	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.	Compared with usual care, there was insufficient evidence to determine clinical effects between interventions and routine care in the reduction of the proportion of patients who repeated self-harm. Thus, no conclusions could be made regarding psychosocial interventions on reduction of repetitions of self-harm. For the outcome of suicide, no conclusions could be drawn due to the small evidence base.
		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: Psychotherapy	
Any psychological therapy (including problem-solving therapy, CBT, and psychodynamic therapy)			10 studies were combined, though study heterogeneity suggests that results should be interpreted with caution. Repetition of self-harm (up to 6 months, 2 studies): Less people from the treatment group had a repetition of self-harm compared with the TAU group; low quality. Repetition of self-harm (6 to 12 months, 5 studies): Less people from the treatment group had a repetition of self-harm compared with the TAU group; moderate quality. Repetition of self-harm (more than 12 months, 2 studies): Less people from the treatment group had a repetition of self-harm compared with the TAU group; low quality. Repetition of self-harm (at last follow-up, 9 studies): There was a statistically significant 24% reduction in chance of repetition in the treatment group compared with TAU; low quality.
Cognitive behavioral counseling/cognitive therapy	No significant difference in repeated suicidal behavior in one cohort study.	Cognitive therapy halved the reattempt rate in suicide attempters in one RCT.	Manual Assisted Cognitive Treatment: One study showed a non-significant reduction in self-harm, another showed a significant reduction. Results should be interpreted with caution due to study limitations.

	Gaynes 2004[9]	Mann 2005[10]	NICE 2011[11]
DBT	One RCT showed a reduction in repetition of deliberate self-harm in female veterans with borderline personality disorder.	Reduced suicidal behavior in people with borderline personality disorder.	DBT: The evidence showed some benefit in reducing rates of self-harm.
Intensive care plus outreach		Fewer suicide attempts.	
Interpersonal psychotherapy	Patients in therapy group were less likely to have a repeated episode of deliberate self-harm.	Fewer suicide attempts.	
Outpatient day hospitalization	No difference between groups.		
Problem-solving therapy	Meta-analysis of 5 studies showed a trend toward decreasing repetition of deliberate self-harm.	Fewer suicide attempts.	
Psychoanalytically oriented partial hospitalization	Fewer patients in the treatment group had attempted suicide at 36-month follow-up.	Reduced suicidal behavior in people with borderline personality disorder.	
Transference focused psychotherapy			Transference focused psychotherapy vs treatment by community psychotherapists: Significantly fewer attempted suicides in transference focused therapy group, but no difference in reduction of self-harm in either group. Results should be interpreted with caution due to study limitations.
Video education plus family therapy		No benefit in terms of re-attempt rate when compared to standard care.	
Main results: Comparative effectiveness of different types of therapy			
Home vs outpatient problem-solving therapy			No significant difference in repetition of self-harm in the year following treatment entry.
Inpatient behavior therapy vs inpatient insight-oriented therapy	No difference between groups.		Insufficient evidence to determine clinical differences between groups for repetition of self-harm.
Interpersonal problem-solving skills training vs brief problem-oriented therapy			Insufficient evidence to determine clinical differences between groups for repetition of self-harm. No suicides in either group.
Long-term therapy vs short-term therapy	No difference between groups.		Insufficient evidence to determine clinical differences between groups for repetition of self-harm.
Same therapist (continuity of care) vs different therapist (change of care)	No benefit for continuity of care.		Limited evidence suggesting that there was a clinically significant difference favoring different therapist over same therapist on reducing the likelihood of repetition of self-harm.