	Gaynes 2004[9]	Mann 2005[10]	NICE 2011[11]
Overall conclusions	The poor generalizability of the studies makes the overall strength of evidence fair, at best, while the results are mixed. Although some trends suggest incremental benefit from several interventions, no consistent statistically significant effects have emerged for interventions for which more than one study has been done.	Interventions need more evidence of efficacy.	The evidence base for the pharmacological treatment for self-harm remains very limited. The clinical efficacy of these medications remains uncertain. The variations in the treatment lengths, follow-up period, and participants' psychiatric diagnosis in these trials made it more difficult to warrant conclusions about the clinical effects of these medications.
		Scope	
Search dates	1966-October 2002	1966-June 2005	Up to January 2011
Populations included	Population of interest was primary care patients with previously unidentified suicide risk. Included RCTs were conducted in high-risk groups as identified by a deliberate self-harm episode, diagnosis of borderline personality disorder, or admission to a psychiatric unit.	Not specified	Adults, children, and young people with previous self-harm behavior
Interventions included	Pharmacotherapy, psychotherapy, referral/follow-up	Pharmacotherapy, psychotherapy, referral/follow-up	Pharmacotherapy, psychotherapy, referral/follow-up
Suicide-related outcomes included	Suicide completions, suicide attempts	Completed and attempted suicide	Primary outcome was repetition of self-harm; also included suicide outcomes.
Settings/countries included	Primary or specialty care settings; no exclusions based on country.	Included settings not specified; no exclusions based on country.	No exclusions by country
Other exclusion criteria	Clinical trials targeting patients with chronic psychotic illnesses; studies without adequate comparison groups.	No additional exclusion criteria specified.	
		Main Results: Pharmacotherapy	
Antidepressants	Meta-analysis showed no statistically significant effects. No benefit for fluoxetine vs placebo in patients without major depression with 2 more suicide attempts.	Meta-analyses of RCTS have generally not detected benefit for suicide or suicide attempts in mood and other psychiatric disorders.	Insufficient evidence for suicide and self-harm
Antipsychotics	Flupenthixol significantly reduced the proportion of repeated deliberate self-harm for those with at least 2 previous suicide attempts compared with placebo. No benefit for low-dose vs. ultra low-dose fluphenazine in nonpsychotic patients with a previous suicide attempt.	Benefit for clozapine in people with schizophrenia spectrum disorders in 2 RCTs.	One RCT provides limited evidence of benefit of flupenthixol on self-harm repetition prevention compared to placebo, though no recommendation was made due to study limitations and potential harms. One RCT provides insufficient evidence of benefit of fluphenazine on reducing repeated self-harm or suicide.
Mood stabilizers		One RCT showed an antisuicidal effect of lithium in major mood disorders.	One RCT resulted in no significant differences between lithium and placebo on repetition of self-harm. Though 3 cases of suicide in the placebo arm were compared to the 0 cases in the lithium arm, study limitations precluded making recommendations.
Omega-3 fatty acid supplements			One RCT reported no significant differences for self-harm repetition.