</th>
<th>Country / Mean Age</th>
<th>Eligibility Criteria</th>
<th>Quality Measurements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motto JA et al. 2001</td>
<td>RCT / Psychiatric</td>
<td>843</td>
<td>1 yr/ 843 5 yrs/ 843 15 yrs/ 843</td>
<td>No / No</td>
<td>US / NR</td>
<td>Hospitalized for depression or suicidality</td>
<td>Don’t Know  Don’t Know  Yes  Don’t Know</td>
</tr>
<tr>
<td>Morgan HG et al. 1993</td>
<td>RCT / Psychiatric</td>
<td>212</td>
<td>1 yr/ 212</td>
<td>No / No</td>
<td>UK / 30.1</td>
<td>Admission follow up episode of deliberate self harm</td>
<td>Don’t Know  Don’t Know  Yes  Don’t Know</td>
</tr>
<tr>
<td>Evans MO et al. 1999</td>
<td>RCT / Other</td>
<td>827</td>
<td>6 mths/ 827</td>
<td>No / No</td>
<td>UK / 33.3</td>
<td>Hospitalization for deliberate self harm</td>
<td>Don’t Know  Don’t Know  Yes  Don’t Know</td>
</tr>
<tr>
<td>Carter GL et al. 2005</td>
<td>RCT / Psychiatric</td>
<td>772</td>
<td>12 mths/ 772</td>
<td>No / No</td>
<td>Australia / NR</td>
<td>ED contact for deliberate self poisoning</td>
<td>Don’t Know  Don’t Know  Yes  Yes</td>
</tr>
</tbody>
</table>

- **Description of Randomized Intervention**
  - Duration of Treatment
  - Outcome
  - Adverse Events

- **Eligibility Criteria**
  - Hospitalized for depression or suicidality

- **Quality Measurements**
  - Point estimates & measures of variability for primary outcomes variable
  - Co-interventions avoided

- **Drop-out rate described**
  - Timing of Outcome Assessment
  - Similarity between groups

- **Adverse Events**
  - No suicides occurred; 5 repeated self harm (serious threats) in experiment & 15 in control
  - 2 suicides in “green card” group & 1 in control
  - 57 repeat self harm in intervention & 68 in control

- **Follow up letter**
  - 1 year follow up after first admission
  - 6 months following discharge

- **“green card” offering easy access to psychiatrist on call**
  - “green card” offering 24 hr crisis phone consultation

- **Drop-out rate**
  - After 15 years there were 25 suicides in the contact group, & 26 in the no contact group

- **Randomized patients analyzed in group they were allocated to**
  - Randomized patients analyzed in group they were allocated to

- **Drop-out rate described**
  - Timing of Outcome Assessment
  - Similarity between groups

- **Adverse Events**
  - No suicides occurred; 5 repeated self harm (serious threats) in experiment & 15 in control
  - 2 suicides in “green card” group & 1 in control
  - 57 repeat self harm in intervention & 68 in control

- **Follow up letter**
  - 1 year follow up after first admission
  - 6 months following discharge

- **“green card” offering easy access to psychiatrist on call**
  - “green card” offering 24 hr crisis phone consultation
<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Study Design / Setting</th>
<th>Sample Size Enrolled</th>
<th>Follow Up Time Points / Follow Up</th>
<th>Veterans / Military</th>
<th>Country / Mean Age</th>
<th>Eligibility Criteria</th>
<th>Quality Measurements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waterhouse J et al. 1990</td>
<td>RCT / Primary Care &amp; Hospital</td>
<td>99</td>
<td>1 wk/ NR 16 wk/ NR</td>
<td>No / No</td>
<td>UK / NR</td>
<td>ED contact for para-suicidal act by self poisoning</td>
<td>Described as Randomized: Yes Eligibility Criteria Specified: Yes Point estimates &amp; measures of variability for primary outcomes variable: Yes Co-interventions avoided: Don’t Know</td>
</tr>
<tr>
<td>Unutzer J et al. 2006</td>
<td>RCT / Primary Care</td>
<td>1801</td>
<td>2 yrs/ NR</td>
<td>Yes / No</td>
<td>US / 71.2</td>
<td>Elderly with depression</td>
<td>Described as Randomized: Yes Eligibility Criteria Specified: Yes Point estimates &amp; measures of variability for primary outcomes variable: Yes Co-interventions avoided: Don’t Know</td>
</tr>
<tr>
<td>Mishara BL et al. 2005</td>
<td>CCT / Other</td>
<td>120</td>
<td>2 mths/ 120 6 mths/ 120</td>
<td>No / No</td>
<td>Canada / NR</td>
<td>Family friend (of suicidal men) who called suicide hotline</td>
<td>Described as Randomized: Don’t Know Eligibility Criteria Specified: No Point estimates &amp; measures of variability for primary outcomes variable: No Co-interventions avoided: Don’t Know</td>
</tr>
</tbody>
</table>

**Outcome**
- Waterhouse J et al. 1990: Attempters & SI
- Unutzer J et al. 2006: Completers & SI
- Mishara BL et al. 2005: Attempts

**Adverse Events**
- Waterhouse J et al. 1990: attempted & 4 discharged patients repeated parasuicide
- Unutzer J et al. 2006: No completed suicides during 2 year follow up
- Mishara BL et al. 2005: 22.0% attempt rate at entry, 10.6% at 2 mo., 2.7% at 6 mo.
# Evidence Table 3. Studies Describing Interventions Restricting the Access to Firearms

<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Study Design</th>
<th>Country / Setting</th>
<th>Veteran / Military</th>
<th>Legislation</th>
<th>Study Period</th>
<th>Outcome</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loftin C et al. 1991&lt;sup&gt;47&lt;/sup&gt;</td>
<td>Interrupted Time Series</td>
<td>US / Population</td>
<td>No / No</td>
<td>District of Columbia’s Firearms Control Regulations Act 1976</td>
<td>1968-1987</td>
<td>Mean number of suicides per month</td>
<td>Suicides using firearms decreased from 2.6 per month to 2.0 per month (p=.005). Non-firearm related suicides did not experience a decrease of similar magnitude.</td>
</tr>
<tr>
<td>Ludwig J et al. 2006&lt;sup&gt;48&lt;/sup&gt;</td>
<td>Interrupted Time Series</td>
<td>US / Population</td>
<td>No / No</td>
<td>Brady Handgun Violence Prevention Act, 1994</td>
<td>1985-1997</td>
<td>Total suicide rates per 100,000 of population for adults (≥21 years and ≥55 years) controlling for age, race, poverty and income levels, urban residence, and alcohol consumption, the effected states (32 states where Brady handgun act was implemented)</td>
<td>Firearm suicide rates declined by 0.32 (95% CI: -0.73, 0.20) for adults over 21 years old. For adults 55 or older suicide rates declined by 0.92 (95% CI: -1.43, -0.42, p&lt;.05).</td>
</tr>
<tr>
<td>Lott JR et al. 2001&lt;sup&gt;49&lt;/sup&gt;</td>
<td>Interrupted Time Series</td>
<td>US / Population</td>
<td>No / No</td>
<td>Multi-State: ‘Shall issue’ (concealed weapons), minimum age of private purchase 21, minimum age of private possession 21, on gun per month, Junk gun ban</td>
<td>1979-1996</td>
<td>Comparison of suicide rates, accidental deaths and crimes in states with and without Safe-Storage laws</td>
<td>Regression estimates were not statistically significant from 0 or from each other with and without including control variables. Thus the gun laws did not seem to have a statistically significant effect on suicide rates.</td>
</tr>
<tr>
<td>Rosengart M et al. 2005&lt;sup&gt;50&lt;/sup&gt;</td>
<td>Interrupted Time Series</td>
<td>US / Population</td>
<td>No / No</td>
<td>A cross sectional time series study of firearm suicides and homicides</td>
<td>1979-1998</td>
<td>None of the 5 laws were associated with a statistically significant change in firearm suicide rates.</td>
<td></td>
</tr>
<tr>
<td>Webster et al. 2004&lt;sup&gt;51&lt;/sup&gt;</td>
<td>Interrupted Time Series</td>
<td>US / Population</td>
<td>No / No</td>
<td>State and federal Child Access Prevention laws (requiring safe storage)</td>
<td>1976-2001</td>
<td>Number of total suicides per 100,000 and methods used for youth between 14 to 20 years old</td>
<td>Of the 63,954 suicides between 1976-2001, 62% were committed with firearms. Firearm suicides increased from 2.6 in 1976 to a high of 5.7 in 1994. They quickly decreased to 2.5 in 2001. For youth between 14-17 child access prevention laws at the state level are associated with a 10.8% decrease in firearm suicides (RR, 0.89, 95% CI: 0.83-0.96). For adults between 18-20 state child access prevention laws are associated with a 11.1% decrease in suicides from firearms (RR, 0.89, 95% CI: 0.85-0.93).</td>
</tr>
<tr>
<td>Rich CL et al. 1990&lt;sup&gt;52&lt;/sup&gt;</td>
<td>Interrupted Time Series</td>
<td>Canada / US / Population</td>
<td>No / No</td>
<td>1978 Criminal Code of Canada</td>
<td>1973-1983</td>
<td>Number of suicides in Ontario and Toronto and method of suicide for Toronto</td>
<td>The mean percent of suicides by firearms decreased significantly after the legislation went into effect (23.2% to 16.2%, difference 7%, p=0.0001). The total number of suicides did not significantly decrease.</td>
</tr>
<tr>
<td>Carrington PJ et al. 1994&lt;sup&gt;53&lt;/sup&gt;</td>
<td>Interrupted Time Series</td>
<td>Canada / Population</td>
<td>No / No</td>
<td>1978 Criminal Code of Canada</td>
<td>1965-1977</td>
<td>Mean suicide rates per 100,000 and trends.</td>
<td>The suicide rate did not change significantly from the 5 years before and the 5 years after the 1978 gun control law (13.5 to 12.8, p=0.12). Regression analysis found no slope for the 5 years following the legislation.</td>
</tr>
<tr>
<td>Lester D et al. 1993&lt;sup&gt;54&lt;/sup&gt;</td>
<td>Interrupted Time Series</td>
<td>Canada / Population</td>
<td>No / No</td>
<td>Canada's Criminal Law Amendment Act of 1977 (Bill C-51)</td>
<td>1969-1985</td>
<td>Annual suicide rates per 100,000 by all methods.</td>
<td>Suicide by firearm rates decreased after Bill C-51 (*4.2/ to 2.09, p=0.05). But the total suicide rate increased, suggesting that people turned to other methods.</td>
</tr>
<tr>
<td>Lester D et al. 1994&lt;sup&gt;55&lt;/sup&gt;</td>
<td>Interrupted Time Series</td>
<td>Canada &amp; US / Population</td>
<td>No / No</td>
<td>Comment on assertion that Bill C-51 did not lessen suicide rates</td>
<td>1969-1991</td>
<td>Change in suicide rates for the period following the 1977 Bill C-51.</td>
<td>Before the passage of Bill C-51, firearm suicide rate was increasing (simple linear regression slope, b=0.608, p=0.01), as were the total suicide rate and suicide rate from other methods. From 1978 to 1985 the overall suicide rate did not change and the rate by other methods did not change. The percentage of suicides by firearms did decrease (b=0.574, p=0.03).</td>
</tr>
</tbody>
</table>

*Note: All studies were conducted using interrupted time series analysis, except for the study by Lester D et al. 1993 and Rich CL et al. 1990, which used other methods.*
<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Study Design</th>
<th>Country / Setting</th>
<th>Veteran / Military</th>
<th>Legislation</th>
<th>Study Period</th>
<th>Outcome</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leenaars AA et al. 1997</td>
<td>Interrupted Time Series</td>
<td>Canada / Population</td>
<td>No / No</td>
<td>Canada’s Criminal Law Amendment Act of 1977 (Bill C-51)</td>
<td>1969-1985</td>
<td>Suicide rates before (1969-1976) and after (1978-1985) the enactment of Bill C-51</td>
<td>Suicide rates by firearms decreased significantly (p=0.05) after the passage of Bill C-51. Also the percentage of suicides by firearms also significantly decreased.</td>
</tr>
<tr>
<td>Lester D et al. 2001</td>
<td>Interrupted Time Series</td>
<td>Canada / Population</td>
<td>No / No</td>
<td>Canada’s Criminal Law Amendment Act of 1977 (Bill C-51)</td>
<td>1970-1995</td>
<td>Firearm suicide and homicide rates per 100,000</td>
<td>The correlation between year and the percentage of suicides and homicides by firearms is -0.86 (one-tailed p&lt;0.001).</td>
</tr>
<tr>
<td>Leenaars AA et al. 1997</td>
<td>Observational</td>
<td>Canada / Population</td>
<td>No / No</td>
<td>Canada’s Criminal Law Amendment Act of 1977 (Bill C-51)</td>
<td>1969-1985</td>
<td>Suicide and homicide rates per 100,000 before and after Bill C-51 was passed</td>
<td>The mean annual suicide numbers decreased for those in the following age groups 15-24 (&lt;0.001), 35-64 (&lt;0.05), and 75 and over (&lt;0.01). Prior to the law the rate of suicides was increasing (regression line slope = 0.16) where as after the law went into effect the rate began to decrease (regression line slope = -0.13).</td>
</tr>
<tr>
<td>Leenaars AA et al. 2003</td>
<td>Interrupted Time Series</td>
<td>Canada / Population</td>
<td>No / No</td>
<td>Canada’s Criminal Law Amendment Act of 1977 (Bill C-51)</td>
<td>1969-1985</td>
<td>Suicide rates compared from before and after the 1977 Bill C-51.</td>
<td>Least squares regression showed that the introduction of the Bill had no statistically significant increase or decrease in the rate of suicides, overall or by firearms. However the Bill had a negative effect on the slope of the line, thus the Bill decreased the trend in suicide rates.</td>
</tr>
<tr>
<td>Bridges FS 2004</td>
<td>Interrupted Time Series</td>
<td>Canada / Population</td>
<td>No / No</td>
<td>Canadian Bill C-17</td>
<td>1984-1998</td>
<td>Total suicide and homicide rates per 100,000, as well as methods, before and after Bill C-51</td>
<td>The mean annual number of suicides significantly decreased from the first 7 year period to the 7 years following instatement of the Bill (4.09 to 3.17, p&lt;0.001). The rates by other methods increased significantly (9.02 to 9.76, p&lt;0.01). The total average number of suicides did not significantly differ between the 2 study periods (13.11 to 12.93).</td>
</tr>
<tr>
<td>Chung AH et al. 2004</td>
<td>Interrupted Time Series</td>
<td>Canada / Population</td>
<td>No / No</td>
<td>Canadian Bill C-17</td>
<td>1979-1999</td>
<td>Suicide rates and methods for youth between the ages of 15-19 before and after Bill C-17</td>
<td>The percent of suicide by firearms decreased from 55% in 1979 to 25% in 1999. Death by other means increased during this time. The overall rate of suicides did not decrease.</td>
</tr>
<tr>
<td>Snowdon J et al. 1999</td>
<td>Observational</td>
<td>Australia / Population</td>
<td>No / No</td>
<td>Several?</td>
<td>1968-1989</td>
<td>Suicide rates per 100,000 by gender, State, age and residence</td>
<td>The mean rate of firearm suicides was 6.13 for men and 0.45 for women (p&lt;0.005).</td>
</tr>
<tr>
<td>Cantor CH et al. 1995</td>
<td>Observational</td>
<td>Australia / Population</td>
<td>No / No</td>
<td>Weapons Act 1990 (Old)</td>
<td>1990-1993</td>
<td>Firearm suicide mean annual rates per 100,000 and method for different geographical areas two years before and two years after the legislation went into effect</td>
<td>Suicide rates decreased in metropolitan (3.6 to 2.3) and provincial areas (5.2 to 3.1) (p&lt;0.05). The mean annual rate per 100,000 for rural areas was about double that of metropolitan and provincial areas. This rate did not decrease after the legislation. There was also a significant decrease in suicide rates among men and adults between 15 and 29 years old.</td>
</tr>
<tr>
<td>Ozanne-Smith J et al. 2004</td>
<td>Interrupted Time Series</td>
<td>Australia / Population</td>
<td>No / No</td>
<td>Victoria Response (1988) and Firearms Act of 1996</td>
<td>1979-2000</td>
<td>Following gun control regulations, death rates, trends, and ownership in Victoria and Australia.</td>
<td>The overall death rate decreased for Australia (-3.9%, 95% CI: -4.8% to -3.1%) and Victoria (-9.9% 95% CI: -5.9, -3.9) from 1979 - 2000. Significant decreases in firearm related suicides were seen in Victoria. Suicides by firearms dropped by 54.5% from 1979 to 2000.</td>
</tr>
<tr>
<td>Beaureaus A et al. 2006</td>
<td>Interrupted Time Series</td>
<td>New Zealand / Population</td>
<td>No / No</td>
<td>Amendment to the Arms Act, 1992</td>
<td>1985-2002</td>
<td>Age-specific suicide rates per 100,000 of population for firearm and Non-firearm related suicides</td>
<td>For youths (15-24 years), firearm suicides were reduced by 39% in the 3 year implementation period and decreased 66% in the 5 year post-implementation period. For adults (25+ years) firearm suicides decreased by 25% in the 3 year implementation period and decreased by 39% in the 5 year post-implementation period.</td>
</tr>
</tbody>
</table>
### Appendix D. Peer Review Comments

<table>
<thead>
<tr>
<th>Section</th>
<th>Comment</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>Outcome information was collected for only three categories: “Attempters, Completers, SI.” The synthesis project does not address any literature demonstrating if suicide prevention strategies impact: a) the need for hospitalization, b) number of ER visits, c) patient and provider satisfaction, etc.</td>
<td>The scope of the report was set in consultation with the ESP Advisory Committee and the outcomes were restricted to the ones included in this report. These additional outcomes could be included in an update or new ESP report.</td>
</tr>
<tr>
<td>General</td>
<td>The literature review was detailed but narrative, and it would be helpful to see the summation in a data table. It’s very difficult to find the “take home messages” amidst all the detail. There apparently were data collection forms in Appendix D. Would like to see data tables for the data collected in these forms to better understand the results of the synthesis project.</td>
<td>Summarizing the results of disparate studies is always a challenge. We have included Evidence Tables summarizing most of the data from the included studies in Appendix C. Each report section then also has a narrative summary, as does the report’s conclusion.</td>
</tr>
<tr>
<td>General</td>
<td>Are there any studies on suicide prevention related to this report that we have overlooked?: The use of telemedicine for suicide prevention</td>
<td>We reported all studies identified as of the search date. We found no studies reporting outcomes from telemedicine interventions.</td>
</tr>
<tr>
<td>General</td>
<td>The VA National Center for Suicide Prevention and the MIRECC in Denver may have at least some published data describing the impact of the recent VA national suicide prevention hotline. This would obviously be the most relevant information, yet there was no mention of this in the project synthesis. It would be helpful if the document states explicitly one way or another if there is any recent data to be factored from either of these VA suicide prevention centers, either in the literature, in press or otherwise.</td>
<td>We used standard search techniques to find published literature, and did not attempt to identify unpublished or not yet published results. We’ll check with VA to see if there is anything published about the impact of the VA hotline.</td>
</tr>
<tr>
<td>Executive Summary, Methods</td>
<td>even in this brief summary, it would be useful to list the inclusion criteria yielding studies below, e.g., interventions, controlled studies, outcomes limited to attempts, completed suicides?))</td>
<td>We have added a list of the search criteria in the executive summary.</td>
</tr>
<tr>
<td>Introduction, Background</td>
<td>Section contains much useful information; some statements would benefit from references, to guide the interested reader—e.g., what is known or theorized about media-induced imitation or contagion?</td>
<td>We have added a reference to a recent review on media-induced imitation.</td>
</tr>
<tr>
<td>Methods, Study Selection</td>
<td>This exclusion makes sense but doesn’t seem to be consistently followed. I’ll note examples below. If interional, maybe further clarification of the exclusion here would be useful</td>
<td>Our original description in Study Selection was imprecise. We have added text to clarify the search criteria, especially with respect to exclusion of mental health interventions.</td>
</tr>
</tbody>
</table>
### Appendix D. Peer Review Comments Continued

<table>
<thead>
<tr>
<th>Methods, Grade</th>
<th>I may have missed it, but it’s not clear to me where these quantitative instructions are applied to the studies in this report. If in an appendix, might be useful to steer the reader to it here.</th>
<th>The quality assessment of individual articles appears in tables in Appendix C. The GRADE ratings were applied to sets of evidence taken together, and appear in the text of the results section.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Questions 1 &amp; 2</td>
<td>All of these studies are quite well described. This one, though, left me with a question. Did the study employ a chaplain to deliver a secular counseling/educational intervention? Or was there a religious component to the education? Seems basic to understanding the study/</td>
<td>The article in question does not provide enough detail to allow us to accurately answer this question.</td>
</tr>
<tr>
<td>Key Questions 1 &amp; 2</td>
<td>Referring to Koons et al. This study would seem to be excluded as a “mental health intervention only”. Its foundational efficacy studies specifically addressed suicide. If there’s a reason to include it, consider clarifying criteria?</td>
<td>See answer to item 8</td>
</tr>
<tr>
<td>Key Questions 1 &amp; 2</td>
<td>Referring to Ilgen Also would seem to be excluded as a “mental health intervention only”. If SUD or ‘program’ features set it apart, consider clarifying criteria?</td>
<td>See answer to item 8</td>
</tr>
<tr>
<td>Key Questions 1 &amp; 2</td>
<td>Referring to Gibbons Would seem to be excluded as a “mental health intervention only”. If reason is that the study addresses an induction effect rather than a treatment effect, consider clarifying here.</td>
<td>See answer to item 8</td>
</tr>
<tr>
<td>Key Questions 1 &amp; 2</td>
<td>Referring to Webster et al. Not sure I understand, because it’s not clear to me how representative any one state is (of the country?) Consider listing states and characteristics, e.g., more rural, higher prevalence of alcoholism, etc.?</td>
<td>We have re-written the description of this study’s results to avoid the question of “representativeness.”</td>
</tr>
<tr>
<td>Limitations, Study Quality</td>
<td>I’m sure the authors know more about this than I do; I thought this work constitutes a ‘systematic review’ and that a ‘meta-analysis’ would be distinguished from this review by the pooling of data across studies.</td>
<td>This comment is correct, this synthesis is not a meta-analysis and we have changed the text to reflect that.</td>
</tr>
<tr>
<td>Executive Summary, Key Questions 1 &amp; 2</td>
<td>What about access to and treatment of mental health or sud disorders- does that reduce suicide – addiction treatment, clozapine, etc</td>
<td>See answer to item 8</td>
</tr>
<tr>
<td>Executive Summary, Key Question 3</td>
<td>Perhaps a major statement here on defining terms is needed – this is really a problem in the literature. Define gesture, attempt, ideation, death ideation etc.</td>
<td>We have added more text highlighting the critical nature of such terminology for advancing the field.</td>
</tr>
</tbody>
</table>
## Appendix D. Peer Review Comments Continued

<table>
<thead>
<tr>
<th>Section</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods, Figure 1</td>
<td>Alcohol and drug use isn’t listed as a factor involved in behavior — this seems like an oversight. We have added a comment about the role of substance abuse and other factors not explicitly appearing in the Mann conceptual model to the introduction.</td>
</tr>
<tr>
<td>Methods</td>
<td>Another target might be social situation – homelessness, employment (there is a strong correlation in the jobless rate and suicide rates) so programs like CWT or Supported employment might be important to mention. Same answer as item 18.</td>
</tr>
<tr>
<td>Methods</td>
<td>How about those in mh care See answer to item 8</td>
</tr>
<tr>
<td>Methods</td>
<td>Transition from inpatient to outpatient care – I believe there is data on a critical time intervention by Lisa Dixon on this issue. We found no study by Dixon reporting a direct effect on suicide attempts or completions.</td>
</tr>
<tr>
<td>Results, Literature Flow</td>
<td>It isn’t clear what this means: “were rejected at title review as clearly irrelevant to the project”. If the title clearly indicated that the study did not report an outcome relevant to our search, then it was rejected. This is standard practice in systematic reviews and meta-analyses.</td>
</tr>
<tr>
<td>Key Questions 1 &amp; 2</td>
<td>The prospect study (M Bruce showed a reduction in suicide ideation when treating depression in primary care, should these type studies not be included? We did not consider studies reporting changes in rates of suicidal ideation, only studies that reported direct effects on suicide attempts or completions.</td>
</tr>
<tr>
<td>Limitations</td>
<td>Probably worth saying in the summary: “Our review did not focus on purely mental health interventions. These have been the subject of other reviews. Perhaps somewhat surprisingly given the role of depressive disorders as significant risk factors for suicide, the evidence in support of the use of antidepressants is rather weak”. See answer to item 8</td>
</tr>
<tr>
<td>General</td>
<td>However, I am at a loss to explain why the IMPACT study was discussed but the PROSPECT study was noted as excluded given the extremely similar study designs (perhaps because IMPACT included some VA sites?). If the study reported including veterans, then it was included, but not otherwise. See item 8.</td>
</tr>
<tr>
<td>General</td>
<td>This manuscript is still at a developmental stage so I delineate that which I would like to see in a final version more than providing a peer review per se [interspersed with other editorial observations roughly in order of appearance]: No reply needed.</td>
</tr>
<tr>
<td>Introduction</td>
<td>An initial discussion of known correlates of suicide and suicidality (manuscript leads off suggesting the primary one is substance abuse) and/or conceptual framework for approaching this topic. In the Introduction, we described the Mann review’s conceptual model in moderate detail, because we used its search strategy. Our goal was not to review existing conceptual frameworks or to develop new ones.</td>
</tr>
<tr>
<td><strong>Appendix D. Peer Review Comments Continued</strong></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td>Greater connection and discussion to policy issues and programs; at present it is a very dry list of vignettes from research papers</td>
</tr>
<tr>
<td><strong>Key Question 1</strong></td>
<td>Summary of strategies for key question #1 is largely absent</td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td>Specific data from the quality review are not presented</td>
</tr>
<tr>
<td><strong>General</strong></td>
<td>Page numbers end partway into the manuscript</td>
</tr>
<tr>
<td><strong>General</strong></td>
<td>Needs editing for consistency of tone and some substitution of colloquial or inappropriate word choices [e.g., ‘repertoire’, ‘more easily had’]</td>
</tr>
<tr>
<td><strong>Executive Summary, Key Question 3</strong></td>
<td>Page 10, penultimate paragraph: would revise to “similar…profiles to the antemortem profiles of suicide completers.”</td>
</tr>
<tr>
<td><strong>Introduction</strong></td>
<td>Page 14, first paragraph: consider “nonclinician gatekeepers,” such as “medical clerks, chaplains, or military unit commanders,” since education programs may provide gatekeeper education to staff at medical facilities</td>
</tr>
<tr>
<td><strong>Introduction</strong></td>
<td>Page 14, last paragraph: brief summaries miss some elements (firearm purchase background checks and waiting periods; drug package configurations not just sizes)</td>
</tr>
<tr>
<td><strong>General</strong></td>
<td>Beautrais study: should describe the nature of the additional data; as it reads now it is not clear what distinction is being made in the last sentence</td>
</tr>
<tr>
<td><strong>General</strong></td>
<td>The objectives of the report are not clear. Why was this report commissioned? In response to what pressures? Several key questions were developed following a conference call (page 14). It is not clear who commissioned the Office of R&amp;D for the Evidence Synthesis Project; why were these topics (i.e suicide screening) selected. What were the “key questions” responding to? Why was a key question formulated but not addressed at all in the review?? Therefore, in my opinion additional background might be helpful to better delineate whether the objectives and scope of the report were appropriate. On the other hand, the methods are clearly described.</td>
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<tr>
<td><strong>Appendix D. Peer Review Comments Continued</strong></td>
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<td>-----------------------------------------------</td>
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<tr>
<td><strong>General</strong></td>
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<td>I was impressed with the objectivity of the report. Studies are presented without bias. The strengths and weaknesses of the studies are briefly but clearly described. After each topic, the results of the relevant studies pertaining to that topic are summarized. These are strengths of the review.</td>
<td>No changes needed.</td>
</tr>
<tr>
<td>Are there any studies on suicide prevention related to this report that we have overlooked?: No to my knowledge. Critical studies that have influenced national VHA policy regarding suicide screening and intervention have been included. One possible criticism is that studies that have been pivotal should be identified as such and perhaps discussed more fully. An example might be the US Air Force Study from the BMJ (Knox et al, reference #14).</td>
<td>We agree the methodological advantages of the Knox study and have added extra detail about it.</td>
</tr>
<tr>
<td><strong>Key Questions 1, 2, &amp; 3</strong></td>
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<tr>
<td>This report is well constructed, well written and very helpful. It summarizes a broad range of studies, providing brief commentary in the form of summary statements. The report stops short of suggesting national guidelines or policy based upon the available data (i.e. evidence based recommendations), potentially a limitation as the authors are probably particularly well poised to do so after this thorough review. In fact, Key Question #1 directly asks this question and is left unanswered. The responses to Key Questions #1 and #2 are tentative and very general. For example, the response to Key Question #3 suggests that preliminary data be collected from the computerized medical record (page 8), without discussing any specific thoughts or recommendations as to what data should be collected and how. The use of the computer to help address Key Question #2 is not mentioned although the ability to track patients and ensure that they receive appropriate interventions is a very well recognized use of this resource.</td>
<td>The purpose of the report was to conduct a literature review, not report a policy analysis. We included a few general recommendations in the conclusion. Key Questions 1 and 2 were answered together.</td>
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<tr>
<td><strong>Executive Summary</strong></td>
<td></td>
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<tr>
<td>Page 8 suggest choosing another word than &quot;Rare&quot; in first sentence. Current debate in Congress, press, and email is why rates are so high for veterans. It might be the wrong tone to set.</td>
<td>We have removed that word and simplified the statement.</td>
</tr>
</tbody>
</table>
### Appendix D. Peer Review Comments Continued

<table>
<thead>
<tr>
<th>General</th>
<th>Are there any studies on suicide prevention related to this report that we have overlooked?: Is there any work from VISN19 MIRECC which was designed to focus on suicide issues that might assist with this analysis?</th>
<th>We used standard search techniques to find published literature. <em>We’ll check with the MIRECC to see if there is anything additional we might have missed.</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>This review demonstrated an embarrassing lack of evidence for Veterans in this critical and highly publicized topic. Research $$ should be directed toward remedying this. Perhaps a combination of the currently funded VISN 19 MIRECC and new studies?</td>
<td>No changes needed.</td>
</tr>
<tr>
<td>General</td>
<td>After reading this review and the synthesis review on depression, there seems a consistent theme in those studies having positive impact of additional or directed staff who build a “relationship” with the patient that plays the role of support and intervention as well as providing social contact for discussion, venting of issues, and advice. Perhaps the social isolation component should be studied as a variable that might have predictive value?</td>
<td>We agree that such factors are likely to be important. We have added a comment about this in the conclusion.</td>
</tr>
<tr>
<td>General</td>
<td>Consider studies involving telebuddy type devices, web access and response, etc.</td>
<td>No studies of such interventions were identified.</td>
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