

<b>Author, Year (Country):</b>	<b>Beautrais 2010<sup>53</sup> (New Zealand)</b>
<b>Population:</b>	All individuals aged 16 and older who presented to psychiatric emergency services at Christchurch Hospital, New Zealand, following self-harm or attempted suicide during the period 1 August 2006 to 6 April 2007.
<b>Intervention 1:</b>	Treatment as usual (TAU) consisted of crisis assessment and referral to in-patient community-based mental health services.
<b>Intervention 2:</b>	TAU plus postcard intervention (PC), which consisted of a series of six 'postcards' sent by mail during the 12 months following the participant's index presentation for suicide attempt or self-harm. The postcard read: 'It has been a short time since you were here at PES (Psych Emergency), and we hope things are going well for you. If you wish to drop us a note we would be happy to hear from you'. Postcards were printed on A4 paper and posted in a plain sealed envelope to the participant's residential address. Postcards were posted at the following times after the index presentation: 2 and 6 weeks; 3, 6, 9 and 12 months.
<b>Setting:</b>	Acute psychiatric emergency services, serving a population of approximately 500,000 people
<b>N:</b>	327; PC=153, TAU=174
<b>Mean age, % female, race (variance):</b>	Age, years (variance NR): PC=33.8 vs TAU=33.9 % female: PC=70.4% vs TAU=62.3% Race NR
<b>Outcome assessment:</b>	Re-presentations for self-harm were assessed by monitoring psychiatric emergency service records and hospital medical records were reviewed at the conclusion of the 12-month follow-up period. Three measures of re-presentation were calculated from these data: re-presentations to psychiatric emergency service, re-presentations to Christchurch Hospital emergency department and total re-presentations to either the psychiatric emergency service or emergency department.
<b>Results:</b>	<p><u>Unadjusted analyses:</u></p> <p><i>Re-presentation for self-harm, %:</i></p> <p>To psychiatric emergency service: PC=15.0 vs TAU=23.6, <math>P&lt;0.06</math>, OR= 0.57 (95% CI, 0.33 to 1.01)</p> <p>To emergency department: PC=25.5 vs TAU=27.0, <math>P&gt;0.75</math>; OR=0.92 (95% CI 0.56 to 1.52)</p> <p>Total (psychiatric emergency service or emergency department): PC=25.5 vs TAU=28.2, <math>P&gt;0.58</math>, OR=0.87 (95% CI 0.53 to 1.43)</p> <p><i>Number of self-harm re-presentations:</i></p> <p>To psychiatric emergency service: PC=23.5 vs TAU=51.1, <math>P&lt;0.0001</math>, IRR= 0.46 (95% CI, 0.31 to 0.68)</p> <p>To emergency department: PC=53.6 vs TAU=71.8, <math>P&lt;0.04</math>, IRR= 0.75 (95% CI, 0.56 to 0.99)</p> <p>Total (psychiatric emergency service or emergency department): PC=56.9 vs TAU=78.2, <math>P&lt;0.03</math>; IRR=0.73 (95% CI, 0.56 to 0.95)</p> <p><u>Analyses adjusted for prior self-harm</u></p> <p><i>Re-presentation for self-harm, %</i></p> <p>To psychiatric emergency service: PC=16.2 vs TAU= 22.5; <math>P&gt;0.13</math>; OR=0.64 (95% CI, 0.36 to 1.15)</p> <p>To emergency department: PC=26.6 vs TAU= 26.0; <math>P&gt;0.88</math>; OR=1.04 (95% CI, 0.62 to 1.73)</p> <p>Total (psychiatric emergency service or emergency department): PC=26.6 vs TAU=27.2; <math>P&gt;0.91</math>; OR=0.97 (95% CI, 0.58 to 1.62)</p> <p><i>Number of self-harm re-presentations</i></p> <p>To psychiatric emergency service: PC=28.7 vs TAU=44.1; <math>P&gt;0.04</math>; IRR=0.65 (95% CI, 0.43 to 0.98)</p> <p>To emergency department: PC=67.2 vs TAU=61.0; <math>P&gt;0.52</math>; IRR=1.10 (95% CI, 0.82 to 1.49)</p> <p>Total (psychiatric emergency service or emergency department): PC=71.1 vs TAU=66.4; <math>P&gt;0.64</math>; IRR=1.07 (95% CI, 0.80 to 1.43)</p>

<b>Author, Year (Country):</b>	<b>Carter 2005<sup>54</sup> – 12-month outcomes</b> <b>Carter 2007<sup>55</sup> – 24-month outcomes</b> <b>(Australia)</b>
<b>Population:</b>	Those aged over 16 years who presented with deliberate self poisoning during April 1998 to December 2001 to the Hunter Area Toxicology Service at the Newcastle Mater Hospital, New South Wales, Australia, which serves a primary referral population of 385 000 adults and a tertiary referral population of a further 170 000
<b>Intervention 1:</b>	Treatment as usual (TAU); no details provided
<b>Intervention 2:</b>	A postcard (PC) sent to participants in a sealed envelope at 1, 2, 3, 4, 6, 8, 10, and 12 months after discharge, plus TAU
<b>Setting:</b>	Not specified
<b>N:</b>	772: PC=378 vs TAU=394
<b>Mean age, % female, race (variance):</b>	Median age, years (interquartile range): 33 (24-44) 68% female Race not reported
<b>Other clinical characteristics:</b>	17% previous admission for deliberate self-poisoning Median number of psychiatric diagnoses (interquartile range): 2 (1-2)
<b>Outcome assessment:</b>	Proportion of patients with at least one repeat episode of deliberate self poisoning in 24 months and the number of repeat episodes of deliberate self poisoning per individual over 24 months
<b>Results:</b>	<u>12-month outcomes:</u> Proportion of patients with repeat deliberate self poisoning: PC=57 (15.1%, 95% CI 11.5% to 18.7%) vs TAU=68 (17.3%, 95% CI, 13.5% to 21%); difference between groups -2% (95% CI, -7% to 3%); $\chi^2=0.675$ , $df = 1$ , $P = 0.41$  Cumulative number of repeat episodes of deliberate self poisoning: PC=101 vs TAU=192 Risk of repetition= overall incidence risk ratio (IRR) 0.55 (95% CI, 0.35 to 0.87); men only: IRR= 0.97 (95% CI, 0.48 to 1.98); women only: IRR= 0.54 (95% CI, 0.30 to 0.96)  <u>24-month outcomes</u> Proportion of patients with repeat deliberate self poisoning: PC=21.2% (80/378; 95% CI, 17.0 to 25.3) vs TAU=22.8% (90/394; 95% CI, 18.7 to 27.0); difference between groups -1.7% (95% CI, -7.5 to 4.2); $\chi^2=0.317$ , $df = 1$ , $P = 0.57$  Cumulative number of repeat episodes of deliberate self poisoning: PC=145 vs TAU=310 Risk of repetition= overall IRR 0.49 (95% CI, 0.33 to 0.73); men only: IRR= 0.97 (95% CI, 0.50 to 1.88); women only: IRR= 0.49 (95% CI, 0.30 to 0.80)
<b>Author, Year (Country):</b>	<b>PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) (US)</b> <b>Gallo 2007<sup>59</sup>: 5-year outcomes</b> <b>Bruce 2004<sup>120</sup>, Schulberg 2001<sup>127</sup>: Additional detail on methods</b>
<b>Population:</b>	Age $\geq 60$ years and score greater than 20 on the Centers for Epidemiologic Studies Depression scale
<b>Therapy 1:</b>	Usual Care (UC): Practices received educational sessions for primary care physicians and notification of the depression status of their patients, but no specific recommendations were given to physicians about individual patients, except for psychiatric emergencies.
<b>Therapy 2:</b>	Intervention Group (IG): On-site depression care manager working with primary care physicians to provide algorithm-based care. Depression care manager's role included (1) obtaining needed clinical information from the patient and prompting the physician with timely and targeted recommendations about appropriate care of the patient's depression; (2) monitoring patient's clinical course and encouraging adherence; (3) educating patients, families and physicians on depression and suicidal ideation.

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<b>Medication regimen:</b>	All patients received citalopram, initiated at 10 mg before bedtime on the first day, 20 mg/d for the next 6 days, and 30 mg/d subsequently. After 6 weeks, the target dosage was maintained if the patient exhibited a substantial improvement ( $\geq 50\%$ reduction in the HDRS or was increased if the patient exhibited a partial improvement (30% to 50% reduction in the HDRS score). Nonresponders, for whom guidelines called for switching to another antidepressant, were defined as patients who did not demonstrate either minimal improvement after 6 weeks of treatment at the target dosage or substantial improvement after the dose was increased to the maximum recommended dose after 12 weeks of treatment. For patients who had not responded at 12 weeks, the health specialist followed guidelines for switching antidepressants.
<b>Setting:</b>	20 primary care practices; 16 community-based and 4 were academic practices
<b>Therapist characteristics:</b>	The 15 care managers included social workers, nurses, and psychologists
<b>Treatment duration:</b>	12 months
<b>N:</b>	599; IG=320, UC=279
<b>Mean age, % female, race (variance):</b>	Mean age (SD): IG=71 (7.8) vs UC=70 (8.1) % female: IG=69% vs UC=75% Ethnic minority (Hispanic, non-Hispanic Black, Asian, other non-Hispanic): IG=29% vs UC=37%
<b>Other clinical characteristics:</b>	Mean MMSE score for cognitive function (SD): IG= 27 (2.9) vs UC= 27 (2.5) Major depressive disorder: IG=67% vs UC=65% Mean Hamilton Depression Rating Scale score for depression severity (SD): IG=19 (6.1) vs UC=18 (5.8) % with Scale for Suicidal Ideation score >0: IG= 29% vs UC=20%
<b>Concomitant medications:</b>	4 months: Medication and psychotherapy: IG=5.8% vs UC=8.5%; OR 0.46 (95% CI, 0.13 to 1.66) Medication only : IG=57.7% vs UC=40.4%; OR 4.91 (95% CI, 2.13 to 11.33)  8 months: Medication and psychotherapy: IG=9.7% vs UC=8.9%; OR 1.29 (95% CI, 0.39 to 4.30) Medication only : IG=57.0% vs UC=39.4%; OR 4.20 (95% CI, 1.77 to 9.96)  12 months: Medication and psychotherapy: IG=6.8% vs UC=13.6%; OR 0.25 (95% CI, 0.07 to 0.96) Medication only : IG=66.3% vs UC=44.2%; OR 7.21 (95% CI, 2.86 to 18.18)
<b>Outcome assessment:</b>	National Center for Health Statistics NDI <i>Plus</i> was used to assess vital status over a 5-year period. The underlying causes of death that we obtained from NDI <i>Plus</i> are similar to codes assigned by trained nosologists (Doody 2001, Sathiakumar 1998)
<b>Results:</b>	Suicide N, n/1000 person-years (95% CI) All patients (N=599): IG=1, 0.7 (0.0 to 4.2) vs UC=0, 0.0 (0.0 to 3.3) Patients with major depression disorder (N=396): IG=0, 0.0 (0.0 to 4.1) vs UC=0, 0.0 (0.0 to 5.1) Patients with clinically significant minor depression (n =203): IG=1, 2.2 (0.1 to 2.5) vs UC=0, 0.0 (0.0 to 9.7) Patients without depression (n=627): IG=0, 0.0 (0.0 to 3.0) vs UC=0, 0.0 (0.0 to 2.5)

<b>Author, Year (Country):</b>	<b>REACT study (Randomized Evaluation of Assertive Community Treatment) (UK)</b> <b>Killaspy 2006<sup>58</sup></b>
<b>Population:</b>	People living in independent or low supported accommodations; under the care of the community mental health team for at least 12 months and identified as having difficulty engaging with standard community care; primary diagnosis of serious mental illness (for example, schizophrenia, schizoaffective disorder, other chronic psychosis, bipolar affective disorder); and recent high use of inpatient care (at least 100 consecutive inpatient days or at least five admissions within the past two years or at least 50 consecutive inpatient days or at least three admissions within the past year)
<b>Therapy 1:</b>	Assertive community treatment (ACT): Total team case load=80 to 100; maximum individual case load=12; availability=extended hours (0800 to 2000 every day); locations for appointments=not office based (“in vivo”): meet client at home, in cafes, parks, etc; contact with clients=assertive engagement: multiple attempts, flexible and various approaches (for example, befriending, offering practical support, leisure activities); commitment to care=“no drop-out” policy: continue to try to engage in long term care; case work style=team approach—all team members work with all clients; Frequency of team meetings=frequent (up to daily) to discuss clients and daily plans; source of skills=team rather than outside agencies as far as possible
<b>Therapy 2:</b>	Community mental health (CMH): Total team case load=300 to 350; maximum individual case load=35; availability=office hours only (0900 to 1700 Mon-Fri); locations for appointments=office based appointments and home visits; contact with clients=offer appointments at office or make home visits; commitment to care=discharge if unable to make or maintain contact; case work style=case management—little “sharing” of work with clients between team members; frequency of team meetings=weekly; source of skills=“brokerage”: referral to outside agencies for advice (for example, social security benefits, housing)
<b>Medication regimen:</b>	Not reported
<b>Setting:</b>	See ‘location for appointment’ information for each therapy, respectively
<b>Therapist characteristics:</b>	Not reported
<b>Treatment duration:</b>	18 months
<b>N:</b>	251: ACT=127 vs CMH=124
<b>Mean age, % female, race (variance):</b>	Mean age, years (SD): ACT=38 (11) vs CMH=40 (11) % female: ACT=38% vs CMH=45% % White: ACT=51% vs CMH=57% % African Caribbean: ACT=41% vs CMH=31% % Other Race: ACT=8% vs CMH=11%
<b>Other clinical characteristics:</b>	% patients: Schizophrenia: ACT=68% vs CMH=65% Schizoaffective: ACT=17% vs CMH=15% Bipolar affective: ACT=6% vs CMH=4% Delusional disorder: ACT=3% vs CMH=5% Major depression: ACT=0 vs CMH=2% Other diagnoses: ACT=6% vs CMH=8%
<b>Concomitant medications:</b>	Not reported
<b>Outcome assessment:</b>	Serious incidents concerning deliberate self-harm during the 18-month study period. Outcome criteria were not reported.

<b>Author, Year (Country):</b>	<b>REACT study (Randomized Evaluation of Assertive Community Treatment) (UK)</b> <b>Killaspy 2006<sup>58</sup></b>
<b>Results:</b>	Committed suicide: ACT=0.8% (1/124) vs CMH=2.5% (3/119); between-groups comparison not reported Deliberate self-harm: ACT=8% (10/91) vs CMH=11% (13/75); mean difference= 0.72; <i>P</i> =0.40
<b>Author, Year (Country):</b>	<b>King 2006<sup>57</sup> (US)</b>
<b>Population:</b>	All adolescents who were psychiatrically hospitalized at a university-based or private hospital between August 1998 and December 2000.
<b>Intervention 1:</b>	Treatment as usual (TAU) varied and consisted of psychotherapy (100%), psychoactive medication (96.8%), alcohol/drug treatment (13.4%), partial hospitalization (18.0%), and community services (8.5%).
<b>Intervention 2:</b>	TAU plus Youth-Nominated Support Team – Version 1 (YST-1) consisted of youth nominating support persons from available caring others in their lives (including school, neighborhood/community, and family); support persons underwent training (psychoeducation sessions approximately 1.5-2hrs long), maintained weekly supportive contact with youth, and were contacted regularly by intervention specialists (mental health professionals with previous clinical experience with the youth). The psychoeducation included information on youth’s treatment plan, risk factors for suicidal behavior, availability of emergency services, and strategies for communicating with adolescents.
<b>Setting:</b>	Not specified; 6 month follow-up period post hospitalization
<b>N:</b>	236; TAU=123, TAU+YST-1=113
<b>Mean age, % female, race (variance):</b>	Mean age = 12.0 (SD=3.3); TAU=11.9 (SD=3.5), TAU+YST-1=12.1 (SD=3.0) % female=68.2; TAU=67.4, TAU+YST-1=68.9 % White=82.4; TAU=79.6, TAU+YST-1=85.0
<b>Outcome assessment:</b>	Suicide attempts were measured through self-report on the Spectrum of Suicide Behavior Scale (Pfeffer, 1986)
<b>Results:</b>	No significant differences between groups in percent of adolescents with one or more suicide attempts % with 1 or more suicide attempts during the 6 month follow-up: TAU=11.7, TAU+YST-1=18.1% (fishers exact test, <i>P</i> =.22)
<b>Author, Year (Country):</b>	<b>King 2009<sup>56</sup> (US)</b>
<b>Population:</b>	All adolescents (aged 13-17) psychiatrically hospitalized in either a university or private hospital between 2002 and 2005.
<b>Intervention 1:</b>	Treatment as Usual (TAU) consisted of psychotherapy (mean # sessions=22.47), psychoactive medication (mean # different medications=1.66), medication follow-up (mean #=8.47), alcohol/drug treatment (n=4), psychiatric hospitalization (n=13), residential treatment (n=6)
<b>Intervention 2:</b>	Treatment as Usual plus Youth Support Team-II (TAU+YST-II) consisted of youth nominating caring adults from family, school, or neighborhood/community to serve as their supportive contacts. Intervention specialists were mental health professionals, assisted with the nomination process, and conducted psychoeducation sessions with the support persons. The psychoeducation included information on youth’s treatment plan, risk factors for suicidal behavior, availability of emergency services, and strategies for communicating with adolescents. Support persons had weekly contact with the youth.
<b>Setting:</b>	Not specified; 12 month follow-up period post hospitalization
<b>N:</b>	346; TAU=171, TAU+YST-II=175 (N’s reported and included in analysis after 12 month follow-up period)
<b>Mean age, % female, race (variance):</b>	Mean age=15.59 (SD=1.31), TAU=15.61 (SD=1.37), TAU+YST-II=15.56 (SD=1.24) % female=71 (same in both groups) % White=83.4, TAU=84, TAU+YST-II=83
<b>Outcome assessment:</b>	Presence or absence of one or more suicide attempts during follow-up was assessed via self-report, using the question, “Have you tried to kill yourself?” from the NIMH DISC-IV Mood Disorders Module.
<b>Results:</b>	No significant differences were found between groups for percent of adolescents with one or more attempts. % with one or more attempts in the 12 month follow-up period: TAU=35, TAU+YST-II=29, Chi-square (1, N=354)=0.66, <i>p</i> =.42 One suicide death occurred in the TAU group, no suicide deaths in the TAU+YST-II group