



*Citation for published version:*

Fox, F, Stallard, P & Cooney, G 2015, 'GPs role identifying young people who self-harm: a mixed methods study', *Family Practice*, vol. 32, no. 4, pp. 415-419. <https://doi.org/10.1093/fampra/cmz031>

*DOI:*

[10.1093/fampra/cmz031](https://doi.org/10.1093/fampra/cmz031)

*Publication date:*

2015

*Document Version*

Peer reviewed version

[Link to publication](#)

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1. **Title:** GPs role identifying young people who self-harm: a mixed methods study  
**Running Head:** GPs identifying young people who self-harm
2. **Article category:** Qualitative Research / Mixed Methods
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6. **Structured Abstract**

**Background:** Self-harm is common among young people and is evident in increasingly younger age groups. Many young people who self-harm do visit their General Practitioner (GP) but do not access specialist support. GP's can find it challenging to raise and discuss this sensitive subject with young people during short consultations.

**Objective:** To explore GP's capabilities, motivations and opportunities for discussing self-harm and to identify barriers to and enablers for proactively discussing self-harm with young people.

**Design and Setting:** An exploratory, mixed-methods study was designed comprising an online survey and a qualitative interview study with GPs in the South West of England.

**Methods:** An online survey was completed by 28 GPs. Ten GPs took part by telephone, in semi-structured interviews. Quantitative data was analysed using descriptive statistical techniques and thematic analysis was used to analyse the qualitative data. Findings from the quantitative and qualitative analysis are synthesised to illustrate GPs' skills, knowledge and perceptions about young people who self-harm.

**Results:** Experienced GPs may underestimate the prevalence of self-harm in young people, particularly in the 11-14 age range. Whilst consultations with young people and their carers can be challenging, GPs acknowledge that it is their role to provide support for young people who self-harm. GPs would welcome training for themselves and other practice staff in talking to young people and practical information about self-harm.

Conclusion: All Primary Care staff who provide front line support to young people should receive education and practical training in talking about self-harm.

7. **MeSH compliant keywords:** General Practice; Self-Injurious Behavior; Adolescent; Identification; Education

## Background

The term self-harm broadly describes a range of things that people do to themselves in a deliberate and usually hidden way<sup>1</sup>. Self-harm is common among young people and has been described as a “*particularly adolescent phenomenon*”<sup>2</sup>. Accessing accurate figures is problematic, as self-harm is a private behaviour and many incidents are not brought to the attention of parents or health care professionals<sup>3</sup>. Reports of self-harm prevalence in young people in UK community samples vary from 6-8%<sup>4</sup> to 10%<sup>3</sup> and more than 10% in girls aged 15-16<sup>1</sup>. Evidence also suggests that thoughts and acts of self-harm are evident in younger (less than 14 years)<sup>5</sup>. Thoughts of self-harm in girls aged 13 and 14 were around 22% with up to 15% having harmed themselves at least once over a 6 month period<sup>5</sup>. Self-harm in adolescents is associated with depression, stress and anxiety, conduct disorder and substance misuse<sup>6</sup>, as well as disturbed family relationships, social isolation and poor school record<sup>7</sup>.

Current NICE guidelines<sup>1</sup> identify Primary Care as having an “important role in the assessment and treatment of people who self-harm” recommending that in order to increase prevention, careful attention should be paid to “people at risk of self-harm”<sup>1</sup>. This indicates that General Practitioners (GPs) may need to be proactively vigilant about the warning signs and risk factors associated with self-harm<sup>5</sup>, such as negative emotions and low self-esteem<sup>4,7&8</sup> and self-harm thoughts<sup>5</sup>. A recent study found that a community sample of young people who have self-harmed report that they do visit their GP but very few accessed specialist mental health services<sup>9</sup>. This indicates that either young people are reticent to actively disclose self-harm to their GP, or that GPs are not actively identifying those in need of specialist help<sup>9</sup>. It may also reflect difficulties that GPs experience in achieving mental health referrals for this group of young people.

Self-harm can have a devastating effect on young people and their families and around 1 in 8 adolescents who self-harm will receive emergency hospital care<sup>10</sup>. Research suggests that many frontline professionals, including GPs do not know how to respond to self-harm<sup>3</sup> making this a crucial area for research. A recent report highlighted GP’s concerns that the consultation time available is prohibitive to building the rapport necessary to engage in conversations about self-harm. In addition GP’s are often unsure what language to use when talking to young people about such a sensitive subject, causing concern about miscommunication<sup>11</sup>. These difficulties experienced by some GPs are

of particular concern because young people who self-harm are at increased risk of doing so again<sup>10</sup> and repeated self-harm is a risk factor for suicide<sup>1,12</sup>.

## **Methods**

The aim of the research was to identify barriers to, and enablers for, GP's proactively discussing self-harm with young people. Three interacting conditions from which behaviour is likely to emerge have been defined as the COM-B system; capability (ability to enact the behaviour), motivation (mechanisms that activate or inhibit behaviour) and opportunity (environmental structures enabling behaviour)<sup>13</sup>. This provided a useful structure from which to explore GP behaviour and accordingly an exploratory, mixed-methods study was designed comprising an online survey and an in-depth qualitative interview study investigating GP's capability, motivation and opportunity to identify young people at risk of self-harm.

### *Online Survey*

Constructs from the COM-B system<sup>13</sup> were used as a framework to guide the design of the survey. An iterative process of revision was undertaken in consultation with a GP, resulting in 16 items, comprising both quantitative and open-ended qualitative questions. These 16 items were uploaded to an online survey platform (Bristol Online Surveys).

### *Interviews*

An open-ended interview schedule was designed based on the COM-B constructs<sup>13</sup> to expand upon questions in the online survey. The schedule was revised following a pilot interview with a GP. Semi-structured, in-depth telephone interviews were audio recorded, transcribed verbatim and made anonymous through removal of all identifying information.

### *Participants*

*Sixty-four GP Practices across BANES, Wiltshire, Swindon and Bristol were contacted through emails and letters to Practice Managers, who were asked to pass information about the study to the GPs in*

*their practice. Two GP Education networks also circulated information about the study via their distribution lists*

. At the end of the survey respondents were asked to supply contact details if they were willing to take part in a telephone interview. Of the twenty-eight GPs who completed the online survey 7 were male and 21 were female, with an age range of 20-60 years. Ten GPs participated in telephone interviews with the qualitative research assistant (GC), of whom 9 were female and one was male.

### *Analysis*

Quantitative data was analysed using basic statistical techniques and descriptive statistics are reported. Qualitative data was analysed by the lead qualitative researcher (FF) using inductive Thematic Analysis<sup>14</sup> which involved coding, followed by the identification and clustering of themes and production of a descriptive summary. Reliability was addressed by a second researcher (GC) analysing a selection of transcripts, followed by discussion and consensus about themes. A brief summary of the findings was sent to all GPs who took part in the interviews, 8 of whom responded with comments. The subsequent section is a summary of the findings, which highlights the key issues raised by GPs and draws on evidence from both the quantitative and qualitative data.

### **Results**

The results from both the survey and the interviews are combined and presented under two major themes that emerged from the inductive qualitative analysis, with supporting statistics from the quantitative analysis:

#### *Theme 1: GPs' skills, knowledge and perceptions about young people and self-harm*

*Knowledge:* In the survey GPs reported more contact with older adolescents aged 15-18 compared with the younger group, aged 11-14. Self-harm was seldom discussed with the younger group, with 28.6% (8) reporting that over the past year it had not been discussed at all (see Table 1). In terms of prevalence many GPs thought that self-harm was more common in older adolescents (aged 15-18) than in those aged 11-14 and the majority believed that less than 10% of young adolescents (aged 10-14) self-harmed (See Table 2). An interviewed GP who regularly deals with young people stated; “*I think I talk about self-harm most days*” (GP01), while another expressed surprise that they don't see it

more often; *“I am sure that we see it a lot and perhaps aren’t recognising it or discussing it a lot ... because looking at the figures and hearing about it you think well the amount of people I see I’m sure I should be seeing it”* (GP02)

*Perceptions:* GPs see self-harm in young people as being linked to other social and emotional problems. 89% (25) identified low mood and poor mental health as risk factors for self-harm. Viewed as more of an acute or episodic problem, or a longer term coping strategy than a chronic medical issue, most GP’s interviewed perceived self-harm as being on a ‘spectrum of risk’ for suicide. Self-harm was recognized as a coping strategy for some young people; *“she’s using this as a way of coping with stress and you can’t suddenly stop her from doing it because actually that’s a coping mechanism she’s developed and it’s going to take some time for her to be able to change that behaviour and putting more pressure on her isn’t going to help”* (GP04).

*Skills:* Some GPs interviewed said that they lacked confidence when talking to young people about self-harm and were anxious about the potential link to suicide; *“I think not everyone feels confident in asking about it. I think a lot of it depends on how much you see and how much you kind of get used to doing it”* (GP05). All GPs felt that education about, and training in talking to young people about self-harm would be useful. It was suggested that training should be available to GP’s via a range of formats (eg. online/face to face) and would be most useful if linked to local resources. Suggestions for the content of training included; myth busting; risk factors for self-harm and how it presents in young people; raising the issue; using the right language, including phrases and questions to ask and techniques for dealing with difficult consultations with anxious parents. Training was identified as being especially effective when people with personal experience of self-harm are involved.

Participants reported that Practice nurses, Health Care Assistants and reception staff also play a role in the identification and support of young people who are self-harming and highlighted the importance of training for these professionals.

## *Theme 2: Identifying, talking to & supporting young people who self-harm*

*Identifying:* GPs said that parents often act as enablers, initially by bringing their child to the GP and subsequently by helping them to access services. However distressed parents can become a barrier with 57% (16) of surveyed GPs reporting that the presence of a parent would affect their decision to discuss self-harm with a young person. Reasons for this included confidentiality, the difficulty talking

about an emotionally sensitive issue with a parent present and the parent's desire for the GP to stop the self-harm. GPs therefore gauge the need to talk to a young person alone and then negotiate conflicting issues around parental rights and responsibilities and the best interests of the young person. Deciding whether to discuss self-harm with a young person on their own is sometimes dependent on their age, although their maturity and confidence were seen as more important factors than age. While GPs see less self-harm in young people aged 11-13, some would have additional concerns about this age group and would hope to 'catch it early'; *"if you think you have got an eleven, twelve, thirteen year old who is self-harming you could probably get in there quite quickly, do a bit of work and help them to process emotional distress in a safer way"* (GP08).

*Talking*; The majority of GPs interviewed raise the issue of self-harm directly, as part of routine questioning about a range of issues including; mood, relationships, eating disorders, or substance abuse. Some GPs begin by asking about self-harm thoughts, or by saying that; *"some people who are feeling like this might cut themselves or burn themselves or do other things like that, you know, have you ever done that or thought about doing it? If they think that it's something that other people do and it's okay to say that, they're more likely to sort of open up about it."* (GP05). It was acknowledged that questions should be asked in a careful and sensitive way and tailored to the individual.

Although 85.7% (24) of surveyed GPs indicated that they would find it useful to have access to a screening tool to identify young people who may be self-harming or at risk of self-harming, most interviewees felt that screening questionnaires were too formal, too hard to fit into a ten minute consultation and may be a barrier to listening; *"you're not getting a rapport with someone by asking them questions or getting them to fill something in. If you're going to get somebody to talk to you about something that is causing them distress, you've got to be open to what they're saying and listening. Not saying, "Oh right, okay fill this in"* (GP07). However a few suggested that questionnaires can be useful when given to young people to take away, fill in and bring back to the next consultation.

Just over half the survey sample, 57% (16) indicated that there may be negative outcomes associated with raising the issue of self-harm. These included concerns about increasing conflict with parents, or the risk of alienating the young person. However interviewed GPs felt that the issue should never be ignored and that acknowledging and normalising self-harm was important both for parents and young



people. Other difficulties identified included lack of time, concern about opening a 'can of worms' and concerns that parents of younger teens may think it's inappropriate.

In interviews GPs indicated that they don't necessarily raise the issue of self-harm during the first consultation, unless they have major concerns, instead preferring to establish rapport with a young person over time. All 10 GPs interviewed said that demonstrating that they are available for the young person in the future was a key strategy to building trust. Showing that they were familiar with self-harm and using a young person's own language, or adapting language to suit each individual, was seen as crucial to establishing dialogue; *"I think we have to adapt the language and the difficulty of conversation to the individual and the situation. I don't think there is a one size fits all, especially over that age range"* (GP02).

*Supporting;* GPs who were interviewed see their profession as being 'part of the service', acting as frontline support for young people who self-harm, and also providing 'stop gap' support whilst waiting for a referral. Difficulties were highlighted where self-harm alone is not deemed severe or complex enough for a referral to the Child & Adolescent Mental Health Service (CAMHS) and where alternative services to support these young people do not exist. GPs do signpost services, although they are concerned that many young people lack the confidence or maturity to access services. Some GPs also offer ongoing support; *"I tend to follow it up because I think it is important for continuity because when they drop out of the CAMHS they will still need a GP and will need to know we can see them"* (GP09). Whatever their degree of experience with young people who self-harm, all GPs in the survey (100%) and all of those interviewed felt that ongoing education, training and practical information was needed for GPs to provide an effective service to young people who self-harm.

## **Discussion**

GPs see the identification and support of young people who are self-harming as part of their role. However, given recent reports that increasing numbers of young people are self-harming at a younger age<sup>5</sup> our findings suggest that GPs may be underestimating the prevalence of self-harm in young people and particularly in 11-14 age range. In addition, GPs reported feeling under skilled when raising the issue of self-harm in front of parents and were concerned that discussion may escalate existing problems within families. As reported in other work<sup>12</sup>, GPs were also concerned that there was no time within a typical consultation to build sufficient rapport with the young person to discuss

this sensitive issue. Taken together this suggests that many young people who are self-harming will not currently be identified during routine consultations with their GPs. A number of tools have been developed that directly inquire about self-harm and suicidal ideation in adolescents including; The Columbia Suicide Screen<sup>15</sup> (Shaffer et al., 2004); The Suicide Risk Screen<sup>16</sup> (Thompson et al., 1999); The Risk-Taking and Self-Harm Inventory for Adolescents<sup>17</sup> (Vrouva et al 2010). However the extent to which and the reasons why these are or are not used in GP consultations is unclear. In our study GP's felt that the use of screening tools was detrimental and detracted from listening to and building rapport with young people.

Previous research reports that 3 in 5 GPs are concerned that they do not know what language to use when talking to a young person about self-harm<sup>12</sup>. Our study identified examples of good practice with interviewed GPs describing how they had developed a comfortable way of raising the subject and discussing this with young people. However there was unanimous agreement that further professional development was required, including factual information about prevalence, presentation, and risk factors of self-harm in young people. Training in how to talk with young people (e.g. language, useful phrases) and how to manage and advise parents was also suggested. GPs were clear that this training should be available to all members of the practice and that this would be particularly powerful if it involved young people who had/are self-harming. This may not necessarily change practice, as previous research indicates that even after training health care professionals who are not specialists in mental health may still be reluctant to ask patients about self-harm<sup>17</sup>. However the particular focus on how to talk to young people who self-harm might go some way towards increasing confidence in this area.

GPs saw themselves as providing front line support for young people who self-harm. However GPs noted that access to specialist local support was often difficult and reported long waiting lists, or the self-harm being viewed as insufficiently severe or complex for referral to specialist CAMHS. This might provide another possible explanation as to why many young people who self-harm and who visit their GP do not access specialist mental health services<sup>10</sup>. However our finding suggests a need to develop stronger links between GPs and their local CAMHS so that GPs are provided with appropriate advice and support to assess on-going risk and service sign-posting in order to improve the service that young people receive<sup>2</sup>.

Our study was exploratory and involved a small sample of, mostly female, GPs who were either experienced in, or have interest in the area. Despite recruitment efforts it was difficult to establish whether the low response rate to the online survey reflected a lack of interest or expertise in the area or a lack of time to participate. It is therefore not possible to determine how representative these views are of the wider GP population. However, assuming that this group are more interested and possibly more experienced, the training issues they raise would seem to be relevant to all GPs.

## **Conclusion**

Knowledge about and perceptions of self-harm in young people varied among this sample, indicating that GPs should be aware of the prevalence of self-harm among younger teenagers. GPs feel that it is their role to provide first line, stop-gap and ongoing support for young people who self-harm through offering ongoing consultations. However, identifying, talking to and supporting young people who self-harm and their families can prove challenging for some GPs. While examples were offered of ways to negotiate these sensitive discussions, GPs would welcome training for themselves and other practice staff in talking to young people and practical information about self-harm. Training should be linked to current local resources that can offer support to young people when a referral to CAMHS is not possible or appropriate.

## **9. Declarations/ Acknowledgements**

**Ethical approval:** The study received approval from the Research Ethics Approval Committee for Health at The University of Bath (ref no: EP12/1317) and NHS R&D approval.

**Funding:** Funding for this study was provided by Oxford Health NHS Foundation Trust.

**Conflict of interests:** None

**Acknowledgements:** We are grateful for the support of Mrs Lisa Austin, Research Manager for Bath Research and Development.

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**Table 1: GP estimates of number of times self-harm has been discussed in their consultations with young people aged 11-14 / 15-18 over the past year**

	11-14	15-18
Not at all	28.6%	3.6%
1-4 times	42.9%	21.4%
5-9 times	21.4%	21.4%
10-14 times	0.0%	25%
15+ times	7.1%	28.6%

**Table 2: GP estimates of self-harm among all young people aged 11-14 / 15-18**

	11-14	15-18
Less than 5%	21.4%	7.1%
6-10%	67.9%	46.4%
11-20%	7.1%	39.3%
20%+	3.6%	7.1%