

Locally developed guidelines for the aftercare of deliberate self-harm patients in general practice

Deborah Sharp, Angela Liebenau, Nigel Stocks and Olive Bennewith Division of Primary Health Care, University of Bristol, **Mark Evans** Division of Psychiatry, University of Bristol, **William Bruce Jones** Bath Mental Health Care Trust, **Tim Peters** Department of Social Medicine, University of Bristol, **David Goldberg** Institute of Psychiatry, London, **David Gunnell** Department of Social Medicine, University of Bristol

In England & Wales at least 140 000 people present at hospital annually following an episode of deliberate self-harm (DSH), and 12% to 16% make a repeat attempt. The time of greatest risk of repetition is within three months of an attempt. Around 50% of these patients visit their GP in the four to eight weeks after an episode of DSH. Guidelines for the aftercare of patients who have self-harmed in general practice may reduce repetition rates and could possibly have an impact on suicide rates. The aim of this study was to develop a clinical practice guideline for the aftercare of DSH patients in general practice. A modified Delphi technique was used with a consensus group consisting of GPs with an interest in mental health, psychiatrists, a psychologist, a specialist nurse, a voluntary organization and patients with a history of self-harm. The template for the guidelines was based on ICD-10 PHC. Consensus was reached on all points after two rounds of the Delphi and the guidelines were formatted to facilitate their use in the GP consultation. There is a difficulty developing guidelines for common problems where the evidence base is weak. The use of formal consensus methods can be employed but it must be acknowledged that the validity of the resulting guideline is related to the composition of the consensus group, the identification and analysis of any relevant evidence and the method of guideline dissemination. The guidelines are being evaluated in a randomized controlled trial of a general practice based intervention to reduce repeat deliberate self-harm.

Key words: deliberate self-harm; general practitioners; guidelines

Introduction

Deliberate self-harm (DSH) is a large clinical problem in the UK. In England & Wales about 140 000 people present at hospital annually following attempted suicide (Hawton *et al.*, 1997). In the South West, DSH is the third most frequent cause of acute medical admission (Gunnell *et al.*, 1996) and nationally there is evidence that this figure is increasing (Hawton *et al.*, 1997). The significance of this behaviour is further increased by two related

consequences. First, 12% to 16% of patients will be seen for treatment of another episode of DSH within one year and 25% within two years (Bancroft and Marsack, 1997; Hawton *et al.*, 1997; Gilbody *et al.*, 1997). A long term, 13 year, follow-up of DSH in Scotland (Hall *et al.*, 1998) confirmed not only that people admitted to hospital after DSH were at high risk for further episodes but also that the all cause mortality over that period was elevated. Secondly, 30% to 47% of suicides have a history of DSH and approximately 1% will die by suicide in the subsequent year after an attempt and 3% to 5% within five to ten years (Gunnell and Frankel, 1994).

The 1992 Government White Paper, Health of the Nation (Secretary of State for Health, 1992) set

Address for correspondence: Professor D J Sharp, Professor of Primary Health Care, University of Bristol, Cotham House, Cotham Hill, Bristol, BS6 6JL, UK. Email: debbie.sharp@bristol.ac.uk

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a target to reduce the overall suicide rate by at least 15% by the year 2000. The recent Green Paper 'Our Healthier Nation' (Secretary of State for Health, 1998) extends this to reduce the death rate from suicide and undetermined injury by at least a further sixth (17%) by 2010 from a baseline in 1996. Although opportunities for the prevention of suicide are limited, targeting high risk groups is one possibility. Such groups might include those who have recently been psychiatric in-patients and those with a history of DSH.

Evidence on the best management for patients who have self-harmed is lacking (Hawton *et al.*, 1998). At the secondary care level, it seems that there is striking variation in clinical practice for patients who self-harm by poisoning in terms of the number who receive a psychosocial assessment (Kapur *et al.*, 1998). Many patients who self-harm will have a mental health problem – depression, alcohol dependence, schizophrenia and bipolar disorder all have significant associations with DSH (Effective Health Care Bulletin Deliberate Self Harm, 1998), but detecting those most at risk of repeat DSH has so far not proved possible (Appleby *et al.*, 1996; Diekstra and van Egmond, 1989; Power *et al.*, 1997). This is despite the fact that patients who self-harm are high consulters in general practice (Crockett, 1987) and about one third will see their GP in the week prior to an attempt (Gorman and Masterson, 1990). The most powerful predictors for repetition of DSH are a previous episode, previous psychiatric care and substance abuse. However, since only about 50% of repeaters are correctly identified using these predictors, their clinical usefulness may be limited (Myers, 1988). The time of greatest risk of DSH repetition is within three months of the index episode and a significant number repeat within the first week of an episode (Gilbody *et al.*, 1997). Several studies have shown that about 50% of DSH patients will visit their GP in the four to eight weeks after the attempt (Crockett, 1987; Gorman and Masterson, 1990). Thus, there is an opportunity for early intervention in primary care with the possibility that this may have an impact on suicide rates.

Few intervention studies have demonstrated noteworthy reductions in DSH repetition (Hawton *et al.*, 1998), and there have been no primary care based trials of DSH management. In light of the current interest in developing clinical practice

guidelines for specific mental health problems in primary care (Ustun *et al.*, 1995), we have developed such a guideline for DSH for use by GPs. We defined DSH as a deliberate nonfatal act whether physical, drug overdose or poisoning, done in the knowledge that it was potentially harmful and in the case of drug overdose, that the amount was excessive (Hawton *et al.*, 1998). Further, in order to evaluate the guidelines, a randomized controlled trial (RCT), designed to reduce repeat DSH, was planned to examine the impact of GPs inviting patients to attend a special consultation after an episode of DSH. At that consultation the GP would have available the DSH guideline to help define the clinical problem and agree a management plan with the patient. This paper describes the development of the DSH guideline; results from the RCT will be presented elsewhere.

Methods

Ideally, a systematic review of the available evidence is required as the basis of a clinical guideline when promoting a particular therapeutic approach. Such an approach is to be preferred to developing guidelines based solely on expert opinions (Grimshaw and Russell, 1993; Grimshaw *et al.*, 1995). However, the lack of evidence from randomized controlled trials on the effectiveness of aftercare programmes in primary care for those who self-harm made it impossible to adopt a formal evidence based approach to guideline development. Instead a formal consensus method – the modified Delphi technique – was used for the development of this guideline. The Delphi method was developed by the RAND corporation in the 1950s, to synthesize expert opinion on the emergence of new technologies (Delbecq *et al.*, 1975). The Delphi technique is a useful way of producing a consensus on a subject from a large group of geographically dispersed individuals and as such is increasingly being used in health care research (Murphy *et al.*, 1998).

The consensus panel was constituted with the aim of achieving wide representation from specific interest groups, experts and stakeholders in the management of DSH. Initial criteria for consideration were: whether members were known to have a particular interest in the area from either a service provision or research perspective, likely to have

had previous experience in guideline development for use in general practice, and to be known as an opinion leader by colleagues. Potential participants were mainly identified from the Third British Isles Meeting on Research on Suicidal Behaviour (Oxford, October 1996) invitation list (academic psychiatrists), the Wessex Primary Care Research Network (GPs), and the local Samaritans group. In addition, a Mental Health liaison nurse who specialised in the follow-up of DSH patients presenting at a local A&E department was invited to participate.

The research team, that is the authors of this paper, identified 47 potential participants for the consensus panel. By stipulating that at least three members of the research team endorse them, 26 people were finally identified (Table 1). A letter was sent to all potential participants explaining the purpose of the study and inviting them to be part of the consensus panel. It was also agreed to approach a small number of patients who had self-harmed, to ascertain their views on the acceptability of the proposed guideline in terms of the issues it would invite the GP to discuss with them.

The guideline was initially developed by the research team, who reviewed the available literature and used the ICD10-PHC guidelines for mental health as a template. The use of ICD10-PHC as a means of improving mental health care in primary care settings has been studied in UK field trials (Goldberg *et al.*, 1995). The first draft of the guideline, comprising a brief introductory statement on the epidemiology of DSH, a section on assessment of DSH and a section on management,

was sent to the consensus panel who were asked to state their agreement with the inclusion or exclusion of each item and invited to make any additional comments on an enclosed structured questionnaire. This entailed modification of the basic Delphi technique into a 'reactive Delphi' (McKenna, 1994), where respondents react to previously prepared information, in this instance the first draft of the guideline.

Using summary lists of all the issues identified by the consensus panel and notes from the interviews with the patients who had self-harmed, the research team produced a second draft of the guideline. This second draft was then sent out to the consensus panel with a further questionnaire for completion. The structured interview for patients was modified according to the second draft of the guideline and interviews with a further four patients who had recently self-harmed were conducted. Responses to the second draft were analysed by the research team. The timescale and steps involved in the development process are illustrated in Figure 1.

The interviews with the patients were conducted using a semi-structured schedule in a two phase format. First, patients were asked some general questions about their views on discussing issues to do with the incident of self-harm with their GP, and were asked to comment on a draft of the letter that GPs would be sending to patients to invite them to consult. Secondly, patients were shown a draft of the guideline and asked how helpful it would be to discuss each of the points on assessment and management with their GP. They were also given the opportunity to suggest additional

Table 1 Consensus panel composition

Discipline/Profession	Invited	Replied in Round 1	Replied in Round 2
Academic psychiatrist	15	10	8
GP	5	4	4
Psychiatrist	2	2	1
Member of voluntary organisation	2	2	2
Mental Health Nurse	1	1	1
Clinical Psychologist	1	1	1
DSH patients	7	3	4
Total	26 + 7	20 + 3	17 + 4

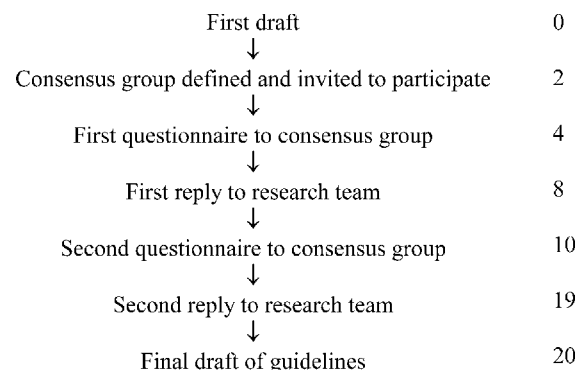


Figure 1 Timescale of the guideline development process in weeks.

areas that they thought should be included in the guideline. In effect they underwent exactly the same process as the expert panel but in a one-to-one interview format.

Results

Guideline development

The first draft of the guideline comprised six discrete areas in relation to assessment and five in relation to management (Figure 2). In the first round of the Delphi, 20 (77%) of the 26 consensus panel members replied. With regard to the areas of

assessment that it was suggested GPs might like to cover in their consultation with a patient after a recent episode of self-harm, there was nearly unanimous agreement that all six areas should be included in that section of the guideline. However, most respondents made several qualifying comments about the detail of the individual items. For example, one item covered the circumstances of the recent episode of DSH. For this item there were suggestions made about obtaining more information about previous episodes, documenting the patient's present views about the episode and examining the patient's expectations of the outcome of the act of self-harm. All of these sugges-

Clinical Guidelines for the management and aftercare of deliberate self harm (DSH)

In England & Wales at least 120,000 people present at hospital following attempted suicide. In the following year 1-2% succeed in committing suicide, 15-30% make a repeat attempt. The time of greatest risk is 3 months after the attempt. Every year 3-4 patients from a GP's list are admitted to hospital following DSH. DSH is the third most frequent cause for acute medical admission in the South West.

ASSESSMENT:

1. Current episode of DSH

- Exactly what did they do (patient's intent, precaution against discovery, premeditation, suicide note)?
- Any previous episodes (*increased risk of suicide and repetition of DSH*)?
- What Mental Health follow-up has been arranged?

2. Precipitating event or difficulty

- Is the situation unresolved, or is it likely to recur?

3. Current suicidal risk (*if yes to any of these consider referral*)

- Does the patient think that life is not worth living or does patient have a sense of hopelessness?
- Does the patient have a suicide plan and immediate means to carry it out?
Is the patient likely to act on this?

4. Psychiatric co-morbidity

- Current *depression* - some associated symptoms are:
 - ↳ Disturbed sleep
 - ↳ Hopelessness
 - ↳ Fatigue or loss of energy
 - ↳ Guilt or self-reproach
 - ↳ Poor concentration / Irritability
 - ↳ Disturbed appetite or weight loss
 - ↳ Agitation or slowing of movement & speech
- *Schizophrenia*
- Heavy *alcohol* use or use of illicit *drugs*

5. Any associated problems

- *Physical* illness, chronic disabling, or painful conditions
- *Bereavement* / other loss
- Past *psychiatric* history
- Victim or perpetrator of *violence*

6. Current social situation

- Do they have an intimate confidante or are they socially isolated?
- Have others failed to react supportively?
- Is the patient unemployed/homeless/in financial or other difficulties?

Figure 2 Clinical Guidelines for the management and aftercare of deliberate self harm (DSH).

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tions related to an identified need for GPs to be better able to assess current suicidal risk and likelihood of a repeat episode of DSH. The item which attracted the most comment, was one concerning the assessment of current suicidal risk, an area

where it was felt that GPs do not in general gather sufficient information. Several respondents stressed the importance of identifying the presence of hopelessness as both a symptom of current mental disorder e.g., depression, and a predictor of the

MANAGEMENT:

1. Ask the patient what help they think they need

- Allow time for sympathetic, non-judgemental listening. This may be all that is required. Consider prompt referral for counselling or other psychological therapy.

2. General management plan

- Consider regular monitoring of patient's mental state
- Encourage uptake of mental health follow-up if offered, consider referral to Social Services / housing etc., involve family / friends as appropriate
- Help the patient identify positive aspects of their life
- Assess potential risk to others

3. Treat any associated illnesses

- Depressive illness:*
- Identify current life problems; focus on small, specific steps to reduce these and manage them better
 - Encourage resistance of pessimism and self-criticism with counterarguments; advise not to act on pessimistic ideas (i.e. ending marriage, leaving job)
 - Plan short term activities which give enjoyment or build confidence
 - Consider medication (*prescribe limited quantities with low toxicity in people who have taken an overdose*)

- Alcohol and drugs:*
- Stress adverse effects on health via leaflets or other written information
 - If patient is motivated set definite day to quit, or negotiate goal for decreased use
 - Identify family members/friends who will support stopping, see NA, AA, ACAD
 - If evidence of alcohol dependence consider specialist referral
 - Identify and avoid high risk situations; plan how to respond to friends who still use; restrict times when drugs are used, use smaller quantities

- Pain and insomnia:*
- Provide medication in limited quantities for pain or insomnia due to physical illness, providing that patient gives undertaking not to abuse medication

- Bereavement:*
- Allow patient to talk about deceased, and circumstances of death
 - Explain that intense grieving will fade over several months

4. Discuss strategies for coping with future urge to self harm

- Seek help from GP or community mental health team
- Stress GP's or Primary Care's 24-hour availability

5. Discuss need for further follow-up

- e.g. GP / PC nurse / mental health professionals / voluntary organisation/ Social Services

Figure 2 Continued.

likelihood of repeat DSH. There were also suggestions as to the coverage of specific social situations that might predispose towards a further episode of DSH such as unemployment, homelessness and being the victim of violence.

The five items chosen for the management section were similarly almost unanimously endorsed by the panel. Comments on this section tended to focus on the importance of nonjudgemental listening on the part of the GP, with offers of appropriate referral where enduring mental health problems were evident for example: problem solving and counselling. Several panel members requested increased emphasis on assessing social support for ongoing problems such as drug or alcohol abuse and bereavement. There were also several recommendations to include discussion of strategies for coping with any future urge to self-harm.

The second draft was sent to the 20 panel members who replied to the first draft, of whom 17 (85%) replied (Table 1). The questionnaire responses to the second draft of the guideline resulted in remarkably few substantial comments or criticisms for the research team to address. The only significant suggested alteration to the assessment section was to include an inquiry about any physical illness which might be associated with an episode of DSH, as conditions that were chronically disabling and/or painful were most likely to be implicated. There were more comments on the management section for the research team to consider. These suggested that GPs needed to be made more aware of the need to give the patient time to tell their story and to offer patients repeat appointments in order to monitor their mental state. In addition, several respondents mentioned the importance of considering whether anyone else was at risk should the patient have a definable mental illness or be at risk of a further episode of DSH. All the responses were assessed by the research team, and a consensus was finally reached on all points of the guidelines.

The final DSH guidelines are shown in Figure 2.

Evaluation of the guidelines

The guidelines currently form the basis of a primary care based intervention to reduce DSH repetition rates which has been evaluated in a randomized controlled trial. The specific intervention evaluated was a written invitation from the GP to patients who had recently self-harmed to make an

appointment to discuss their recent problems. At this consultation, a double-sided colour copy of the guidelines, formatted so that it may be placed in the patient's medical record, was available to aid the GP in the assessment and management of DSH. General practices were randomized (cluster randomization) to intervention and control groups on a 1:1 basis. GPs in the intervention group received a letter from the research team informing them that one of their patients had recently been seen at a local hospital for DSH. Enclosed with this letter was another letter to be sent to the patient inviting them to make an appointment and a copy of the guidelines to put in the records so that they are easily accessible when the patient attends (Bennewith *et al.*, 2002). Good access to guidelines should give GPs an additional incentive for use with this relatively rare condition in primary care (Forrest *et al.*, 1996).

Discussion

Several recent reviews have offered recommendations for future research aiming to reduce suicide and repeat DSH rates (Gunnell and Frankel, 1994; Effective Health Care Bulletin Deliberate Self Harm, 1998; Hawton *et al.*, 1998). All the trials reported in a recent systematic review (Hawton *et al.*, 1998) were undertaken in secondary care settings and none resulted in statistically significant reductions in the repetition rate. No studies of primary care interventions designed to reduce DSH rates have been reported, although the Gotland study in Sweden, using GP postgraduate education on the diagnosis and management of depression, produced a reduction in suicide rates in the year following the intervention. However, this was not the primary objective of the study and the observed reduction may simply have reflected chance fluctuations in suicide rates that occur in small populations (Rutz *et al.*, 1992). A qualitative study investigating the views of GPs on managing DSH in general practice found the participants to be sceptical of guidelines (Prasad *et al.*, 1999), although a small study in the north of England found that a 'guidance manual' for assessing suicide risk in general practice led to a significant improvement in GPs' ability to assess and manage suicide risk, but this was carried out using audit methodology rather than as an RCT. Interest in

DSH and suicide is not confined to the UK and researchers in Belgium (Van Casteren *et al.*, 1993) and the Netherlands (Diekstra and van Egmond, 1989) report similar frustrations in their inability to identify those at high risk.

The development of a clinical practice guideline, for use by GPs with patients who have recently had an episode of DSH, is in line with current thinking about identifying patients at risk of further DSH and therefore possibly suicide. The GP is the health care professional who is most likely to be able to make an impact on DSH and possibly suicide rates (Gunnell, 1994). Depression is a major risk factor for DSH and suicide and most patients with depression will consult their GP in the course of a year. Up to a half of these may go undetected and very few are referred to secondary care. Several studies have found that about 40% of patients will see their GP in the month before suicide (Haste *et al.*, 1998), a high proportion of whom will have had mental health problems (Diekstra and van Egmond, 1989; Power *et al.*, 1997). With the increasing skills of primary care nurses concerning the management of patients with mental health problems, it is possible that patients who have suicidal thoughts may find that the nature and length of consultations with nurses might be more facilitating in terms of disclosure.

Guideline validity is related to the composition of the consensus group, the identification and analysis of the evidence and the method of guideline dissemination and implementation (Murphy *et al.*, 1998). The consensus method chosen for the development of the guideline in this study, a modified Delphi technique, offered the research team the opportunity to benefit from the input of a large number of acknowledged experts in the field without the administrative complexity and cost of arranging face to face meetings. In this particular situation, where it was possible to use a previously tried and tested template (ICD10-PHC) as a model, where the clinical issue under consideration has very little diagnostic uncertainty, and the evidence base is scant, a Delphi process had much to recommend it. Although there is much debate about the optimal size of a panel, how its members should be chosen, who should lead the process and how the resulting deliberations should be structured, we believe that the process that we have undertaken and described was sufficiently robust to allow us to move on to investigating the usefulness

of the guideline in the clinical setting for which it was designed. The value of these guidelines for the aftercare of DSH will be assessed at the end of the RCT when their impact on repeat DSH rates can be measured. When developing guidelines, the implementation strategy is of particular importance when making plans to evaluate their effectiveness (Roche and Durieux, 1994). In the case of DSH, which is still a relatively rare event for any one GP, none of the usual implementation methods – mass media mailing, educational outreach, or academic detailing – were thought likely to be useful (Mittman *et al.*, 1992). At the end of the RCT, information will be obtained from GPs regarding their actual use of the guidelines and in addition interviews will be performed with two samples of patients, drawn from those who did and did not take up the GP's offer of a special consultation.

Conclusion

Repeat deliberate self-harm presents an important clinical problem both economically and in terms of the suicide risk it presents. A large proportion of people who deliberately self-harm consult with their GP within four to eight weeks of the attempt. For any one GP, however, DSH is a relatively rare event and guidance on its assessment and further management may reduce subsequent DSH attempts or even suicide. We have developed concise and easily accessible clinical guidelines for GPs and have recently evaluated their utility in an RCT.

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References

- Appleby, L., Amos, T., Doyle, U., Tomenson, B., and Woodman, M. 1996: General practitioners and young suicides: a preventive role for primary care. *British Journal of Psychiatry* 168, 330–33.
- Bancroft, J. and Marsack, P. 1997: The repetitiveness of self poisoning and self injury. *British Journal of Psychiatry* 31, 394–99.
- Bennewith, O., Stocks, N., Gunnell, D., Peters, T., Evans, M., and Sharp, D. 2002: General practice based intervention to prevent repeat episodes of deliberate self-harm: cluster randomised controlled trial. *British Medical Journal* 324, 1254–7.
- Crockett, A.W.B. 1987: Patterns of consultation and parasuicide. *British Medical Journal* 295, 476–78.
- Delbecq, A.L., van de Ven, A.H. and Gustafson, D.H. editors 1975: *Group techniques for program planning. A guide to nominal group and delphi processes*. 1st edn. Illinois: Scott, Foresman & Co. Glenview.
- Diekstra, R.F. and van Egmond, M. 1989: Suicide and attempted suicide in general practice, 1979–1986. *Acta Psych Scand* 79, 268–75.
- Effective Health Care Bulletin Deliberate Self Harm 1998: *NHS Centre for Reviews and Dissemination, University of York*.
- Forrest, D., Hoskins, A. and Hussey, R. 1996: Clinical guidelines and their implementation. *Postgraduate Medical Journal* 72, 19–22.
- Gilbody, S., House, A. and Owens, D. 1997: The early repetition of deliberate self harm. *Journal of the Royal College of Physicians* 31, 171–72.
- Goldberg, D., Sharp, D. and Nanayakkarak, K. 1995: The field trial of the mental disorders section of the ICD-10 designed for primary care (ICD-10 PHC) in England. *Family Practice* 12, 466–73.
- Gorman, G. and Masterson, G. 1990: General practice consultation patterns before and after intentional overdose: a matched control study. *British Journal of General Practice* 40, 102–05.
- Grimshaw, J., Eccles, M. and Russell, I. 1995: Developing clinically valid practice guidelines. *Journal of Evaluation in Clinical Practice* 1, 37–48.
- Grimshaw, J.M. and Russell, I.T. 1993: Achieving health gains through clinical guidelines. I: developing scientifically valid guidelines. *Quality in Health Care* 2, 243–48.
- Gunnell, D. 1994: Recent studies of contact with services prior to suicide: Somerset. In: Jenkins, R., Griffiths, S., Wylie, I., Hawton, K., Morgan, G., & Tyre, A. editors *The prevention of suicide*. (pp. 114–20). London: HMSO.
- Gunnell, D. and Frankel, S. 1994: Prevention of suicide: aspirations and evidence. *British Medical Journal* 308, 1227–33.
- Gunnell, D.J., Brooks, J., and Peters, T. J. 1996: Epidemiology and patterns of hospital use after parasuicide in the South West of England. *Journal of Epidemiology & Community Health* 50, 24–29.
- Hall, D.J., O'Brien, F., Stark, C., Pelosi, A., and Smith, H. 1998: Thirteen year follow-up of deliberate self-harm, using linked data. *British Journal of Psychiatry* 172, 239–42.
- Haste, F., Charlton, J. and Jenkins, R. 1998: Potential for suicide prevention in primary care? An analysis of factors associated with suicide. *British Journal of General Practice* 48, 1759–63.
- Hawton, K., Fagg, J., Simkin, S., Bale, E., and Bond, A. 1997: Trends in deliberate self-harm in Oxford, 1985–1995. Implications for clinical services and the prevention of suicide. *British Journal of Psychiatry* 171, 556–60.
- Hawton, K., Arensman, E., Townsend, E., Bremner, S., Feldman, E., Goldney, R., Gunnell, D., Hazell, P., van Heeringen, K., House, A., Owen, O. and Sakinofsky, I. 1998: Deliberate self-harm: A systematic review of the efficacy of psychosocial and pharmacological treatments in preventing relapse. *British Medical Journal* 317, 441–47.
- Kapur, N., House, A., Creed, F., Feldman, E., Friedman, T., and Guthrie, E. 1998: Management of deliberate self poisoning in adults in four teaching hospitals: descriptive study. *British Medical Journal* 316, 831–32.
- McKenna, H.P. 1994: The Delphi technique: a worthwhile research approach for nursing? *Journal of Advanced Nursing* 9, 1221–25.
- Mittman, B.S., Tonesk, X. and Jacobson, P. D. 1992: Making good the promise: Disseminating and implementing practice guidelines. *Quality Review Bulletin* 18, 413–22.
- Murphy, M., Black, N., Lamping, D., McKee, C., Sanderson, C., Askham, J. and Marteau, T. 1998: Consensus development methods, and their use in clinical guideline development. *Health Technology Assessment* 2 (3).
- Myers, E.D. 1988: Predicting repetition of deliberate self-harm. A review of the literature in the light of a current study. *Acta Psych Scand* 77, 314–19.
- Power, K., Davies, C., Swanson, V., Gordon, D., and Carter, H. 1997: Case-control study of GP attendance rates by suicide cases with or without a psychiatric history. *British Journal of General Practice* 47, 211–15.
- Prasad, L., Gantley, M. and Underwood, M. 1999: Management of deliberate self harm in general practice: a qualitative study. *British Journal of General Practice* 49, 721–24.
- Roche, N. and Durieux, P. 1994: Clinical practice guidelines: from methodological to practical issues. *Intensive Care Medicine* 20, 593–601.
- Rutz, W., von Knorring, L. and Wallinder, J. 1992: Long term effects of an educational program for general practitioners given by the Swedish Committee for Prevention and Treatment of Depression. *Acta Psych Scand* 85, 83–88.
- Secretary of State for Health 1992: *The Health of the nation: a strategy for health in England*. London: HMSO.
- Secretary of State for Health 1998: *Our Healthier Nation*. London: The Stationary Office.
- Ustun, B., Goldberg, D., Cooper, J., Simon, G.E, and Santorius, N. 1995: A new classification of mental disorders based on management for use in primary care. *British Journal of General Practice* 45, 211–15.
- Van Casteren, V., Van der Veken, J., Tafforeau, J., and van Oyen, H. 1993: Suicide and attempted suicide reported by general practitioners in Belgium, 1990–1991. *Acta Psych Scand* 87, 451–55.