School of Primary, Community & Social Care

Keele UNIVERSITY

Role of the general practitioner in the management of self-harm behaviour in primary care

National Suicide Prevention Alliance Conference
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Conflicts of interest:

- FM is supported by a National Institute for Health Research (NIHR) In-Practice Fellowship
- FM has received RCGP Scientific Foundation Board funding for research on young people who self-harm
- CCG is a member of the NICE Guideline Development Group, Depression (update)
- CCG has received NIHR funding to investigate self-harm
- Views expressed during this presentation are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care

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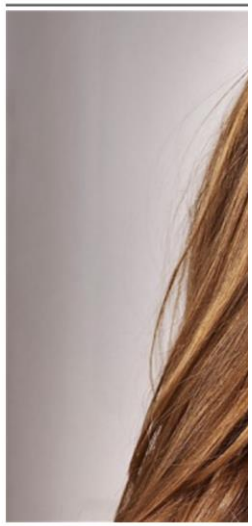
Why are more talented kids self-harming than ever before?

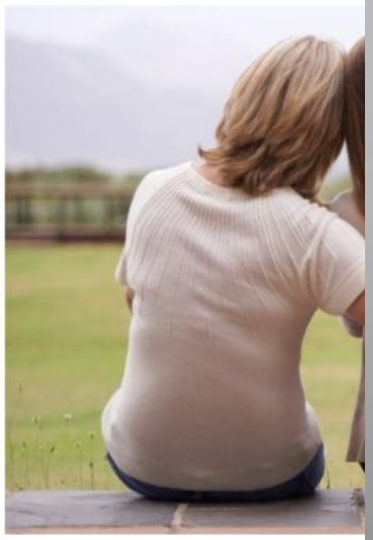
The number of children encouraging them to do Sanghani



Health

'Alarming rise in self-harm - but only half get care'

5 June 2019



Background

- Self-harm (SH) is 'self-injury or self-poisoning irrespective of suicidal intent'
  (NICE CG133)
- Major national public health concern and the **strongest** risk factor for suicide
- Over 98% of the population is registered with a general practice
- **Two-thirds** of patients present to their GP in month prior to SH
- **Two-thirds** of patients present to their GP in month after a SH episode
- The GP may be well placed to intervene early to prevent repeat SH and reduce suicide risk

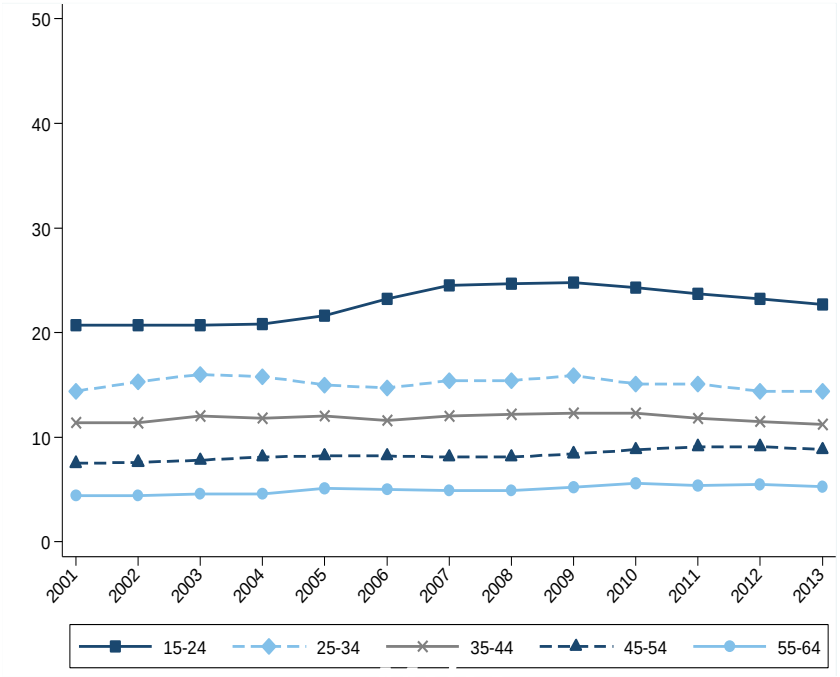
Some statistics

- Data Source:
  - **Clinical Practice Research Datalink** (CPRD):
    - Contains anonymised electronic medical records
    - Large population-based, longitudinal, primary care database:
      - 677 general practices
      - >10 million patients contributed data during 2001-2013
    - Records on:
      - Clinical events, tests, diagnoses, medication, referrals to external services, practice-level information
    - Clinical data entered using Read codes

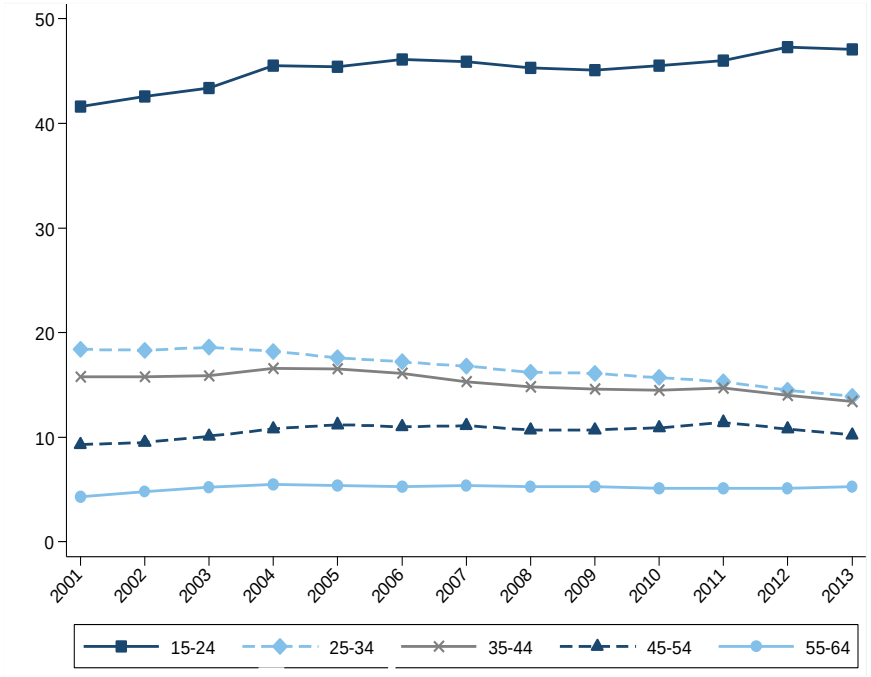
Carr MJ, Ashcroft DM, Kontopantelis E, *et al*. The epidemiology of self-harm in the UK primary care patient population, 2001-2013. *BMC Psychiatry* 2016; **16**:53.

Carr M, Ashcroft DM, Kontopantelis E, While D, Awenat Y, Cooper J, Chew-Graham CA, Kapur N, Webb RT. Clinical management following self-harm in a UK-wide primary care cohort. Journal of Affective Disorders. 2016: 197: 182–188.

Comparing incidence across age bands and by gender



males

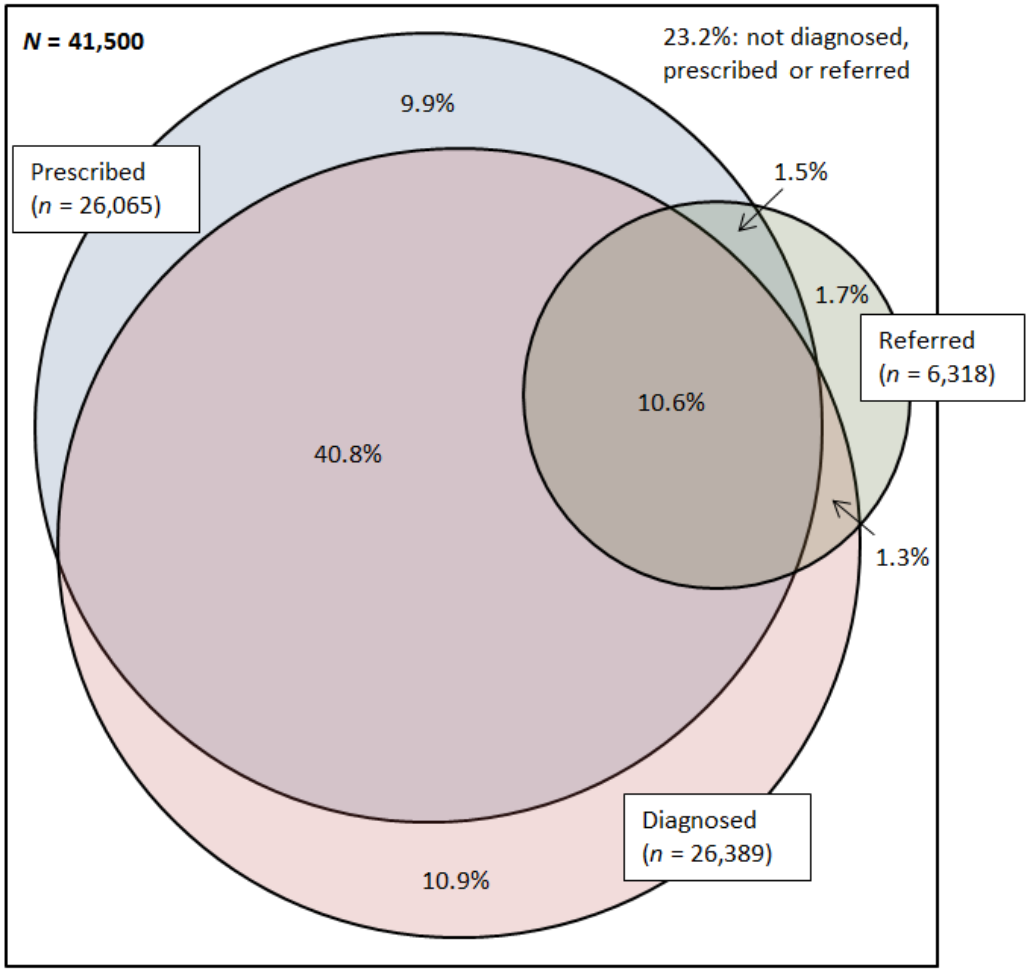


females

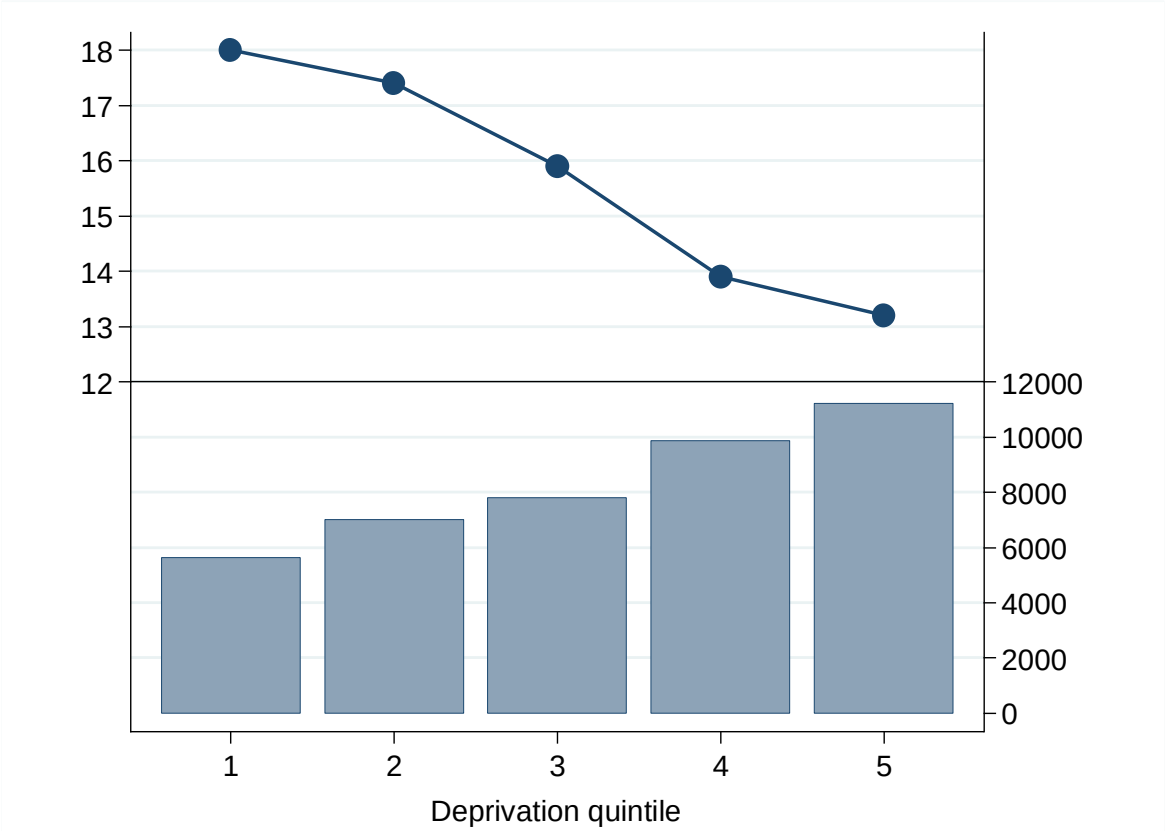
45% increase in incidence for female patients (56% for presentations)

Psychiatric diagnoses, referrals and medications

Diagnosed: 63.6%, referred: 15.2%, medication prescribed: 62.8%



Diagnoses, referrals and prescriptions within 12 months

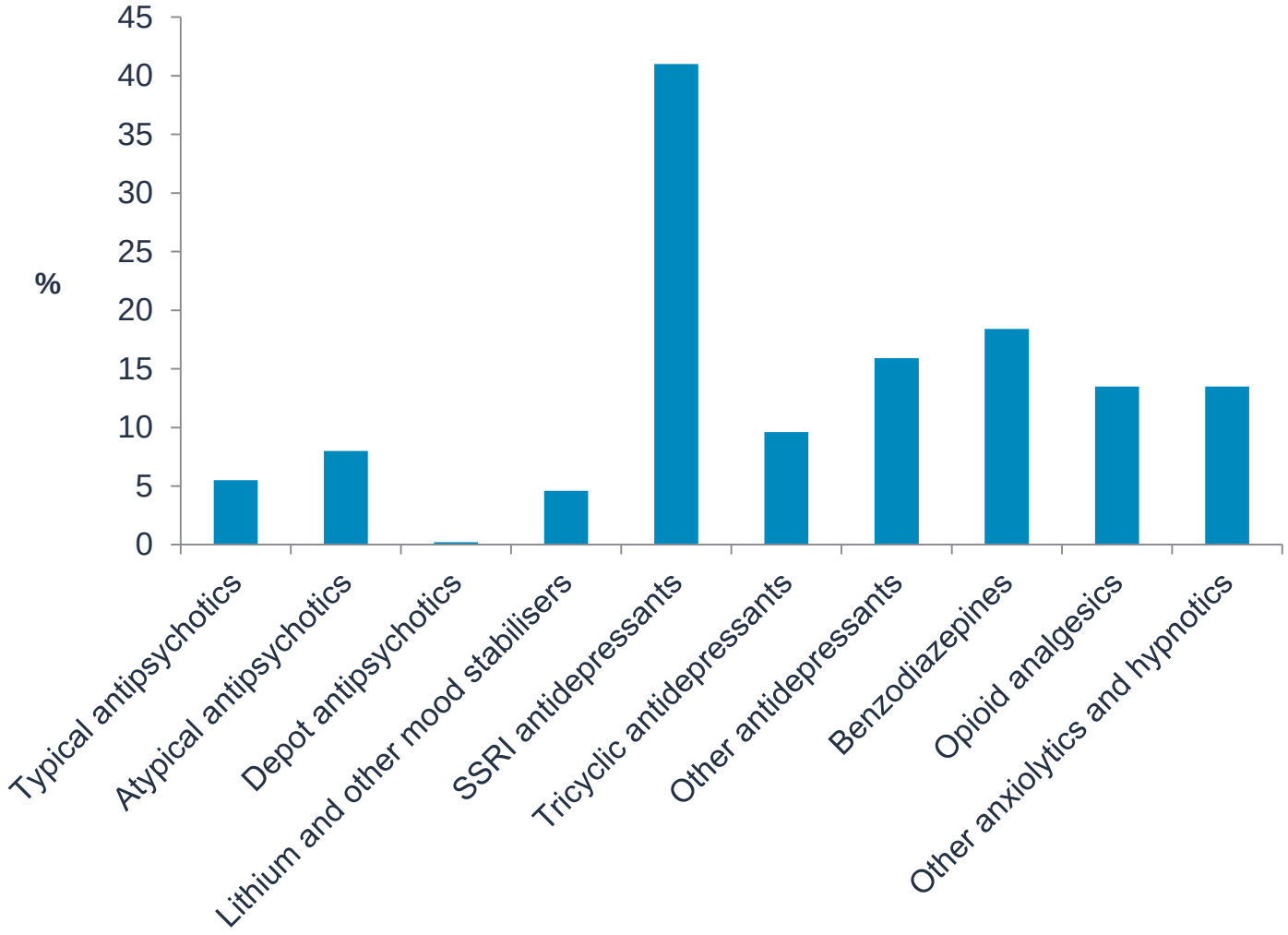


Inverse care law

- Tudor-Hart (*Lancet*, 1971)

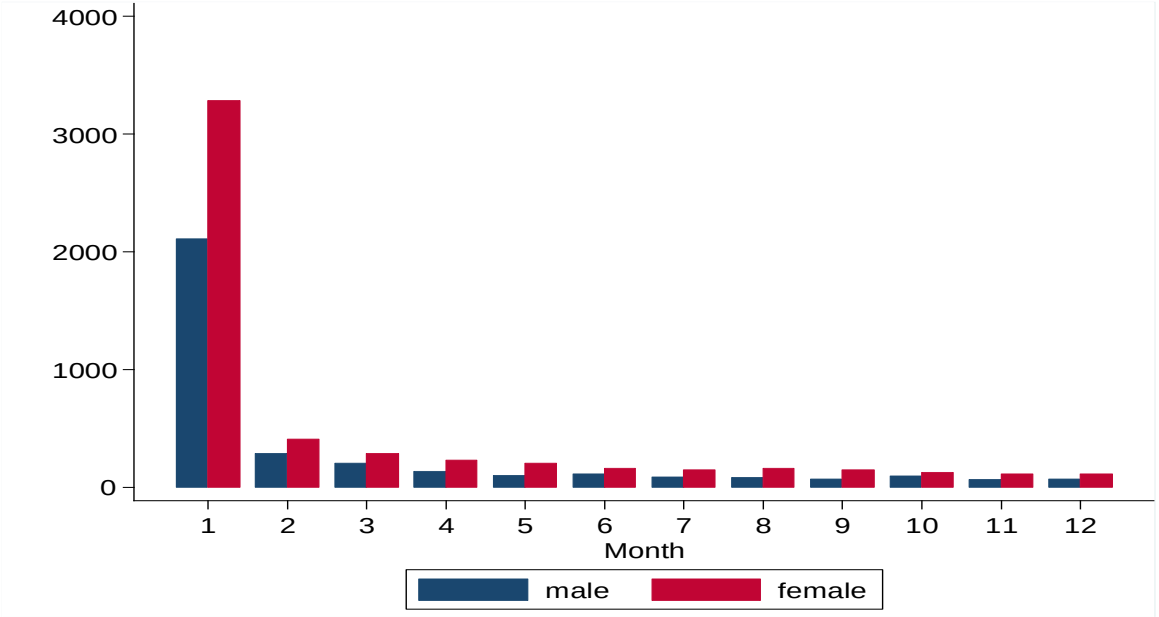
Prescriptions by class of psychotropic medication

In the 12 months following self-harm



Repetition of self-harm

- 20% of patients - non-fatal repeat event within a year



Time-to-repetition of non-fatal self-harm

PPIE

- PPIE input
  - At start of study to ensure we were asking the 'right' questions
  - To discuss results – and their meaning
  - At final Stakeholder meeting
    - Advice on dissemination
    - Next steps

Summary

• 10% patients had one or more psychotropic medication prescribed with **no** psychiatric diagnosis, and 9.6% were prescribed a tricyclic antidepressant within a year of self-harm

• *Inverse Care Law:* a lower likelihood of being referred among patients registered at practices in deprived areas

• Patients who have harmed themselves are at elevated risk of non-fatal repetition or premature death within a year of the index episode

- A relatively high consultation frequency among these patients presents an *opportunity* for preventive action in primary care
    - Lifestyle risk factors in these patients (e.g. alcohol) are potentially modifiable, with support from primary care clinicians
    - *How can GPs effectively intervene with patients who self-harm?*

- So what do you feel are the implications of this evidence?

For GPs to effectively intervene, we need to……

Review Question

To explore the role of the GP in the management of patients with self-harm behaviour in primary care

Methodology

- Systematic search of: MEDLINE, PsycINFO, EMBASE, CINAHL, AMED, and Web of Science from inception to **February 2018** (*PROSPERO (CRD42018084703)*)
- SH in all ages and international primary care
- **Studies included**: Observational, cross-sectional, qualitative, and mixed methods.
- Screening of titles, abstracts, and full-texts + data extraction and quality appraisal conducted independently by two reviewers – discrepancies resolved by third reviewer
- Quality assessed by the **Mixed Methods Appraisal Tool (MMAT)**
- **Outcomes**: knowledge, attitudes, behaviours of GPs, barriers/facilitators of GP management, training needs, and outcomes of GP consultations
- A narrative synthesis undertaken (*Popay et al, 2006*)

Results

12 studies of **789** GPs/family medicine physicians of good methodological quality from **Europe** (n=10), **America** (n=1), and **Australia** (n=1)

GP knowledge:

- Some GPs attain some knowledge of managing SH, through training and teaching.
- GPs reported challenge of assessing SH against suicide risk and how to establish future SH risk

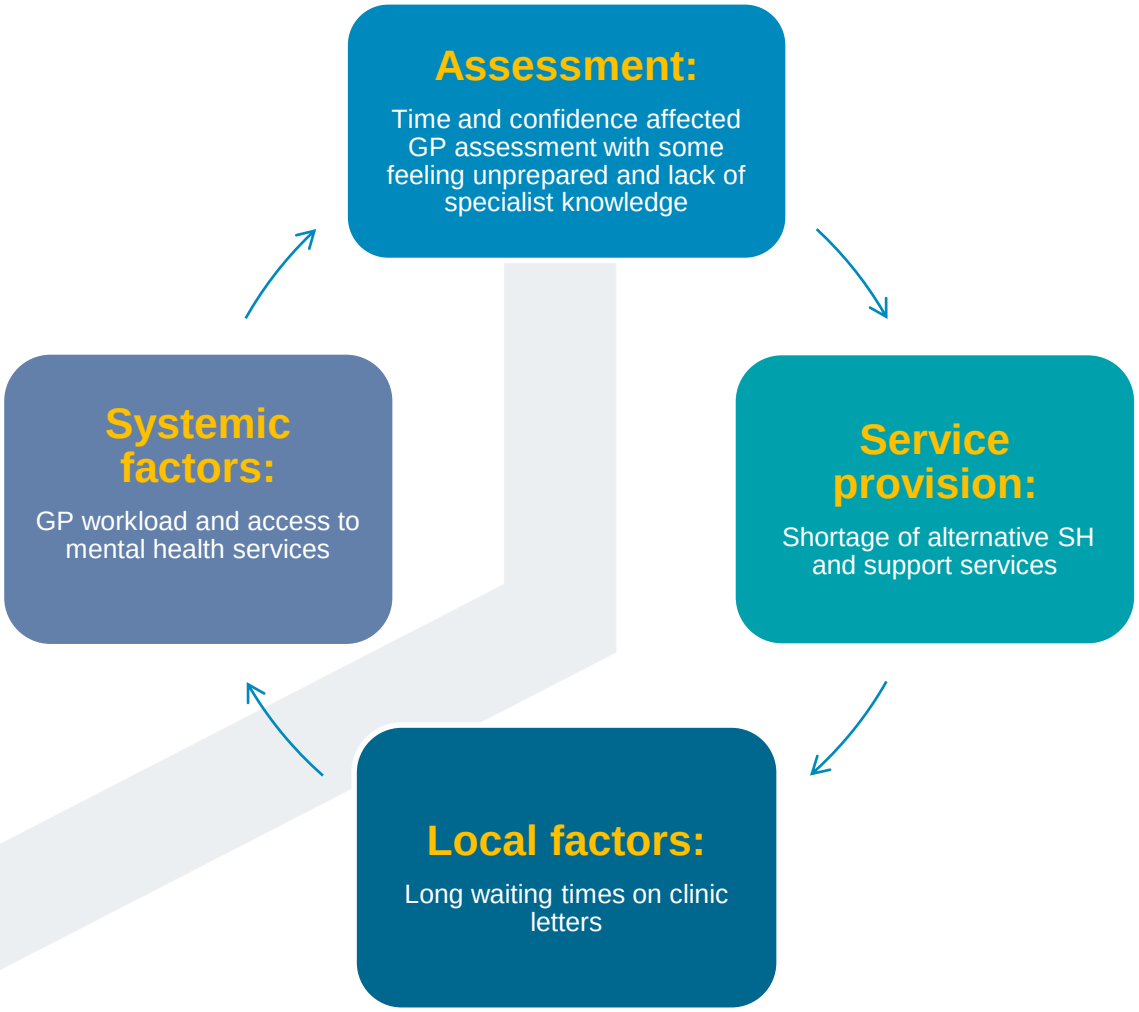
GP attitudes:

- GPs recognised challenge of identifying suicidal intent in SH

GP behaviours:

- GPs use different consultation strategies when assessing SH in adults and young people (*passing back responsibility vs. direct Qs, lay terms, and building rapport*)
- GPs managed SH in primary (n=4) and through secondary care (n=3)

Barriers for GP management of SH



Facilitators for GP management of SH

Implications for research and practice

- Review highlights the small evidence base on role of the GP in SH management
- Role of GP is multidimensional including frontline assessment, referring for specialist care, and on-going support in primary care
- Need for acceptable, on-going, evidence-informed SH training for GPs that must be evaluated and cost-effective
- SH clinical guidelines and practice policies should be **co-produced**
- Primary care networks should develop and incorporate SH guidelines and policies into wider suicide prevention strategies

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Popay J et al for the narrative synthesis guidance

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Thank you

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