



Top tips: supporting the patient who self-harms

Dr Dominique Thompson provides 10 top tips on recognising self-harm and how to help reduce the risks of further self-harm or suicide

It is hard to be sure exactly how prevalent self-harm may be in the general population as so much of it is hidden, but recent studies have demonstrated a sharp increase in such behaviours in young people in particular.^{1,2} Self-harm is much more common in females^{1,3} and can start at a young age, so the NICE guidelines cover the management of self-harm in people aged 8 years and above.^{4,5} However, the most common age for self-harm, according to NICE, is during adolescence and young adulthood.

Only a small proportion of self-harm occurs in older people (aged over 65 years) but those who do are at substantially higher risk of further self-harm and suicide.⁶

Self-harm matters, not just as a condition in its own right with symptoms and risks requiring assessment and treatment, but because it is associated with a significantly increased risk of suicide.^{1,5} Therefore, if primary care teams see someone who has self-harmed they have a potentially life-changing opportunity to intervene compassionately and prevent further self-harm or a tragic outcome. Self-harm should always be taken seriously, as it may be the opportunity to save a life.^{7,8}

In this article, 'self-harm' will encompass self-injury and self-poisoning but not broader self-harmful behaviours such as alcoholism or eating disorders, which many people might consider to be related.

Read this article to learn more about:

- recognising different forms of self-harm
- reasons and risk-factors for self-harm
- recommended therapies and coping strategies for people who self-harm.

Read this article at: GinP.co.uk/jul19-selfharm



1 Self-harm is strongly associated with increased mortality

There are very few primary care specific guidelines around care or prevention of self-harm but a 2016 analysis of what guidance did exist found that people who attended primary care following self-harm then went on to repeat self-harm, with 1 in 5 doing so within a year.^{1,7}

People who attended primary care for self-harm had an increased risk of mortality from all causes, also highest within the first year of follow up, and the strongest predictor of mortality

was alcohol misuse or dependence.⁷ Alcohol misuse may also lower inhibitions to self-harm, and is often associated with self-harm in adults.⁹

In terms of guidance applicable to primary care, the NICE Pathways on *Managing self-harm in primary care* is particularly accessible and well laid out for quick reference; all the self-harm advice is in one place in a neat flowchart.¹⁰ It should however be noted that NICE has scheduled an update for 2022 to provide clearer guidance on the transition between short- and long-term care, and up-to-date, concise guidance that reflects current practice for self-harm.¹¹

2 Think prevention as well as treatment

Prevention of future self-harm may be as important as treatment of the acute episode.⁷ Having dealt with the immediate wound care or poisoning risk assessment, it is important to consider longer-term risk. To prevent future self-harm and reduce future risk it is therefore crucial to recognise a behaviour as self-harm, then gently address the issue with the patient. Prevention of self-harm requires

Self-harm should always be taken seriously, as it may be the opportunity to save a life

healthcare professionals to understand the *why* behind the behaviour, not just to focus on the *what* (cutting/poisoning and so on).⁵

3 Recognise the variety of self-harm

Self-harm can involve cutting, scratching, burning, and squeezing, but it can also be seen in the punching of a wall or banging a head against a hard object. It can include self-poisoning with over-the-counter or prescription medication, often not the patient's own.^{12,13} Males and females may choose different methods, which may lead to under-recognition, for example in men punching walls and presenting with a 'boxer's fracture'.² Awareness of this as a potential method of self-harm may allow a conversation to begin even if the patient is not ready to fully discuss the underlying issues yet. They will however know that you are ready to talk when they are.

4 Address the underlying issues—the 'why' of self-harm

If we are to support our patients to stop self-harming, we need to 'get alongside them' and discover the reasons behind their behaviours. It is only by addressing and tackling underlying problems, distress, and trauma that any progress will be made on stopping acutely damaging behaviour. People self-harm for many reasons. For some it is to distract themselves from emotional pain, by replacing it with physical pain, for others it is self-punishment for their own (perceived) wrongdoing, and for some it is to demonstrate to others how awful they are feeling if they lack the words to communicate their distress. Self-harm is commonly associated with relationship difficulties,⁹ but also with depression, anxiety, or bipolar disorder,¹⁴ or following abuse⁵ or bereavement.⁹ Dealing with these issues will allow the person the space

they need to find alternatives to self-harm.

5 Offer to support them to stop self-harming

To understand self-harm it can help to use the 'boiling pot' analogy. When someone self-harms, it can be like lifting the lid off a boiling pot; there is a sudden release of pressure, a sense of relief, and a temporary feeling of calm.¹³ If we ask someone who self-harms to stop, *without* finding helpful alternatives for emotional relief, then it may be like pushing the lid back on to the boiling pot. The pressure may build and the consequences could be devastating.

It is reasonable to ask if they feel able to stop but if they feel unable to do so, NICE CG133 recommends talking to the patient about harm minimisation, while they address the long-term underlying issues and find more healthy coping strategies through therapy.⁵ It is important to explain though that there is 'no safe way to self-poison'.⁵

... understand the why behind the behaviour, not just the what ...

6 Support the patient to find safe alternatives to self-harm

Learning to tolerate the feelings of frustration and emotional despair are part of the approach to recovery, alongside finding safer ways to manage the feelings that lead to self-harm.¹⁵ The main aims of treatment for self-harm are to reduce or stop self-

harm, reduce likelihood of escalation reduce suicide risk, and address the factors driving the self-destructive behaviours.⁵ Improving quality of life and daily functioning, and addressing associated mental health conditions is also key.⁵ Psychological therapy is the recommended long-term approach for treatment of self-harm and the underlying causes.⁵

You may wish to suggest alternatives to self-harm, and the following are recommended by the free *distrACT* app which is recommended by the NHS app library.¹⁶ Instead of cutting or hurting themselves they may wish to try a sudden burst of 'on the spot' activity such as star jumps or punching a pillow, drawing on their skin instead of cutting it, rubbing in a scented cream where they would hurt themselves (to nurture instead of punish), use fake tattoos to remind themselves of safer alternatives, or put a plaster on their skin as a reminder of healing.

7 Prescribe safely—consider instalment prescribing

Although psychological approaches are the mainstay of treatment for self-harm, medication may still be required for associated conditions such as depression or anxiety, and so safe prescribing is vital. Some studies have found that GPs are unfortunately more likely to prescribe than refer the patient for talking therapies⁸ but that may of course be related to the availability of psychological services locally.

If medication is needed, then it is crucial to consider which will be the safest type (for example, avoid tricyclic antidepressants⁵), and if possible consider prescribing small amounts only, such as a 7-day supply repeated weekly.⁴ The unfortunate downside of this latter option is that if the patient pays for prescriptions they will be charged each time, which can then reduce the likelihood of them taking their medication at all.

Prescribing Information

Trimbow 87/5/9 Pressurised Metered Dose Inhaler (pMDI) Prescribing Information. Please refer to the full Summary of Product Characteristics (SPC) before prescribing.

Presentation: Each Trimbow 87/5/9 pMDI delivered dose contains 87micrograms (mcg) of beclometasone dipropionate (BDP), 5mcg of formoterol fumarate dihydrate (formoterol) and 9mcg of glycopyrronium. This is equivalent to a metered dose of 100mcg BDP, 6mcg formoterol and 10mcg glycopyrronium.

Indication: Maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta₂-agonist or a combination of a long-acting beta₂-agonist and a long-acting muscarinic antagonist (for effects on symptoms control and prevention of exacerbations see section 5.1 of the SPC). **Dosage and administration:** For inhalation in adult patients (≥18 years), 2 inhalations twice daily. Can be used with the AeroChamber Plus[®] spacer device. BDP in Trimbow is characterised by an extrafine particle size distribution which results in a more potent effect than formulations of BDP with a non-extrafine particle size distribution (100mcg of BDP extrafine in Trimbow are equivalent to 250mcg of BDP in a non-extrafine formulation). **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. **Warnings and precautions:** Not for acute use in treatment of acute episodes of bronchospasm or to treat COPD exacerbation. Discontinue immediately if hypersensitivity or paradoxical bronchospasm. **Deterioration of disease:** Trimbow should not be stopped abruptly. **Cardiovascular effects:** Use with caution in patients with cardiac arrhythmias, aortic stenosis, hypertrophic obstructive cardiomyopathy, severe heart disease, occlusive vascular diseases, arterial hypertension and aneurysm. Caution should also be used when treating patients with known or suspected prolongation of the QTc interval (QTc > 450 milliseconds for males, or > 470 milliseconds for females) either congenital or induced by medicinal products. Trimbow should not be administered for at least 12 hours before the start of anaesthesia as there is a risk of cardiac arrhythmias. Caution in patients with thyrotoxicosis, diabetes mellitus, phaeochromocytoma and untreated hypokalaemia. Increase in pneumonia and pneumonia hospitalisation in COPD patients receiving ICS observed. Clinical features of pneumonia may overlap with symptoms of COPD exacerbations. Systemic effects of ICS may occur, particularly at high doses for long periods, but are less likely than with oral steroids. These include Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation, decrease in bone mineral density, cataract, glaucoma and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression and aggression. Use with caution in patients with pulmonary tuberculosis or fungal/viral airway infections. Potentially serious hypokalaemia may result from beta₂-agonist therapy. Formoterol may cause a rise in blood glucose levels. Glycopyrronium should be used with caution in patients with narrow-angle glaucoma, prostatic hyperplasia or urinary retention. Use in patients with severe hepatic or renal impairment should only be considered if benefit outweighs the risk. Consider referral of patients reporting blurred vision or visual disturbances to an ophthalmologist as causes may include cataract, glaucoma or rare diseases such as central serous chorioretinopathy. **Interactions:** Since glycopyrronium is eliminated via renal route, potential drug interactions could occur with medicinal products affecting renal excretion mechanisms e.g. with cimetidine (an inhibitor of OCT2 and MATE1 transporters in the kidney) co-administration, glycopyrronium showed a slight decrease in renal excretion (20%) and a limited increase in total systemic exposure (16%). Possibility of systemic effects with concomitant use of strong CYP3A inhibitors (e.g. ritonavir, cobicistat) cannot be excluded and therefore caution and appropriate monitoring is advised. **Related to formoterol:** Non-cardioselective beta-blockers (including eye drops) should be avoided. Concomitant administration of other beta-adrenergic drugs may have potentially additive effects. Concomitant treatment with quinidine, disopyramide, procainamide, antihistamines, monoamine oxidase inhibitors (MAOIs), tricyclic antidepressants and phenothiazines can prolong the QTc interval and increase the risk of ventricular arrhythmias. L-dopa, L-tyrosine, oxytocin and alcohol can impair cardiac tolerance towards beta₂-sympathomimetics. Hypertensive reactions may occur following co-administration with MAOIs including drugs with similar properties (e.g. furazolidone, procabazine). Risk of arrhythmias in patients receiving concomitant anaesthesia with halogenated hydrocarbons. Concomitant treatment with xanthine derivatives, steroids or diuretics may potentiate a possible hypokalaemic effect of beta₂-agonists. Hypokalaemia may increase the likelihood of arrhythmias in patients receiving digitalis glycosides. **Related to glycopyrronium:** Co-administration with other anticholinergic-containing medicinal products is not recommended. **Excipients:** Presence of ethanol may cause medicinal interaction in sensitive patients taking metronidazole or disulfiram. **Fertility, pregnancy and lactation:** Should only be used during pregnancy if the expected benefits outweigh the potential risks. Children born to mothers receiving substantial doses should be observed for adrenal suppression. Glucocorticoids and metabolites are excreted in human milk. It is unknown whether formoterol or glycopyrronium (including their metabolites) pass into human breast-milk but they have been detected in the milk of lactating animals. Anticholinergic agents like glycopyrronium could suppress lactation. A risk/benefit decision should be taken to discontinue therapy in the mother or discontinue breastfeeding. A decision must be made whether to discontinue breastfeeding or to discontinue/abstain from therapy. **Effects on driving and operating machinery:** None or negligible. **Side effects:** Common: pneumonia (in COPD patients), pharyngitis, oral candidiasis, urinary tract infection, nasopharyngitis, headache, dysphonia. **Uncommon:** influenza, oral fungal infection, oropharyngeal candidiasis, oesophageal candidiasis, sinusitis, rhinitis, gastroenteritis, vulvovaginal candidiasis, granulocytopenia, dermatitis allergic, hypokalaemia, hyperglycaemia, restlessness, tremor, dizziness, dysgeusia, hypoaesthesia, otosalginitis, atrial fibrillation, electrocardiogram QT prolonged, tachycardia, tachyarrhythmia, palpitations, hyperaemia, flushing, hypertension, cough, productive cough, throat irritation, epistaxis, diarrhoea, dry mouth, dysphagia, nausea, dyspepsia, burning sensation of the lips, dental caries, aphthous stomatitis, rash, urticaria, pruritus, hyperhidrosis, muscle spasms, myalgia, pain in extremity, musculoskeletal chest pain, fatigue, C-reactive protein increased, platelet count increased, Free fatty acids increased, blood insulin increased, blood ketone body increased, cortisol decreased. **Rare:** Lower respiratory tract infection (fungal), hypersensitivity reactions, including erythema, lips, face, eye and pharyngeal oedema, decreased appetite, insomnia, hypersomnia, angina pectoris (stable and unstable), ventricular extrasystoles, nodal rhythm, sinus bradycardia, blood extravasation, paradoxical bronchospasm, oropharyngeal pain, pharyngeal erythema, pharyngeal inflammation, dry throat, angioedema, dysuria, urinary retention, nephritis, asthenia, blood pressure increased, blood pressure decreased. **Very rare:** thrombocytopenia, adrenal suppression, glaucoma, cataract, dyspnoea, growth retardation, peripheral oedema, bone density decreased. **Frequency not known:** psychomotor hyperactivity, sleep disorders, anxiety, depression, aggression, behavioural changes, blurred vision. (Refer to SPC for full list of side effects). **Legal category:** POM **Price and Pack:** £44.50 1x120 actuations. **Marketing authorisation (MA) no:** EU/1/17/1208/002 **UK Distributor:** Chiesi Limited, 333 Sneyd Road, Manchester, M22 5LG. **Date of Preparation:** Jan 2019. AeroChamber Plus[®] is a registered trademark of Trudell Medical International.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Chiesi Limited on 0800 0092329 (UK) or PV.UK@Chiesi.com.

Reference: 1. Trimbow Summary of Product Characteristics, Chiesi Limited. Available at: www.medicines.org.uk/emc/product/761.

Trimbow

beclometasone/formoterol/
glycopyrronium (87/5/9 mcg)

8 Risk assessment is notoriously tricky—try to avoid the 'high'/'low' risk trap

When assessing risk of further self-harm, it may be helpful to recall the 'low risk paradox' of suicide assessment.¹ It has been found that a significant proportion (80%) of those who die by suicide were classified as 'low risk' at their last assessment or contact with healthcare services.¹⁷ With self-harm the challenges may be similar. Risk is ever changing, as people are constantly reacting to whatever is happening in their life at that time, and added to this flat background is the fact that a clinician may not have all relevant information in front of them.

Risk assessment tools for self-harm are generally not recommended by NICE, and any risk assessment should look for known (evidence-based) risk factors (including a history of self-harm or psychiatric treatment, alcohol or drug misuse, being LGBT+, isolation, or personality disorder),^{18,19} alongside depression, hopelessness and ongoing suicidal intent.⁴ NICE CG133 recommends referral, especially in those aged under 18 years, if distress or risk is felt to be rising, unmanageable, unresponsive to offers of help, or the impact on family and carers is significant and rising.⁵

Mental capacity may need assessment in extreme cases and referral for specialist support will be essential in such difficult scenarios.

The recently updated NICE guideline on depression in children and young people recommends that early referral should be considered if there is evidence of depression and/or self-harm. Repeated self-harm warrants referral to tier 4 Child and Adolescent Mental Health Services, and inpatient treatment should be considered for children and young people presenting with a high risk of suicide, serious self-harm, or self-neglect.²⁰

9 Address other issues while awaiting therapy and suggest a safety plan

There may be a delay before therapy can begin, and this may mean that the person is continuing to harm themselves, albeit while being encouraged to try to stop and replace the behaviours with safer alternatives. This may be a time during which healthcare teams can address other mental health conditions, review medication, discuss harm minimisation, refer for financial or housing support, address substance issues, check on physical health, and review safeguarding needs or the needs of dependants. This may in turn ensure that the patient is in a better place emotionally and socially when therapy does commence.

Drawing up a 'safety plan' may be a useful and practical activity. There are a variety of templates and apps, often provided by charities in the suicide prevention sector, such as Papyrus or Connecting with People, that allow people to record what they might do to keep themselves safe, what their triggers are, and who they might call on when feeling desperate, instead of self-harming.²¹ See Box 1 for examples of resources for further support.

10 Listen, believe, and give hope

A compassionate, kind, non-judgemental and trusting relationship between healthcare professional and patient is key to progress and recovery. Taking the time to listen and believe them (you may be the first to do either) and to give hope and be optimistic about recovery may be powerfully therapeutic.

Try to avoid phrases that may appear dismissive such as 'it's a phase' or 'attention seeking' or negative framing of questions such as 'you're *not* thinking of harming yourself again, are you?' which may elicit a shake of the head, despite there being a significant chance that they might. Avoid guilt trips, or comments like 'things can't be *that* bad', as they are unhelpful and will not build the positive relationship required for recovery.

Try to be direct but kind, show empathy, and avoid using stigmatising language ('deliberate' self-harm is no longer used as it can appear to apportion blame¹⁵).

People can feel terribly ashamed and guilty, or a burden to others, and it is important to let them feel heard and listened to, taken seriously, and cared for. Box 2 contains a number of questions and phrases a GP can use to connect with people and create a constructive relationship.

Box 1: Resources for further support

Websites

- Self injury support website
 - www.selfinjurysupport.org.uk/
- Mental Health foundation
 - www.mentalhealth.org.uk/a-to-z/s/self-harm
- Papyrus
 - papyrus-uk.org
- Papyrus HOPELINEUK
 - papyrus-uk.org/hopelineuk
- Connecting with people
 - www.connectingwithpeople.org
- Money and Mental Health Policy Institute
 - www.moneyandmentalhealth.org

Apps

- Calm Harm
 - www.nhs.uk/apps-library/calm-harm
- DistrACT
 - www.nhs.uk/apps-library/distract
- Blue Ice
 - www.nhs.uk/apps-library/blueice

Box 2: Suggested questions and phrases to use in a consultation with a patient who self-harms

- 'How do you see the future?'
- 'Have things got so bad that you feel you may harm yourself or have you had thoughts of ending your life?'
- 'If you ever did start to think or feel like this, can you think of people you could tell or things you could do to help yourself?'
- 'Have you made any plans to end your life, or prepared at all?'
- 'What has stopped you from carrying out this plan so far?'
- 'I want to support you, and need you to know that we are here for you...'

Conclusion


Self-harm is a common, distressing, and challenging condition that needs to be taken seriously, yet it is unfortunately not always recognised as such. Every contact with a person who self-harms is an opportunity to intervene with compassion and try to reduce both the immediate risk of harm and the longer-term risks

of suicide and significant negative impact on life. It is a condition that can dominate people's lives yet is amenable to treatment, and engaging in therapy can be transformational. GPs need to be alert to self-harm in all its forms, and aware of the predisposing risk factors and long-term risks. By remaining vigilant and being kind and supportive, practitioners can help their patients to identify underlying reasons and

triggers, find safe alternatives, and help them to recover successfully in the longer term.

Dr Dominique Thompson
GP, Bristol

References

- Morgan C, Webb R, Carr M et al. Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care. *BMJ* 2017; **359**: j4351. Available at: www.bmj.com/content/359/bmj.j4351
- SelfharmUK. *Self-harm statistics*. www.selfharm.co.uk/get-information/the-facts/self-harm-statistics (accessed 12 July 2019).
- Hawton, K, Bergen, H, Waters, K et al. Epidemiology and nature of self-harm in children and adolescents: findings from the multicentre study of self-harm in England. *Eur Child Adolesc Psychiatry* 2012; **21** (7): 369.
- NICE. *Self-harm in over 8s: short-term management and prevention of recurrence*. Clinical Guideline 16. NICE, 2004 (last updated 2018). Available at: www.nice.org.uk/cg16
- NICE. *Self-harm in over 8s: long-term management*. Clinical Guideline 133. NICE, 2011. Available at: www.nice.org.uk/cg133
- NICE. *Self-harm in over 8s: short-term management and prevention of recurrence*. Full guideline. Clinical Guideline 16. NICE, 2004. Available at: www.nice.org.uk/guidance/cg16/evidence/full-guideline-189936541
- Kirtly O, Cole-King A. Self-harm in primary care: more prescribing than referrals. National Elf Service website. Blog, 22 April 2016. www.nationalelfservice.net/mental-health/self-harm/self-harm-in-primary-care-more-prescribing-than-referrals/ (accessed 21 June 2019).
- Carr M, Ashcroft D, Kontopantelis E et al. Clinical management following self-harm in a UK-wide primary care cohort. *J Affect Disord* 2016; **197**: 182–188.
- Townsend E, Ness J, Waters K et al. Self-harm and life problems: findings from the Multicentre Study of Self-harm in England. *Soc Psychiatry Psychiatr Epidemiol* 2016; **51** (2): 183–192.
- NICE. *Managing self-harm in primary care*. NICE Pathways. Available at: pathways.nice.org.uk/pathways/self-harm#path=view%3A/pathways/self-harm/managing-self-harm-in-primary-care.xml&content=view-index
- NICE. *Self-harm in over 8s: long-term management*. Evidence. 2019 exceptional surveillance of self-harm in over 8s (NICE guidelines CG16 and CG133). NICE, January 2019. www.nice.org.uk/guidance/cg133/resources/2019-exceptional-surveillance-of-self-harm-in-over-8s-nice-guidelines-cg16-and-cg133-6653100205/chapter/Surveillance-decision?tab=evidence (accessed 21 June 2019).
- Mental Health Foundation website. *Self-harm*. www.mentalhealth.org.uk/a-to-z/s/self-harm (accessed 21 June 2019).
- Mind website. *Self-harm*. www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/# (accessed 21 June 2019).
- Weintraub M, Van de Loo M, Gitlin M, Miklowitz D. Self-harm, affective traits, and psychosocial functioning in adults with depressive and bipolar disorders. *J Nerv Ment Dis* 2017; **205** (11): 896–899.
- Royal College of Psychiatrists website. *Self-harm*. www.rcpsych.ac.uk/mental-health/problems-disorders/self-harm (accessed 21 June 2019).
- NHS website. *NHS apps library. distrACT*. www.nhs.uk/apps-library/distract/ (accessed 21 June 2019).
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. *Quality of risk assessment prior to suicide and homicide: a pilot study*. NCISH, 2013. Available at: documents.manchester.ac.uk/display.aspx?DocID=37576
- Larkin C, Di Blasi Z, Arensman E. Risk factors for repetition of self-harm: a systematic review of prospective hospital-based studies. *PLoS ONE* 2014; **9** (1): e84282.
- Mental Health Foundation website. *Mental health statistics: LGBT people*. www.mentalhealth.org.uk/statistics/mental-health-statistics-lgbt-people (accessed 21 June 2019).
- NICE. *Depression in children and young people: identification and management*. NICE Guideline 134. NICE, 2019. Available at: www.nice.org.uk/ng134
- Papyrus. Prevention of young suicide. *Suicide safety plan*. Available at: papyrus-uk.org/wp-content/uploads/2018/09/Suicide-Safety-Plan-Letter.pdf 

Want to read more top tips articles?

Guidelines in Practice top tips articles offer key points on the primary care treatment and management of a range of different conditions.

A few of our recent top tips articles are listed below. To see the full list, visit: ginp.co.uk/top-tips



Top tips: sexually transmitted infections

Dr Toni Hazell highlights key points for managing sexually transmitted infections in this two-part series
www.ginp.co.uk/may19-sti
www.ginp.co.uk/jun19-sti



Top tips: preparing for appraisal and revalidation

Dr Honor Merriman provides 10 top tips on how GPs can ensure they are ready for their appraisal, and how to get the most out of it
www.ginp.co.uk/may19-appraisal



Top tips: anxiety disorders

Dr Ed Beveridge offers ten top tips on the diagnosis, management, and treatment of adults with anxiety disorders in primary care
www.ginp.co.uk/apr19-anxiety