Title: **‘Self-harm in young people: the exceptional potential of the general practice consultation’**

**Authors**: Mughal F, Babatunde O, Dikomitis L, Shaw J, Townsend E, Troya I, Chew-Graham CA,

**Corresponding author:** Dr Faraz Mughal, GP and NIHR In-Practice Fellow, Research Institute for Primary Care and Health Sciences, Keele University, Staffordshire, ST5 5BG

Dr Opeyemi Babatunde

Centre for Prognosis Research, Research Institute for Primary Care and Health Sciences, Keele University, Staffordshire, ST5 5BG

Dr Lisa Dikomitis

School of Medicine and Research Institute for Primary Care and Health Sciences, Keele University, Staffordshire, ST5 5BG

Ms Judith Shaw

Group Coordinator, B-WELL, West End Centre and Café West End, Stoke, ST4 5AW

Professor Ellen Townsend

Self-Harm Research Group, School of Psychology, University of Nottingham, University Park, Nottingham, NG7 2RD

Ms M. Isabela Troya

Research Institute for Primary Care and Health Sciences, Keele University, Staffordshire, ST5 5BG

Professor Carolyn Chew-Graham

Research Institute for Primary Care and Health Sciences, Keele University, Staffordshire, ST5 5BG and Midlands Partnership NHS Foundation Trust, St Georges Hospital, Stafford, ST16 3SR

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**SELF-HARM IN YOUNG PEOPLE**

We welcome the editorial by Bailey et al describing the challenge of dealing with self-harm (SH) in young people (YP) in general practice. (1) We agree that managing YP who SH within the ten minute general practice consultation can be a challenge. However, we would like to highlight available opportunities which will enable us to maximise the exceptional potential of the general practice consultation. (2)

SH is complex, multifaceted, multifactorial, and a major risk factor for suicide and all cause and cause-specific mortality in YP. (3)

YP (to 25 years of age) today are likely navigating several life transitions that can be stressful, often immersed in educational, employment, family, and social situations that may pose a significant threat to their mental health (MH). Both SH and suicide increase sharply in the mid-teenage years so this is a vital time to support and intervene with YP who may be struggling and/or in distress. (4)

**A NATIONAL PRIORITY**

The MH of YP is a leading national priority. Several recent policy documents highlight this with the government’s 2017 Green Paper leading the way. (5) Mental illness is associated with significant costs to individuals and society. We know 75% of mental ill-health begins before the age of 24 therefore early interventions are key in preventing debilitating mental illness into and throughout adulthood. (5) £1.4 billion has been allocated by the government to children and YP’s MH care over the next few years and Local Transformation Plans include children and YP’s MH. (5)

The Green Paper aims to increase the number of senior leads for MH in schools and colleges where close access to Children and Adolescent MH services (CAMHS) is planned and supported by community MH Support Teams (MHSTs). A 4-week waiting time following referral to CAMHS is also intended.(5) What is important, however, and somewhat overlooked in the Green Paper, is that general practices should be in liaison with the MHSTs, and General Practitioners (GPs) must be incorporated into the MH care which YP receive in the education setting for continuity of care and a joined-up holistic approach.

**WHERE IS ACTION NEEDED IN SELF-HARM?**

SH not only affects the individual, but impacts on families, friends, and those around the person who self-harms. (6) Integrated care involving families, schools and colleges, third-sector organisations, and NHS healthcare services is crucial to enhance safety among distressed YP in the short term, and to help secure their future mental health and well-being in the long-term. GPs should involve families/care-givers in the management of SH in YP where the YP’s has given consent.

The role of third sector organisations should not be overlooked. Charities such as [ECHO](http://www.brighter-futures.org.uk/echo/) and [Harmless](http://www.harmless.org.uk/) are vital community services that provide YP with a supportive, informal, and non-judgmental environment to openly discuss SH. However, it is vital that such services are evidence-based in their approach to supporting those who SH and follow existing NICE guidance. (7)

It is troubling that YP find the Internet helpful in normalising SH, with images of SH providing inspiration for SH acts. (8) Online resources also offer an avenue for YP seeking MH support and in reducing social isolation. (8) A recent Public Health England report identified that a focus on the protective factors of family, school environment, and wider community should inform public mental health strategies in preventing SH in YP. (9) Public mental health measures should improve the digital literacy of parents and teachers, and target prevention and early detection of adverse childhood experiences.

The National Institute for Health and Care Excellence (NICE) SH clinical guideline (CG16) states that ‘primary care has an important role in the assessment and treatment of people who SH’ and provides guidance on when to refer YP who may SH to secondary care. (7)

**PRIMARY CARE AND GENERAL PRACTICE**

General practice remains a pillar of primary care, with the consultation the cornerstone of general practice.

Morgan et al (2017) highlight the important role of primary care in early intervention and inquiry, monitoring, and targeting of YP who may not openly engage with healthcare services for current self-harming behaviour. (3) SH incidence in YP in primary care is rising and GPs are seeing more SH than previously. (3)

A youth-friendly general practice can make YP feel welcomed, accepted, supported, and more likely to disclose information such as SH thoughts or acts. General practices should at minimum attempt to make their practice youth-friendly for YP who are known to be regular attendees.(10) Offering online appointment booking and a text messaging service will improve YP engagement and facilitate the opportunity of support and intervention in the consultation.(11) Figure 1 suggests ways of adopting a youth-friendly practice approach.

GPs are uniquely placed to provide comprehensive holistic care and should be central to the health journey of a young person and their family. YP may see their GP before and after an episode of SH, so play a key role in assessing, managing, and preventing SH, repeat SH, and suicide.(12) The challenge of providing such care and support in a time-limited consultation, however, should not be under-estimated. It is important digital resources such as [Calm Harm](https://calmharm.co.uk/) are developed with YP as these can help GPs in supporting YP in the community. [Kooth.com](https://kooth.com/) is a free and anonymous online service where YP can be signposted to. GPs can refer to tailored [Charlie Waller Memorial T](https://www.cwmt.org.uk/gp-training)rust GP training, [Royal College of General Practitioners](http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/mental-health-toolkit.aspx) SH in children and YP guidance, and [MindEd’s](https://www.minded.org.uk/) SH in YP e-learning for educational resources.

We feel GPs must take seriously and be vigilant in responding to the disclosure of SH thoughts and episodes empathetically with consideration and compassion towards the YP. This will facilitate rapport building and make YP feel listened to in the consultation. SH behaviour evolves over time and suicidal intent is fluid thus all SH, irrespective of suicidal intent, should be taken seriously.(13)

To date, only mentalisation-based therapy has shown a modest reduction in frequency of repeat SH in YP up to age 18.(14) In aged 18 and over, CBT-based psychological therapy can reduce repeat SH.(15) The development of acceptable and effective SH interventions are needed to ensure a consistent clinical management approach for SH among children and YP in primary care, specifically in the general practice setting.

**Figure 1:** points to consider in a youth-friendly practice – refer to RCN/RCGP ‘Getting it right for young people in your practice’ document for further information

* **Reassure confidentiality to YP and advertise policy on website, posters, and waiting room screens and walls**
* **Adopt whole-team approach to making practice youth-friendly**
* **Speak to YP (men and women) and involve them in the patient participation group**
* **Seek input from parents/carers/guardians and educate them on capacity, consent, and confidentiality**

**IN CONCLUSION**

Realising the full potential of a consultation with YP with SH depends on the GP’s ability to, listen non-judgementally and communicate effectively, and the organisation of primary care services. Deficiencies in either of these, according to Stott and Davis, will harm the potential of the consultation. (2) In the context of SH in YP, both factors are equally and crucially as important.

Given the strong association of SH, regardless of suicidal intent, with death by suicide, it is vital to view providing adequate support to YP who SH as a key element in suicide prevention. (4) It is an opportunity not to be missed.

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