

# Management of deliberate self harm in general practice: a qualitative study

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## SUMMARY

**Background.** It has been estimated that the incidence of deliberate self harm (DSH) is at least 10 times that of suicide. Accident and emergency discharge figures also point to an almost doubling of reported cases of DSH in the early 1990s.

**Aim.** To assess general practitioners' (GPs') views on, and educational requirements for, managing patients following an episode of DSH.

**Method.** A qualitative study with 14 GPs (seven male and seven female) from two outer-London boroughs, selected in order to provide a maximum variety sample. Interviews took place between February and April 1997, and data were analysed using the principles of grounded theory.

**Results.** Most GPs felt that all patients presenting with DSH should be assessed by a psychiatrist. They expressed a preference for working with a community psychiatric nurse rather than a counsellor. Suggestions to improve their working relationship with community mental health teams included provision of one centralized point of referral and ease of access to the service in times of crisis. GPs were sceptical of guidelines, emphasizing that they needed joint ownership in writing them, but most importantly that they needed adequate resources to implement them. Specific changes to postgraduate education were suggested, such as individual educational portfolios.

**Conclusion.** Improved working relationships between GPs and community mental health teams are needed in order to provide a more efficient and effective service for patients. Lifelong learning needs to be adapted in a style and approach to suit GPs' individual requirements.

**Keywords:** deliberate self harm; general practitioners; qualitative analysis; learning needs.

## Introduction

THE incidence of deliberate self harm (DSH) is estimated to be at least 10 times that of suicide.<sup>1</sup> It is a term often used interchangeably with parasuicide.

There has been an increase in total numbers of patients with DSH, with the proportion of discharges from accident and emergency recorded as DSH almost doubling from about 15% to 30% in the early 1990s.<sup>2</sup> Many of these patients may not have been adequately assessed prior to discharge.<sup>2</sup> Although in an average practice list of 2500 patients, a general practitioner (GP) may

expect only five to seven patients per year with DSH,<sup>3</sup> it accounts for more than 100 000 hospital attendances annually.<sup>4</sup>

## Method

### Rationale for a qualitative approach

What distinguishes qualitative from quantitative methodology is its concern with understanding responders' rather than researchers' meanings, and its use of open-ended research questions.<sup>5</sup> In other words, the aim is to discover the interviewee's own framework of meanings, and the research task is to avoid, as far as possible, imposing the researcher's assumptions.<sup>6</sup> The methodology is particularly valuable in studies designed to assess the views of professionals — GPs in this study — of health services in times of policy change.<sup>7</sup>

### Sampling

Qualitative research uses purposive sampling, and the specific strategy chosen was that of maximum variation,<sup>8</sup> which is designed to ensure, through an ongoing review of the characteristics of the interviewees and of the data generated, that a maximum range of views is investigated. Some of the criteria used to achieve this were age, number of partners, postgraduate qualifications, interest in mental health, and deprivation score (Table 1). The sample included four 'information-rich' cases<sup>8</sup> selected for their intensive experience and interest in this field, and continued until no new analytical categories were generated.

Recruitment was made by sending letters followed up by telephone calls. All of the GPs invited to participate did so.

### Interviews

Interviews were arranged to suit individual GPs and largely took place in their surgeries; they were conducted and tape recorded by LP, who introduced herself as a GP/researcher.<sup>9,10</sup> A topic guide, piloted with primary health care team members who were not part of the study, was used to ensure that core areas of interest were covered. It was modified as further data were collected.

General practitioners were encouraged to set their own agenda and to express their unconstrained views. They were asked to reflect on their own practice, their rationale for decision-making and the context of their decisions. Interviews were transcribed, transcripts anonymized, and the data analysed through an iterative process of identifying categories and grouping them into themes.<sup>11,12</sup> Thus, data collection and analysis interacted from the beginning of the research.<sup>13</sup>

## Results

Analysis was based on the principles of grounded theory — a method entailing the generation of an analytical framework from the data. Seven core themes and their constituent categories (Figure 1) were identified. They distinguish between GPs' views of government and health authority roles, their own practice concerns, and their educational needs.

### Service provision for patients with DSH

General practitioners distinguished between the role of government, the role of the health authority, and their own role:

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ANALYTICAL THEMES	1ST LEVEL CATEGORIES	
Service provision for patients with DSH	Government	
	Health authorities Secondary care sector e.g. CMHTs, A&E	General provision
Approach to management of patients with DSH after referral by GPs	Length of waiting list Assessment Type of care	
Access to CMHTs	Geographical boundaries Domiciliary visits Crisis team Ethnic minority groups	Specific provision
Administrative policies for patients with DSH	Record placed on GP's computer Procedure for follow-up Letters from A&E/CMHTs	
Alternative models of care: counsellors, psychologists, CPNs, or specialist GPs	Attached Perceived role	
Guidelines	Resources needed for implementation Ownership	
Attitudes towards educational initiatives for GPs	Style Content	GPs' educational needs

*'The government is throwing money at psychotic patients who are the minority, rather than at the majority of, for example, anxious and depressed patients who see general practitioners...'* (GP 1)

General practitioners voiced their concerns that:

*'Adequate community provision does not appear to have been made (by the health authority) before the hospitals closed.'* (GP 1)

Several suggestions were made about how to make referral procedures easier for GPs:

*'I would like one central number to contact who would then coordinate where the patient would be sent to.'* (GP 9)

#### *Approach to management of patients with DSH*

Most GPs wanted a community psychiatric nurse or counsellor or psychologist attached to the surgery, although they complained that the waiting list of eight to 24 weeks to see any of them was far too long.

Most GPs felt that *all* patients presenting with DSH should be assessed by a psychiatrist.

One GP summed up her requirements from the community mental health teams (CMHTs) succinctly:

*'What I would really like from the community mental health team is rapid response in an emergency situation and the situation treated with the sensitivity it deserves.'* (GP 10)

#### *Access to community mental health teams*

Geographical boundaries were felt to cause problems when deciding where and to whom to refer patients, as well as causing

inequities in service provision.

Three GPs said that they wanted urgent access to domiciliary visits by consultants, especially in the case of patients who refused to go to hospital for assessment and were not sectionable:

*'When you refer a patient for an urgent domiciliary visit, this can take three days or more to happen. Then patients complain about GPs.'* (GP 8)

Several GPs mentioned difficulties accessing counsellors who spoke minority languages:

*'...not just for emergencies or crises but also for simple things...'* (GP 4)

#### *Administrative policies for patients with DSH*

Few GPs recorded episodes of DSH on the computer. Most had no formal policy of follow-up of patients with DSH, even those about whom they had received letters from accident and emergency (A&E) departments. GPs felt that letters from A&E departments were often late or non-existent, and, although they thought standards were improving, they were generally critical about their content:

*'Letters from casualty are often lacking in details such as whether or not they have been referred to a psychiatrist, or even how much or what they have taken in the case of overdose medication.'* (GP 11)

A frequently cited complaint was the length of time it took getting reports about patients whom the CMHTs were treating:

*'The communications with the CMHT are poor — we are not given a treatment plan nor told what has been done for the patient...'* (GP 5)

**Table 1.** Characteristics of the general practitioners in the study.

Characteristics of GPs	General practitioner													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Age (years)	56	45	34	35	44	45	37	57	49	40	36	61	63	48
Sex	M	F	F	M	M	M	F	M	M	F	M	F	M	F
Chosen for information richness	✓	×	✓	✓	×	×	✓	✓	×	×	×	×	×	×
Postgraduate qualifications	×	✓	✓	✓	×	×	✓	×	✓	✓	✓	✓	✓	✓
Fundholding status	F	NF	F	F	F	F	NF	NF	NF	NF	F	NF	F	F
Deprivation score of practice catchment area (Jarman score) <sup>a</sup>	16.77	5.42	3.63	3.02	32.46	3.63	3.02	32.46	28.76	28.76	32.46	28.76	5.42	32.46

<sup>a</sup>Public Health Common Data Set 1996; F = fundholding; NF = nonfundholding.

### Alternative models of care

General practitioners felt that they did not have the time to provide counselling for patients themselves. Eight GPs could see a role for specialist GPs (similar to a clinical assistant) who could manage patients with DSH as well as other psychiatric disorders. However, concerns were voiced about the workload and financing of such a position. Most GPs expressed a preference for working with community psychiatric nurses rather than counsellors:

*'I am not happy to use counsellors, as their training is so variable.'* (GP 7)

### Guidelines

All responding GPs agreed that they needed to have joint ownership of guidelines by being involved in writing them. However, they were sceptical about whether the resources would be available to implement them once agreed.

### Educational initiatives

Attitudes towards postgraduate education varied, with some GPs describing their preferred style and presentation of lectures such as small group teaching:

*'I would like to see training for GPs along the line of a GP tutor and educational mentoring — providing individual educational portfolios...'* (GP 13)

Another GP advocated a multidisciplinary approach:

*'Postgraduate education is a question of individual choice, but perhaps more interest in mental health issues would be fuelled by working in effective teams and having people (from other disciplines) on site.'* (GP 10)

## Discussion

### Sampling

The sample was purposive and thus not intended to be statistically representative; it made use of a sampling strategy designed to achieve detailed data from GPs showing a 'maximum variety' of interest and experience in the field of managing DSH.<sup>12</sup>

### External validity

The external validity of the findings is supported by the fact that, after 14 in-depth interviews — each analysed iteratively with

subsequent interviews — it was clear that no major new themes were emerging. There is good reason to believe, therefore, that the most important themes have been captured in the data.<sup>7,12</sup>

### Internal validity

The interviewer was a GP at the time of data collection and analysis; she thus had the potential disadvantage of lack of distance from the subject matter, but the advantage of relatively easy access to GPs as well as insight into the perceptions of roles within the multi-professional primary care team. To maximize internal validity, we attempted to adopt criteria for rigorous qualitative research, including a review of the sampling strategy and of data collection by all three authors, and using more than one author to analyse parts of the data to validate the analytical framework.<sup>12</sup>

### Follow-up of patients

The importance of having some systematic form of follow-up is supported by the figures available on repeated attempts of self harm.<sup>1</sup> The risk of repetition is highest in the first six months after self harm and continues to remain relatively high until at least eight years after an attempt.<sup>14</sup> Continuity of care, which GPs are able to provide, has also been shown to improve treatment compliance.<sup>15</sup>

### Communication

The desire for more complete letters from A&E departments may be partly because not all patients are necessarily seen by a psychiatrist before discharge, nor are they even referred to one on an outpatient basis. This may well stem from the Department of Health circular of 1985, which suggested that the previous policy of automatic referral of patients to a psychiatrist be discontinued, and that each health authority should determine its own policy on management.<sup>16</sup> These policies may be inconsistent within and between hospitals. Where they are unclear or absent, patients may not be referred for appropriate management.<sup>17</sup>

Poor communications may be improved by linking a keyworker shared between several different practices to help with information sharing and better integration of mental health services.<sup>3</sup>

### Access to the secondary sector

Geographical boundaries were identified as being one of the key areas for change. Kerwick and Goldberg<sup>18,19</sup> state that a strong case can be made for basing catchment areas on groups of GPs

rather than on patients' street addresses. This system would produce problems in providing local authority social services, but these would be more than compensated for by the resultant improved liaison between the primary care team and the CMHT. It could also help to remove any inequity in service provision that may have arisen as a result of geographical divisions.<sup>18</sup>

### Administration

Administrative improvements could be made by producing case registers for the chronically mentally ill, whose information could be obtained from repeat prescribing, computers, and local mental health services. This would help in the setting up and operation of an efficient call/recall system.<sup>20</sup>

### Postgraduate education

General practitioners expressed a range of ideas about mode and content of delivery of postgraduate education, which reflected their own priorities and learning styles. The request by one of the GPs for postgraduate teaching to comprise small groups, interactive, and dynamic, appears to be supported in some aspects by research.<sup>21</sup> One such study showed that knowledge as well as attitudes of GPs to suicide prevention could be influenced by seminar teaching in groups but not by written material alone.<sup>21</sup>

### Implications for the future

Some of the GPs' views have already been turned into action locally; e.g. providing individual educational portfolios. However, much more can still be done, and, with the advent of primary care commissioning within primary care groups, GPs are well placed to develop integrated multidisciplinary practice and education in the field of mental health.

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