Author, Year (Country):	**Bateman 2008[117] (UK)**
Population:	Adults with borderline personality disorder
Therapy 1:	MBT by partial hospitalization consists of 18-month individual and group psychotherapy in a partial hospital setting offered within a structured and integrated program provided by a supervised team. Expressive therapy using art and writing groups is included. Crises are managed within the team; medication is prescribed according to protocol by a psychiatrist working in the therapy program. The understanding of behavior in terms of underlying mental states forms a common thread running across all aspects of treatment. The focus of therapy is on the patient's moment-to-moment state of mind. The patient and therapist collaboratively try to generate alternative perspectives to the patient's subjective experience of himself or herself and others by moving from validating and supportive interventions to exploring the therapy relationship itself as it suggests alternative understanding. This psychodynamic therapy is manualized (17) and in many respects overlaps with transference-focused psychotherapy. At the end of 18 months, the MBT by partial hospitalization patients were offered twice-weekly outpatient mentalizing group psychotherapy for a further 18 months,
Therapy 2:	Treatment as usual (TAU) consists of general psychiatric outpatient care with medication prescribed by the consultant psychiatrist, community support from mental health nurses, and periods of partial hospital and inpatient treatment as necessary but no specialist psychotherapy. After 18 months, the TAU group continued with general psychiatric care with psychotherapy but not MBT if recommended by the consultant psychiatrist.
Medication regimen:	Not specified
Setting:	Partial hospital program
Therapist characteristics:	Generic mental health professionals
Treatment duration:	36 months
N:	41: MBT=22, TAU=19
Mean age, % female, race (variance):	Age (SD): MBT=30.3 years (5.86), TAU=33.3 years (6.60) % Female: MBT=68%, TAU=47% Race NR
Other clinical characteristics:	Not reported
Concomitant medications:	Medication years (SD) Antidepressants: MBT=1.1 (1.8) vs TAU=3.3 (2.3) F (df=1, 35)=11.6, *P*= 0.002; effect size 1.10 (95% CI, 0.45 to 1.70) Antipsychotics: MBT= 0.16 (0.28) vs TAU= 3.1 (2.1); U=9.0, z=5.4, *P*=0.0000000005; effect size= 2.04 (95% CI, 1.60 to 2.50) Mood stabilizers: MBT=0.11 (0.26) vs TAU=1.8(2.1); U=105.0, z=3.2, *P*=0.001; effect size=1.17 (95% CI, 0.73 to 1.60) Three or more drugs (including hypnotics): MBT=0.02 (0.11) vs TAU=1.9 (1.9); U=58.5, z=4.6, *P*=0.0000009; effect size=1.45 (95% CI, 1.10 to 1.80)
Outcome assessment:	Number of suicide attempts over the whole of the 5-year postdischarge follow-up period. Suicidal behavior: 1) deliberate, 2) life-threatening, 3) resulted in medical intervention, and 4) medical assessment consistent with a suicide attempt. Self-harm: 1) deliberate, 2) resulted in visible tissue damage, and 3) nursing or medical intervention required.
Results:	Any suicide attempt: MBT=5/22 (23%) vs TAU=14/19 (74%); χ^2 (df=1)=8.7, *P*=0.003; effect size d=2.0 (95% CI, 1.4 to 4.9) Mean total number of suicide attempts (SD): MBT=0.05 (0.9) vs TAU=0.52 (0.48); U=73, z=3.9, *P*=0.00004; effect size d=1.4 (95% CI, 1.3 to 1.5)

Author, Year (Country):	**Bateman 2009[37] (UK)**
Population:	Adults with borderline personality disorder
Therapy 1:	MBT: Focused on helping patients reinstate mentalizing during a crisis via telephone contact and included: 1) once-weekly individual psychoanalytic psychotherapy; 2) thrice weekly group analytic psychotherapy (1 hour each); 3) once-a-week expressive therapy oriented toward psychodrama techniques (1 hour); and 4) a weekly community meeting (1 hour), all spread over 5 days. In addition, on a once-per-month basis, subjects had: 5) a meeting with the case administrator (1 hour); and 6) medication review by the resident psychiatrist.
Therapy 2:	SCM: Focused on support and problem solving, and included weekly combined individual and group psychotherapy and psychiatric review every 3 months. Therapy was based on a counseling model closest to a supportive approach with case management, advocacy support, and problem-oriented psychotherapeutic interventions.
Medication regimen:	The initial types and doses of medication were the same for both groups, and consisted of antidepressant and antipsychotic drugs prescribed as appropriate; polypharmacy was discouraged.
Setting:	Outpatient context in publicly-funded specialist personality disorder treatment center

Therapist characteristics:	Nonspecialist mental health practitioners
Treatment duration:	18 months
N:	134; MBT=71, SCM=63
Mean age, % female, race (variance):	Age, years: MBT=31.3 (SD=7.6); SCM=30.9 (SD=7.9) % female: MBT=80.3%, SCM=79.4% White British/European: MBT=76.1%, SCM=68.3% Black African/Afro-Caribbean: MBT=15.5%, SCM=20.6% Other Chinese/Turkish/Pakistani: MBT=8.5%, SCM=11.1%
Other clinical characteristics:	Rape: MBT=33.8% vs SCM=17.5% Drug use (> 4 times/week): MBT=40.8% vs 41.3% Suicide attempt past 6 months: MBT=74.6% vs 66.7% Current Axis I disorders: Major depressive disorder: MBT=57.7% vs SCM=54.0%; Depressive disorders include dysthymia: MBT=78.9% vs SCM=74.6%; Posttraumatic stress disorder: MBT=12.7% vs SCM=15.9%; any anxiety disorder: MBT=59.2% vs SCM=63.5%; Any substance use disorder: MBT=54.9% vs SCM=52.4%; Any eating disorder: MBT=28.2% vs SCM=27.0%; Somatoform disorder: MBT=11.3% vs SCM=14.3%
Concomitant medications:	Not reported
Outcome assessment:	Suicidal behavior: 1) deliberate, 2) life-threatening, 3) resulted in medical intervention, and 4) medical assessment consistent with a suicide attempt. Self-harm: 1) deliberate, 2) resulted in visible tissue damage, and 3) nursing or medical intervention required. Outcomes assessed at 6, 12, and 18 months.
Results:	<u>Life-threatening suicide attempts: (A) Proportion with episode=N/%; (B) Average count=Mean(SD)</u> After 6 months: MBT=(A) 37/52.1%, (B) 0.62 (0.74) vs SCM=(A) 33/52.4%, (B) 0.70 (0.81) After 12 months: MBT=(A) 23/32.4%, (B) 0.36 (0.57) vs SCM=(A) 30/47.6%, (B) 0.60 (0.77) After 18 months: MBT=(A) 2/2.8%, (B) 0.03 (0.17) vs SCM=(A) 16/25.4%, (B) 0.32 (0.62) Proportion with episode analysis: Wald χ^2 (df=3):76.21, *P*<0.001 Change over time=OR 0.41 (95% CI, 0.30 to 0.57); Group effect over time=OR 0.37 (95% CI, 0.21 to 0.62) At 12 months=RR 0.68 (95% CI, 0.44 to 1.04) In last 6 months=RR 0.11 (95% CI, 0.02 to 0.46) End of treatment difference=d=0.65 (95% CI, 0.58 to 0.73) Average count analysis: Wald χ^2 (df=3):212.56, *P*<0.001 Change over time=IRR 0.70 (95% CI, 0.62 to 0.80) Group effect over time=IRR 0.63 (95% CI, 0.53 to 0.75) <u>Severe self-harm incidents: (A) Proportion with episode=N/%; (B) Average count=Mean(SD)</u> After 6 months: MBT=(A) 53/74.6%, (B) 2.61(3.08) vs SCM=(A) 37/58.7%, (B) 1.79 (2.62) After 12 months: MBT=(A) 26/36.6%, (B) 1.30 (2.47) vs SCM=(A) 37/58.7%, (B) 1.73 (2.27) After 18 months: MBT=(A) 17/23.9%, (B) 0.38 (0.83) vs SCM=(A) 27/42.9%, (B) 1.66 (2.86) Proportion with episode analysis: Wald χ^2 (df=3):62.77, *P*<0.001 Change over time=OR 0.49(95% CI, 0.35 to 0.69); Group effect over time=OR 0.39 (95% CI, 0.23 to 0.66) First 6 months: RR 1.27 (95% CI, 0.99 to 1.63) 6 to 18 months: RR NR, but “MBT showed steeper decline” In last 6 months=RR 0.55 (95% CI, 0.33 to 0.92) End of treatment difference=d=0.62 (95% CI, 0.28 to 0.97) Average count analysis: Wald χ^2 (df=3):224.11, *P*<0.001 Change over time=IRR 0.74 (95% CI, 0.65 to 0.85) Group effect over time=IRR 0.69 (95% CI, 0.59 to 0.82)

Author, Year (Country):	**Blum 2008[39] (US)**
Population:	Adults with borderline personality disorder

Therapy 1:	Treatment as usual (TAU): Continuation of usual care, including individual psychotherapy, medication, and case management. Subjects received no instructions or advice about other pharmacologic or psychotherapeutic treatments.
Therapy 2:	Systems Training for Emotional Predictability and Problem Solving (STEPPS) plus TAU: STEPPS is a manual-based group treatment program that combines cognitive behavioral elements with skills training and has the following three main components: 1) psychoeducation, 2) emotion management skills training, and 3) behavior management skills training. The program involves 20 2-hour weekly sessions with 2 co-facilitators who follow a detailed lesson plan that includes homework assignments. STEPPS is systems-based in that family members, significant others, and health care professionals are educated about borderline personality disorder and instructed how best to interact with their relative or friend with the disorder.
Medication regimen:	Not specified
Setting:	Outpatient, group sessions with the look and feel of a seminar. Exact setting not specified.
Therapist characteristics:	Administered by 2 of the authors of the study (Ms. Blum and Mr. St. John)
Treatment duration:	20 weeks
N:	165: STEPPS=93 vs TAU=72
Mean age, % female, race (variance):	Mean age, years (SD): 31.5 (9.5) 83% female 94% Caucasian 2% African American 3% Other
Other clinical characteristics:	73% past suicide attempts 73% current major depressive disorder 1.8% DSM-IV personality disorders
Concomitant medications:	2.3% psychotropic medication use
Outcome assessment:	Data on suicide attempts and self-harm acts were collected at 1, 3, 6, 9 and 12 months. Outcome criteria were not defined.
Results:	Not reported separately by treatment group: Suicide attempts: 24 (22.2%), median number of attempts was 1.75 per year, and the mean was 2.60 Self-harm acts: 56 (45.2%), the median number of acts was 9.8 per year, and the mean was 16.6 Cox proportional hazards analysis: treatment group was not associated with time to first suicide attempt (χ^2<0.1, df=1, p=0.994) or first self-harm act (χ^2<0.1, df=1, p=0.902)

Author, Year (Country):	**BOSCOT Trial (Borderline Personality Disorder Study of Cognitive Therapy) (UK)** **Davidson 2006[40] – 1-year outcomes** **Davidson 2010[41] – 6-year outcomes**
Population:	Aged between 18 and 65 years, met criteria for at least 5 items of the borderline personality disorder using the Structured Clinical Interview for DSM-IV Axis II Personality Disorders, and had received either in-patient psychiatric services or an assessment at accident and emergency services or an episode of deliberate self-harm (either suicidal act or self-mutilation) in the previous 12 months
Therapy 1:	Treatment as usual (TAU): Included a wide variety of resources such as inpatient and outpatient hospital services, including A&E services, community based services such as drop in centers, and primary and community care services (GP, practice nurse, Community Psychiatric Nurse, etc.).
Therapy 2:	CBT specific to Cluster B personality disorder was delivered in up to 30 sessions of CBT over 1 year, each session lasting an hour, plus TAU.
Medication regimen:	Not reported
Setting:	Within the National Health Service in the U.K
Therapist characteristics:	5 therapists provided CBT in the trial. 4 were registered mental nurses and one, an occupational therapist. 3 of the therapists had completed a 10-month CBT training course and had a certificate in cognitive therapy, and 1 therapist had received CBT training in psychosis. Only 1 therapist had no previous training in CBT but had experience of managing individuals with personality disorder.
Treatment duration:	1 year
N:	106: CBT=54 vs TAU=52

Mean age, % female, race (variance):	Mean age (SD, range): 31.9 (9.1; 18-57) 84% female 100% White
Other clinical characteristics:	Beck Depression Inventory II Total Score, mean (SD): 42.5 (11.2) Average number of years since first act of deliberate self-harm (SD): 14.8 (10.0)
Concomitant medications:	Not reported
Outcome assessment:	Suicidal acts over 6 years, recorded using the Acts of Deliberate Self-Harm Inventory, which requires fulfillment of all 3 of the following criteria: 1) deliberate, 2) life threatening, and 3) the act resulted in medical intervention or intervention would have been warranted.
Results:	0-12 months (N=101): Subjects with suicidal acts: CBT= 18 (37%) vs TAU= 21 (46%). OR= 0.77 (95% CI ; 0.29 to 2.01) Mean episodes of suicidal acts (SD): CBT= 0.61 (0.95) vs TAU= 1.02 (2.14); adjusted Mean Difference (aMD)= −0.36 (95% CI, −0.83 to 0.13) 0-24 months (N=102): Subjects with suicidal acts: CBT= 23 (43%) vs TAU= 26 (54%). OR= 0.78 (95% CI ; 0.30 to 1.98) Mean episodes of suicidal acts (SD): CBT= 0.87 (1.47) vs TAU= 1.73 (3.11); aMD= −0.91 (95% CI, −1.67 to −0.15) 0-6 years (N=76): Subjects with suicidal acts: CBT= 56% (n = 24/43) vs TAU= 73% (n = 24/33); aOR = 0.37 (95% CI, 0.10 to 1.38) Mean episodes of suicidal acts (SD): CBT= 1.88 (3.19) vs TAU= 3.03 (4.16); aMD (TAU-CBT) = 1.26 (95% CI, -0.06 to 2.58)

Author, Year (Country):	**Comtois 2011[47] (US)**
Population:	Adults with a recent suicide attempt or imminent risk who (a) did not have appropriate outpatient mental health treatment available for an appointment in the next 2 weeks; (b) a NDA and weekly outpatient follow-up was an appropriate disposition plan, and (c) the patient was sufficiently stable to be discharged home for a minimum of 24 hours prior to NDA appointment.
Therapy 1:	CAMS: Intervention developed by the second author that modifies how clinicians engage, assess, and treat suicidality. CAMS involves the use of a Suicide Status Form (SSF) to guide assessment, treatment planning, on-going tracking of risk, and outcome/disposition of care. The SSF involves quantitative and qualitative assessments and consideration of empirically-based risk factors. CAMS sessions are provided weekly, generally for 50-60 minutes. CAMS generally lasts from a minimum of 4 sessions up to approximately 12 sessions.
Therapy 2:	E-CAU: Intake with the psychiatrist or psychiatric nurse practitioner followed by 1–11 visits with a case manager and as needed medication management. Treatment ends in 1–3 months when the ‘‘crisis is resolved’’ with referral for primary care follow-up or, when there is an appropriate diagnosis and funding is available, additional mental health or substance abuse treatment. Care in the study was enhanced by funding equivalent clinician time in both conditions and clinicians in both conditions were asked to schedule a minimum of 4 sessions (i.e., the minimum number of sessions in CAMS).
Medication regimen:	Not reported
Setting:	Outpatient crisis intervention setting attached to Harborview Medical Center, a county-owned, safety net hospital focused on underserved and unfunded populations. Study treatment conditions were provided in the Crisis Intervention Service to which all Harborview next-day appointments are referred.
Therapist characteristics:	CAMS: 4 clinicians (1 case manager, 2 psychologists, and 1 psychiatry resident) provided treatment after participating in a 1-day didactic training by Dr. Jobes, the CAMS developer and reaching acceptable levels of adherence. E-CAU: Provided by case managers with average years since degree=27.5, SD53.5
Treatment duration:	Variable, minimum of 4 sessions
N:	32: CAMS=16 vs E-CAU-16
Mean age, % female, race (variance):	Mean age (SD, range)=36.8 years (10.1, 19-62) 62% women 66% Caucasian
Other clinical characteristics:	0 months: mean (SD) Suicide attempts/self-inflicted injuries: CAMS=3.0 (9.3) vs E-CAU=7.7 (24.5) ED admissions: CAMS=1.5 (1.2) vs E-CAU=1.6 (0.8) Behavioral health ED admissions only: CAMS=1.3 (1.1) vs E-CAU=1.1 (0.6) Number of inpatient days: CAMS=5.5 (5.4) vs E-CAU=7.0 (7.0)
Concomitant medications:	Not reported

Outcome assessment:	Suicide attempts and self-inflicted injuries were categorized using the Suicide Attempt and Self-Injury Count SASI-C (Linehan 1996) at all follow-up assessments conducted at 2, 4, 6 and 12 months.
Results:	2 months: mean (SD) Suicide attempts/self-inflicted injuries: CAMS=N/A vs E-CAU=5.5 (7.8) ED admissions: CAMS=N/A vs E-CAU=0.5 (0.7) Behavioral health ED admissions only: CAMS=N/A vs E-CAU=1.1 (0.6) Number of inpatient days: CAMS=N/A vs E-CAU=4.0 (5.7) 4 months: mean (SD) Suicide attempts/self-inflicted injuries: CAMS=0.0 (0.0) vs E-CAU=0.8 (1.8) ED admissions: CAMS=0.4 (0.5) vs E-CAU=0.4 (0.7) Behavioral health ED admissions only: CAMS=0.1 (0.4) vs E-CAU=0.4 (0.7) Number of inpatient days: CAMS=1.4 (2.5) vs E-CAU=1.0 (2.3) 6 months: mean (SD) Suicide attempts/self-inflicted injuries: CAMS=0.2 (0.4) vs E-CAU=0.0 (0.0) ED admissions: CAMS=0.4 (0.5) vs E-CAU=0.2 (0.4) Behavioral health ED admissions only: CAMS=0.2 (0.4) vs E-CAU=0.2 (0.4) Number of inpatient days: CAMS=3.5 (7.0) vs E-CAU=1.3 (4.6) 12 months: mean (SD) Suicide attempts/self-inflicted injuries: CAMS=1.2 (3.9) vs E-CAU=3.3 (7.6) ED admissions: CAMS=0.4 (0.8) vs E-CAU=1.0 (2.4) Behavioral health ED admissions only: CAMS=0.2 (0.4) vs E-CAU=0.6 (1.6) Number of inpatient days: CAMS=1.4 (4.5) vs E-CAU=3.2 (8.0)

Author, Year (Country):	**De Leo 2007[45] (Australia)**
Population:	Men ages 18 years and older with a current admission at the local psychiatric ward due to severe suicidal ideation and/or attempt as the main motive for hospitalization.
Therapy 1:	Intensive case management (ICM): Case managers from a community mental health service had weekly face-to-face sessions with participants; intervention based on the rehabilitation model described by Rapp and Kisthardt. Outreach provided in a variety of settings including home visits; frequent contact, with a minimum of one contact per week for 12 months; staff available outside appointment times but within regular work hours; client-focused approach tailored to each individual; emphasis on skills-building and problem solving, encourages client empowerment and independence; linkage to services; advocacy services; provision of individual and group psychotherapy and counseling services; 2 telephone calls a week from counselors collaborating with case managers.
Therapy 2:	Treatment as usual: Individual Program Plans, pharmacotherapy, referrals to general practitioners, psychologists, psychiatrists, rehabilitation services, and/or the routine level of case management but not telephone calls from counselors.
Medication regimen:	None.
Setting:	Community mental health service.
Therapist characteristics:	Qualified mental health professionals with specialist training in mental psychotherapeutic techniques (e.g., psychologist, psychiatric nurse).
Treatment duration:	Mean 49.75 weeks.
N:	60 (22 completed 12-month treatment: 14 ICM, 8 TAU)
Mean age, % female, race (variance):	ICM vs TAU: Median age 34 years (range 24-59) vs 37 years (range 19-62) 100% male Race not reported
Other clinical characteristics:	80% unipolar depression; 17% bipolar depression; 10% psychotic disorder; 8% substance abuse disorder; 2% other diagnosis; 44% comorbid diagnoses.
Concomitant medications:	Not reported
Outcome assessment:	Questions on functioning in life domains, health service use, and professional contacts determined in structured interviews with trained clinical psychologists, who performed the examinations (including self-report scales) at 6-monthly intervals; the first being immediately following discharge.

Results:	No suicides in the 12-month follow-up period. Self-harming behaviors (ICM vs TAU) 6 months: 3/14 (21.4%) vs 1/8 (12.4%) 12 months: 2/14 (14.3%) vs 2/8 (25.0%) P-values not reported

Author, Year (Country):	**Diamond 2010[46] (US)**
Population:	Suicidal adolescents (Suicidal Ideation Questionnaire (SIQJR) score > 31; Beck Depression Inventory (BDI-II) > 20) between the ages of 12 and 17, identified in primary care and emergency departments
Therapy 1:	Attention-Based Family Therapy (ABFT): Focuses on strengthening parent-adolescent attachment bonds using a process-oriented, emotion-focused semistructured treatment protocol conceptualized as 5 specific tasks: 1) Relational Reframe Task to strengthen relationships; 2) Adolescent Alliance Task to prepare adolescent to discuss core family conflicts with parents; 3) Parent Alliance Task to teach emotionally focused parenting skills; 4) Reattachment Task for families to practice new skills; and 5) Competency Task to promote adolescent autonomy.
Therapy 2:	Enhanced Usual Care (EUC): A facilitated referral process with ongoing clinical monitoring.
Medication regimen:	Antidepressant medication allowed if started ≥12 weeks before randomization.
Setting:	Department of Psychiatry at the Children's Hospital of Philadelphia (CHOP).
Therapist characteristics:	Seven Ph.D.- or M.S.W.-level therapists provided ABFT under supervision of Guy and Gary Diamond
Treatment duration:	24 weeks
N:	66
Mean age, % female, race (variance):	Mean age, years (SD): ABFT=15.11 (1.41) vs EUC=15.29 (1.83) % Female: ABFT=91.4% vs EUC=74.2% African American: ABFT=71.4% vs EUC= 77.4%
Other clinical characteristics:	<u>Current psychiatric diagnoses, % patients</u> Major depressive episode: ABFT=37.1% vs EUC=41.9% Dysthymia: ABFT=8.6% vs EUC=6.52% Any anxiety: ABFT=60.0% vs EUC=74.2% Externalizing disorder (ADHD, ODD, CD): ABFT=65% vs EUC=48% <u>Clinical History, % patients</u> Adolescent attempted suicide in the past: ABFT=61.3% vs EUC=62.9% Multiple attempts: ABFT=81.8% vs EUC=63.2% Past psychiatric hospitalization: ABFT=20.0% vs EUC=24.1% Taking antidepressant medicine: ABFT=8.6% vs EUC=10.3% Family history of suicide attempt: ABFT=30.3% vs EUC=34.3%
Concomitant medications:	Taking antidepressant medicine: ABFT 8.6% vs EUC=10.3%
Outcome assessment:	Clinical status monitored weekly using the SIQ-JR and BDI-II, administered either face-to-face (ABFT) or over the phone (EUC). Definition of "low lethality suicide attempts" not reported.
Results:	Low lethality suicide attempts: ABFT=11% (4/35); EUC=22% (7/31); *p* not reported

Author, Year (Country):	**Donaldson 2005[48] (US)**
Population:	Adolescents (12–17 years old) who presented to a general pediatric emergency department or inpatient unit of an affiliated child psychiatric hospital in the Northeast after a suicide attempt. Any intentional, nonfatal self-injury, regardless of medical lethality, was considered a suicide attempt if intent to die was indicated
Therapy 1:	Skills-Based Treatment (SBT): Focused on problem solving and affect management skills. Each session included an assessment of suicidality, skill education, and skill practice (both in-session and homework assignments). Participants were taught steps of effective problem solving and cognitive and behavioral strategies for affect management (e.g., cognitive restructuring, relaxation) and given homework assignments to assist in skill acquisition and generalization. The SBT included active and maintenance treatment phases. The active phase included 6 individual sessions and 1 adjunct family session administered during the first 3 months of treatment. The maintenance phase included 3 monthly sessions. At the therapist's discretion, 2 additional family sessions and 2 crisis sessions were available.

Therapy 2:	Supportive Relationship Treatment (SRT): Was adapted from the Supportive Relationship Treatment Manual of Brent and Kolko (1991). This treatment was supportive in nature and focused the adolescent's mood and behavior as well as factors that contribute to adolescent suicidal behavior. Sessions were unstructured and addressed reported symptoms and problems. Techniques included exploratory questioning, encouraging affect, connecting affect to events, and providing feedback about changes obtained in treatment. In contrast to SBT, specific skills were not taught and homework assignments were not given during any of the SRT sessions. The session protocol for SRT was identify to that of SBT (described above).
Medication regimen:	Not reported
Setting:	Not reported
Therapist characteristics:	7 therapists provided both treatments. 5 of the therapists held a doctorate in clinical psychology, 1 a master's degree in psychology, and 1 a master's degree in social work. Therapists received training in both approaches to allow for a crossed design
Treatment duration:	6 months
N:	39: SBT=21 vs SRT=18
Mean age, % female, race (variance):	Mean age (SD)=15.0 (1.7) 82% female 85% White 10% Hispanic 5% African American
Other clinical characteristics:	≥ 1 previous attempt: SBT=53 (8%) vs SRT=44 (7%) Major depressive disorder: SBT=27 (4%) vs SRT=31 (5%) Disruptive behavior disorder: SBT=27 (4%) vs SRT=63 (10%) Alcohol use disorder: SBT=13 (2%) vs SRT=25 (4%) Cannabis use disorder: SBT=40 (6%) vs SRT=50 (8%) Number of diagnoses: None: SBT=53 (8%) vs SRT=25 (4%); 1: SBT=20 (3%) vs SRT=38 (6%); >2: SBT=27 (4%) vs SRT= 38 (6%)
Concomitant medications:	50% selective serotonin reuptake inhibitor (SSRI) alone 33% SSRI plus another medication 6% atypical antidepressant 11% mood stabilizer
Outcome assessment:	Outcome measures were administered 3 months (end of active treatment) and 6 months (end of maintenance)
Results:	N=31 Reattempts at 6 months: SBT=26.7% (4/15) vs SRT=12.5% (2/16); χ^2=1.00 The difference in rates of suicide reattempts among those taking (n = 6/6) versus not taking (n = 0/25) medication was statistically significant: χ^2=7.95, P < .05

Author, Year (Country):	**Green 2011[44] (UK)**
Population:	Adolescents aged 12-17 years with at least 2 past episodes of self-harm within the previous 12 months.
Therapy 1:	Developmental group psychotherapy: manual-based treatment designed for self-harming adolescents. Integrated techniques including CBT, DBT, and group psychotherapy. Adolescents learned strategies to deal with difficulties using group based techniques such as role play.
Therapy 2:	Local child and adolescent mental health services teams provided standard routine care according to their clinical judgment. Centers excluded any group intervention from routine care during the trial.
Medication regimen:	None.
Setting:	Child and adolescent mental health service teams in the northwest of England, who served substantial geographical areas.
Therapist characteristics:	Therapists had a minimum of 3 years of relevant post-qualifying experience; had initial training in fidelity to the model and subsequent regular supervision.
Treatment Duration:	Rolling entry; adolescents started attending as soon as their initial assessment and randomization were completed and attendance continued until the young person felt ready to leave. Mean number of group sessions attended was 102 (SD 10.1). Minimum per protocol adherence was 4 sessions per site per year.
N:	366 (183 group therapy, 183 usual care)
Mean age, % female, race (variance):	38% age 12 to 14 years at entry, 62% 15 to 17 years (mean ages not reported) 89% female 7% black and ethnic minority

Other clinical characteristics:	69% high psychosocial risk; 62% depressive disorder; 33% behavioral disorder
Concomitant medications:	Not reported
Outcome assessment:	Primary outcome was the frequency of episodes of self-harm (includes non-suicidal self-harm). Face-to-face interview, structured interviewing techniques, additional monthly telephone interview with patient and family.
Results:	3 episodes of self-harm resulting in severe physical injury (2 usual care, 1 group therapy). No suicides or other deaths.

Author, Year (Country):	**Hatcher 2011[36] (New Zealand)**
Population:	Patients over age 16 who presented to the hospital after self-harm between September 2005 and June 2008. Self-harm included: "intentional self-poisoning or self-injury, irrespective of motivation. Self-poisoning included the intentional ingestion of more than the prescribed amount of any drug, whether or not there was evidence that the act was intended to result in death. This also included poisoning with non-ingestible substances (for example pesticides or carpet cleaner), overdoses of 'recreational' drugs and severe alcohol intoxication where the clinical staff considered such cases to be an act of self-harm. Self-injury was defined as any injury that had been intentionally self-inflicted." Patients receiving DBT or other "management plan which precluded having a short-term therapy" were excluded from the study.
Intervention 1:	Treatment as usual (TAU): Varied and may involve referral to multidisciplinary teams for psychiatric or psychological intervention, referral to mental health crisis teams, recommendations for engagement with alcohol and drug treatment centers or other health and non-health services.
Intervention 2:	Problem-solving therapy plus treatment as usual (PST+TAU): Up to 9 hour-long sessions lasting up to 3 months. Conducted with individual patients in outpatient clinics. Steps included problem orientation, problem listing and definition, brainstorming, devising an action plan and reviewing the plan. Engaged people by getting them to tell the story of their attempt and understanding the motivation behind it. Conducted regular risk assessments and in the final sessions asked participants to apply their new skills to the circumstances around their original self-harm attempt.
Setting:	4 District Health Boards (hospitals providing healthcare to about a third of the New Zealand population).
N:	1094; PST+TAU=522, TAU=572
Mean age, % female, race (variance):	Age, years (SD): PST+TAU=33.2 (12.5) vs TAU=34.2 (13.2) % female: PST+TAU=68% vs TAU=69% Ethnicity (%); PST+TAU vs TAU: NZ European 62% vs 60%, Maori 14% vs 17%, Pacific Island 7% vs 5%, Asian 2% vs 4%, Other 15% vs 13%
Outcome assessment:	Primary outcome was presentation to hospital with self-harm in the year after the index attempt. Obtained from the New Zealand Health Information Service details of hospital contacts throughout New Zealand in the year after the index attempt. Data obtained from the National Minimum Dataset kept by the New Zealand health information service, which contains routinely collected information on all public and private hospital discharges in New Zealand.
Results:	<u>Consenting Patients</u> *Participants re-presenting to hospital for self-harm; PST+TAU vs TAU:* All index episodes (N=253 vs 299): 14.2% vs 17.1%; RR=0.17 (95% CI -0.24 to 0.44); P=0.43 Index episode is first self-harm episode (N=137 vs 169): 13.9% vs 8.9%; RR=-0.56 (95% CI -1.96 to 0.18); P=0.23 Index episode is repeat episode (N=116 vs 130): 14.7% vs 27.7%; RR=0.47 (95% CI 0.11 to 0.69); P=0.02; NNT=8 *Participants with self-reported self-harm; PST+TAU vs TAU:* All index episodes (N=186 vs 226): 27.4% vs 32.7%; RR=0.16 (95% CI -0.13 to 0.38); P=0.29 Index episode is first self-harm episode (N=98 vs 122): 25.5% vs 20.5%; RR= -0.25 (95% CI -1.03 to 0.24); P=0.47 Index episode is repeat episode (N=88 vs 104): 29.5% vs 47.1%; RR=0.37 (95% CI 0.08 to 0.57); P=0.02; NNT=6 *Time to re-presentation to hospital, days : median; PST+TAU vs TAU:* All index episodes: 56 vs 83; HR=0.81 (95% CI 0.53 to 1.25); P=0.92 Index episode is first self-harm episode: 62 vs 75; HR=1.62 (95% CI 0.82 to 3.18); P=0.16 Index episode is repeat episode: 45 vs 104; HR=0.47 (95% CI 0.26 to 0.85); P=0.01 <u>All Patients</u> *Participants re-presenting to hospital for self-harm; PST+TAU vs TAU:* All index episodes (N=522 vs 572): 13.4% vs 14.1%; RR=0.05 (95% CI -0.28 to 0.30); P=0.79 Index episode is first self-harm episode (N=314 vs 360): 13.4% vs 9.4%; RR=-0.42 (95% CI -1.17 to 0.08); P=0.37 Index episode is repeat episode (N=208 vs 212): 13.5% vs 22.1%; RR=0.39 (95% CI 0.07 to 0.60); P=0.03; NNT=12 *Time to re-presentation to hospital, days : median; PST+TAU vs TAU:* All index episodes: 74 vs 75; HR=0.98 (95% CI 0.71 to 1.36); P=0.92 Index episode is first self-harm episode: 74 vs 61; HR=1.55 (95% CI 0.98 to 2.48); P=0.06 Index episode is repeat episode: 80 vs 114; HR=0.58 (95% CI 0.36 to 0.94); P=0.03

Author, Year (Country):	Hazell 2009[49] (Australia)
Population:	Adolescents aged between 12 and 16 years, who had been referred to a child and adolescent mental health service in Australian sites at Newcastle, Brisbane North, or Logan, and reported at least 2 episodes of self-harm in the past year, 1 of which had occurred in the past 3 months
Therapy 1:	Group Therapy (GT): Developed by Wood et al. (2001) and administered as described in treatment manual (Wood 2001). One-hour group sessions conducted weekly. Initial 6 sessions focused on relationships, school and peer relationships, family problems, anger management, depression and self-harm, and hopelessness and feelings about the future. After completion of the initial 6 sessions, adolescents could transition to a longer term group for up to 12 months.
Therapy 2:	Routine Care (RC): Generally consisted of individual counseling (using a variety of therapeutic approaches), family sessions, medication assessment and review, and other care coordination activities
Medication regimen:	Details not reported
Setting:	Community-based adolescent mental health service
Therapist characteristics:	GT: Delivered by 2 clinicians from each participating community-based adolescent mental health service, who were qualified psychologists, clinical psychologists, social workers, or nurses and were supervised by chief investigators RC: Also provided by community-based adolescent mental health services, but monitored via a self-report resource use surveys and the collection of information from electronic health records.
Treatment duration:	Up to 12 months
N:	72
Mean age, % female, race (variance):	Mean age, years (SD): GT=14.57 (1.07) vs RC=14.41 (1.19) % Female: GT=91% vs RC=89% Race not reported
Other clinical characteristics:	% Patients with: At least 1 incident of medication overdose: GT=71% vs RC=43% At least 1 incident of deliberate self-cutting: GT=100% vs RC=97% Medically serious self-harm: GT=9% vs RC=5% Lifetime probable or definite sexual abuse: GT=31% vs RC=32% Alcohol problems: GT=6% vs RC=3% Substance misuse: GT=0 vs RC=0 Depression: GT=49% vs RC=65% Conduct/oppositional defiant disorder: GT=6% vs RC=8%
Concomitant medications:	Not reported
Outcome assessment:	Primary outcome measure was repetition of self-harm, defined as any intentional self-inflicted injury (including poisoning) irrespective of the apparent purpose of the behavior, based on an interview-based assessment of suicide behavior (Kerfoot 1992, Linehan 1999).
Results:	Repetition of Deliberate Self-Harm by 6 months: GT = 88% (30/34); RC = 68% (23/34); $p = 0.04$ Repetition of Deliberate Self-Harm in interval of 6 to 12 months: GT = 88% (30/34); RC = 71% (24/34); $p = 0.07$

Author, Year (Country):	Linehan 2006[38] (US)
Population:	Women between the ages of 18 and 45 years who met criteria for borderline personality disorder and for current and past suicidal behavior as defined by at least 2 suicide attempts or self-injuries n the past 5 years, with at least 1 in the past 8 weeks.
Therapy 1:	DBT: A cognitive behavioral treatment program developed to treat suicidal clients meeting criteria for BPD (Linehan 1993, Linehan 1993) that directly targets: 1) suicidal behavior, 2) behaviors that interfere with treatment delivery, and 3) other dangerous, severe, or destabilizing behaviors. Standard DBT addresses the following 5 functions: 1) increasing behavioral capabilities, 2) improving motivation for skillful behavior (through contingency management and reduction of interfering emotions and cognitions), 3) assuring generalization of gains to the natural environment, 4) structuring the treatment environment so that it reinforces functional rather than dysfunctional behaviors, and 5) enhancing therapist capabilities and motivation to treat patients effectively. These functions are divided among the following 4 modes of service delivery: 1) weekly individual psychotherapy (1 h/wk), 2) group skills training (2½ h/wk), 3) telephone consultation (as needed within the therapist's limits to ensure generalization), and (4) weekly therapist consultation team meetings (to enhance therapist motivation and skills and to provide therapy for the therapists).
Therapy 2:	Community Treatment By Experts (CTBE): This condition was developed specifically for this study to control for factors previously uncontrolled for in DBT studies. Similar to a TAU (treatment as usual) condition, the treatment provided was uncontrolled by the research team. Therapists were asked to provide the type and dose of therapy that they believed was most suited to the patient, with a minimum of 1 scheduled individual session per week. Ancillary treatment could be prescribed as needed. CTBE differs from TAU conditions in that characteristics of CTBE therapists are controlled by the study via selection of therapists and supervisory arrangements. CTBE therapists included heads of inpatient psychiatric units and clinical directors of mental health agencies.

Medication regimen:	Not reported
Setting:	Not reported
Therapist characteristics:	41 therapists (16 DBT and 25 CTBE therapists). Doctoral degree: DBT=75% vs CTBE=56% > 10 years' clinical experience since terminal degree: DBT=25% vs CTBE=56% Male: DBT=31.3% vs CTBE=36% Mean number of study clients: DBT=3.6 (2.9) vs CTBE=2.5 (1.7) Subjects in group consultation: DBT=100% vs 57.1%
Treatment duration:	1 year
N:	111: DBT=60 vs CTBE=51
Mean age, % female, race (variance):	Mean age, years (SD): 29.3 (7.5) 100% women White: 87% African American: 4% Native American: 2% Native American or Alaskan Native: 1% Other Race: 5%
Other clinical characteristics:	Current psychiatric diagnoses meeting *DSM-IV* criteria: Major depressive disorder=72.3%, Panic Disorder=40.6%, Post-Traumatic Stress Disorder=49.5%, Any Anxiety Disorder=78.2%, Any Substance Use Disorder=29.7%, Any Eating Disorder=23.8% Lifetime psychiatric diagnoses meeting *DSM-IV* criteria: Major depressive disorder=96%, Panic Disorder=51.5%, Post-Traumatic Stress Disorder=55.4%, Any Anxiety Disorder=87.1%, Any Substance Use Disorder=73.3%, Any Eating Disorder=39.6% Axis II: Cluster A=3.0%, Cluster B other than borderline personality disorder=10.9%, Cluster C=25.7%, Paranoid=3.0, Schizoid=0.0, Schizotypal=0.0, Antisocial=10.9%, Histrionic=2.0%, Narcissistic=0.0%, Avoidant=20.8%, Dependent=5.9%, Obsessive Compulsive=7.9%, Psychiatric Disorder Not Otherwise Specified=89.1% Median suicide attempts (interquartile range): 1.0 (0.5-4.0) Median nonsuicidal self-injury (interquartile range): 10.0 (2.0 to 47.0)
Concomitant medications:	Proportion of subjects taking any psychotropic medications (Estimated from Figure 2): 12 months: DBT=47% vs CTBE=69% 24 months: DBT=54% vs CTBE=63%
Outcome assessment:	The Suicide Attempt Self-Injury Interview (Seligman 2006) measured the topography, suicide intent, and medical severity of each suicide attempt and nonsuicidal self-injury. Assessments completed at 4-month intervals during the 12-month treatment and 12 months of post-treatment follow-up periods by blinded, independent clinical assessors with master's or doctoral degrees.
Results:	Median suicides (interquartile range): DBT=0 (0 to 0) vs CTBE=0 (0 to 1) Suicide attempts: DBT=23.1% vs CTBE=46%, *P*=0.01, HR=2.66 (95% CI not reported; *P*=0.005), NNT=4.24 (95% CI, 2.40 to 18.07) Nonambivalent suicide attempts: DBT=5.8% vs CTBE=13.3%, *P*=0.18, NNT=13.3 (95% CI, 5.28 to 25.41) Suicide attempts per period: Significantly fewer in the DBT group across the 2 years when controlling for number of suicide attempts during the pretreatment year (F1,94=3.20, *P*=.04, MMANOVA). Mean proportions of suicide attempters per period: DBT=6.2% (95% CI, 3.1% to 11.7%) vs CTBE=12.2% (95% CI, 7.1% to 20.3%)

Author, Year (Country):	**McMain 2009[42] (Canada)**
Population:	Patients who met DSM-IV criteria for borderline personality disorder (BPD), were 18–60 years of age, and had at least two episodes of suicidal or nonsuicidal self-injurious episodes in the past 5 years, at least one of which was in the 3 months preceding enrollment

Therapy 1:	DBT: A cognitive behavioral treatment program developed by Linehan (Linehan 1993, Linehan 1993), which includes the following components: *Theoretical basis:* Learning theory, Zen philosophy, and dialectical philosophy. Pervasive emotion dysregulation is the primary deficit in borderline personality disorder. *Treatment structure:* Multimodal: Individual sessions (1 hour weekly); skills group (2 hours weekly); phone coaching (2 hours weekly); consultation team for therapists mandated (2 hrs weekly); organized according to a hierarchy of targets: suicidal, treatment-interfering, and quality-of-life-interfering behaviors; explicit focus on self-harm and suicidal behavior *Primary strategies:* Psychoeducation about BPD, helping relationship, here-and-now focus, validation and empathy, emotion focus, dialectical strategies, irreverent and reciprocal communication style, formal skills training, behavioral strategies (e.g., exposure, contingency management, diary cards, behavioral aspects) *Crisis management protocols:* Bias toward managing crises on an outpatient basis; phone coaching to assist in managing crises
Therapy 2:	General Psychiatric Management. (GPM): Based on the APA Practice Guideline for the Treatment of Patients With Borderline Personality Disorder and included the following components: *Theoretical basis:* Psychodynamic approach drawn from Gunderson 2001; emphasized the relational aspects and early attachment relationships. Disturbed attachment relationships related to emotion dysregulation as a primary deficit. *Treatment structure:* One mode: Individual sessions (1 hour weekly) including medication management based on structured drug algorithm; therapist supervision meeting mandated (90 minutes weekly); patient preference is given priority—no hierarchy of targets; focus is expanded away from self-harm and suicidal behaviors. *Primary strategies:* Psychoeducation about BPD, helping relationship, here-and-now focus, validation and empathy, emotion focus, active attention to signs of negative transference. Crisis management protocols: Hospitalization if indicated.
Medication regimen:	DBT: Patients encouraged to rely on skills over pills where appropriate (e.g., anxiolytics). Tapering from medications was a treatment goal. Psychopharmacologic intervention was uncontrolled GPM: Patients were encouraged to use medications concurrently. Two medication algorithms, one related to mood lability and one related to impulsive-aggressiveness, were prioritized as symptom targets. Medication intervention was delivered according to the predominant symptom pattern.
Setting:	Treatments conducted at separate University of Toronto teaching hospitals within the same health care system. DBT was conducted at the Centre for Addiction and Mental Health and GPM at St. Michael's Hospital.
Therapist characteristics:	Treatments were delivered by 25 therapists, all with a minimum of 2 years of clinical experience and a minimum of 1 year of experience treatment borderline patients. Therapists included 11 psychiatrists (three and eight providing DBT and general psychiatric management, respectively), five Ph.D.-level psychologists (four and one, respectively), six master's-level clinicians (five and one, respectively), and three nurses (one and two, respectively). There were no between-group differences in the proportion of clinicians with doctoral-level degrees (M.D. and Ph.D.) versus other degrees, but there were significantly more physicians in the general psychiatric management condition (χ^2=4.8, df=1, p=0.028).
Treatment duration:	12 months
N:	180: DBT=90 vs GPM=90
Mean age, % female, race (variance):	Mean age, years (SD): 30.4 (9.9) 86.1% female Race not reported
Other clinical characteristics:	Lifetime DSM-IV axis I disorders, % patients: Major depressive disorder=80.0%, Panic disorder=31.7%, Post-Traumatic Stress Disorder=47.2%, any Anxiety Disorder=76.1%, any Substance Use Disorder=58.9%, any Eating Disorder=30.6% Current DSM-IV axis I and II diagnoses: Major depressive disorder=48.9%, Panic disorder=21.7%, Post-Traumatic Stress Disorder=37.4%, any Anxiety Disorder=75%, any Substance Use Disorder=9.4%, any Eating Disorder=13.3%, Axis II cluster A disorders=7.8%, Axis II cluster B diagnosis (excluding BPD)=17.8%, Axis II cluster C disorders=40.6% Mean lifetime suicide attempts (SD): 24.7 (88.3)
Concomitant medications:	Not reported.
Outcome assessment:	The primary outcome measures were frequency and severity of suicidal and nonsuicidal self-injurious behavior episodes, as assessed every 4 months by the Suicide Attempt Self-Injury Interview (M.M. Linehan et al., unpublished 1983 manuscript).
Results:	Deaths by suicide: None Mean number of suicidal and self-injurious episodes (SD): OR 0.92 (*P*=0.76) 4 months: DBT=10.60 (20.96) vs GPM=14.02 (43.87) 8 months: DBT=8.94 (19.07) vs GPM=11.44 (37.59) 12 months: DBT=4.29 (9.32) vs GPM=12.87 (51.45)

Author, Year (Country):	**Stewart 2009[50] (Australia)**
Population:	People aged 18 years or older receiving inpatient treatment for a suicide attempt.
Therapy 1:	CBT: based on a combination of Beck's CBT and Albert Ellis's theory of rational emotive therapy. Individual weekly sessions.
Therapy 2:	Problem-Solving Therapy (PST): based on the 6-step D'Zurilla and Goldfried model. Individual weekly sessions.
Medication regimen:	None
Setting:	2 hospitals in Australia
Therapist characteristics:	Treatments administered by the researcher (not described)
Treatment duration:	Sessions were one hour, with PST completed over 4 sessions and CBT over approximately 7 sessions.
N:	Unclear: states number of participants was 32, but also reports that 11 patients completed CBT, 12 PST, and 9 treatment as usual
Mean age, % female, race (variance):	Age range 20-58 years (mean not reported) 53% female Race not reported
Other clinical characteristics:	None reported.
Concomitant medications:	None reported.
Outcome assessment:	Four tests of psychological functioning, and repeated attempt data from hospital chart audits that recorded re-presentation to the hospital for suicide attempts. Measures administered when participants were initially screened, directly following treatment (for PST and CBT groups) and at 2-month follow-up (for the treatment as usual group).
Results:	Average number of suicide attempts: CBT: 0.22 (SD=0.64) PST: 0.33 (SD=0.63) TAU: 0.22 (SD=0.50) No significant differences found for repetition of suicide attempts when PST group was compared to TAU (U=35, ns, r=0.13) and when CBT was compared to TAU (U=25, ns, r=0.32)

Author, Year (Country):	**Tarrier 2006[51] (UK)**
Population:	DSM-4 criteria for schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder or psychosis not otherwise specified; either first or second admission to inpatient or daypatient unit for treatment of psychosis; positive psychotic symptoms for 4 weeks or more.
Therapy 1:	CBT: Manual-based and supervised. Addressed delusions and hallucinations, generating alternative hypotheses for abnormal beliefs and hallucinations, identifying precipitating and alleviating factors and reducing associated distress, and teaching coping strategies.
Therapy 2:	Supportive counseling (SC). Delivered in the same 5-week format with 3 boosters, with the aim of matching the duration of total therapist contact time to that in the CBT arm. SC was manual based and supervised; the same 5 therapists administered both interventions.
Therapy 2:	Treatment as usual
Medication regimen:	None as part of the intervention
Setting:	11 mental health units serving 3 geographically defined catchment areas.
Therapist characteristics:	5 therapists trained in CBT for psychosis; 3 were clinical psychologists and 2 nurse therapists
Treatment duration:	Aimed for 15-20 hours treatment envelope within a 5-week post-admission period, plus booster sessions at a further 2 weeks, and 1, 2, and 3 months.
N:	278; unclear how many in each group
Mean age, % female, race (variance):	Not reported by treatment group; reported by low self-harm score (N=242) and high self-harm score (N=36): Mean age, years (SD): 29.7 (10.6) and 28.6 (6.4) % female: 30.6% Ethnic minority (not specified): 12.2%
Other clinical characteristics:	35% detained under MHA 35% no substance misuse; 13.7% daily substance misuse
Concomitant medications:	Chlorpromazine equivalents: mean (SD) Low self-harm score=489.3 (374.4) mg High self-harm score=537.2 (460.2) mg

Outcome assessment:	Deaths for any reason identified from hospital and psychiatric notes. Suicides and possible suicides (where the death might have been intentional or accidental and the coroner ruled the death as accidental) were identified. Suicide ideation and behavior (combined) assessed by the non-accidental self injury scale of the HoNOS (Health of the Nation Outcome Scales). Serious risk (score of 4) indicates suicidal attempts or deliberate self-harm. Assessed at 6 weeks, 3 months, and 18 months.
Results:	Over 18 months, there were 3 definite suicides (1.2%), 2 in the supportive counseling group and 1 in CBT group. Two further deaths classified as accidental by the coroner (1 traffic accident, 1 fall from window, 1 in supportive counseling group, 1 in CBT group). 2 deaths by natural causes. Numbers too small for meaningful statistical analysis. On the HoNOS, there were no significant differences between the 3 treatment groups at any time point. Psychological treatment did not significantly reduce or worsen suicidal behavior compared to treatment as usual. There was a marked reduction in suicidal behavior after admission that would mask any potential treatment effect.

Author, Year (Country):	**Unutzer 2006[52] (US)**
Population:	Aged 60 and older, met criteria for current major depression, dysthymia, or both, and planned to use one of the participating primary care clinics over the following year.
Intervention 1:	IMPACT intervention: 1-year collaborative care program that included a Depression Care manager (DCM, nurses and psychologists). DCMs completed an initial assessment visit and provided education about treatment options, including antidepressant medications and psychotherapy. All patients were encouraged to engage in behavioral activation and offered a choice of treatment with antidepressant medications, or Problem Solving Treatment in Primary Care, a brief behavioral intervention lasting between 4 and 8 sessions that non-mental health providers provide. DCMs received weekly supervision from a PCP and a psychiatrist to monitor progress and adjust treatment plans according to a stepped-care treatment algorighm. The DCM followed patients in person or by telephone approximately every 2 weeks during acute-phase treatment and monthly during the continuation phase.
Intervention 2:	Usual care: patients and their PCPs were told that patients met research diagnostic criteria for major depression or dysthymia. Patients could receive all treatments available, including antidepressant medications or counseling by their PCPs, as well as referral to specialty mental health care.
Setting:	18 primary care clinics affiliated with healthcare organizations in 5 states (Indiana, Texas, North Carolina, California, Washington)
N:	1801; IMPACT=906, Usual care=895
Mean age, % female, race (variance):	IMPACT vs Usual care Age, years (SD): 71.01 (7.35) vs 71.35 (7.6) % female: 64.1% vs 65.6% White: 78.2% vs 75.9% African American: 12.6% vs 12.1% Latino: 6.2% vs 9.1% Other race/ethnicity: 3.0% vs 2.9%
Outcome assessment:	Primary outcome was suicidal ideation. No information on how deaths were ascertained.
Results:	117 participants died before the 24-month follow-up; 61 of them (52%) were in the intervention group. To the authors' knowledge, there were no suicides in either group during the 2-year study period.
Comments	A suicide prevention protocol was in place for both groups: Patients who endorsed thoughts of suicide were asked if they thought they might act on these feelings; if they answered yes or refused to answer, the interviewer encouraged the patient to discuss these thoughts with a professional and offered telephone numbers including a 24-hour emergency contact number and a suicide hotline. The protocol was activated 135 times for 108 study patients (89 times usual care vs 46 times intervention). Of the patients who triggered the risk-reduction protocol, 7.7% were in the usual care group and 4.3% in the intervention group (P<0.01)

Author, Year (Country):	**Winter 2007[43] (UK)**
Population:	People attending two Accident and Emergency departments following episodes of self-harm.
Therapy 1:	Personal construct psychotherapy. Techniques were selected on the basis of their likely impact on the client's construing. Therapeutic techniques appropriate to particular personal construct formulations of the client's self-harm were set out in a brief manual.
Therapy 2:	Normal clinical practice: Assessment by, and possible follow-up appointments with, a mental health team. In one of the Accident and Emergency departments, a psychiatric crisis team visited the client while in the department; in the other, an appointment was made for him/her to attend a psychiatric outpatient clinic.
Medication regimen:	None as part of the intervention
Setting:	Accident and Emergency departments serving a North London Borough
Therapist characteristics:	Clinical psychologist, supervised by an experienced personal construct psychotherapist.
Treatment duration:	Six-session contract, commencing soon after the self-harm, which could be renewed if agreed by therapist and client. Number of sessions ranged from 2 to 22 (mean 10.38 sessions)
N:	40; 24 intervention, 40 control

Mean age, % female, race (variance):	Intervention vs control: Mean age, years (SD)= 33.88 (7.66) vs 35.83 (10.43) % female=42% vs 60% White ethnic group=100%
Other clinical characteristics:	No additional relevant information
Concomitant medications:	Not reported
Outcome assessment:	Primary outcomes were measure of suicidal ideation and depression. For assessment of self-harm, records from the Accident and Emergency departments involved in the study were monitored for repeat episodes of self-harm in the 3 years following their initial presentation.
Results:	Repetition of deliberate self-harm, intervention vs control At 1 year: 17% vs 36% (P=0.12) At 3 years: 35% vs 53% (P=0.18) At 5 years: 39% vs 58% (P=0.15) No repetition within 5 years: 61% vs 42% (P not reported) 3 of the episodes eventuated in successful suicide (1 intervention, 2 control)