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Equitable assessment and treatment of self-harm

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The past 18 months have taxed the coping reserves of children and adolescents worldwide. The COVID-19 pandemic has disrupted even the most basic routines, and it is not clear when or if things will return to how they once were. Very early in the pandemic, it became clear that minoritised ethnic communities would be disproportionately affected.¹

In efforts to limit transmission of SARS-CoV-2, schools around the world shut down and students sheltered in place at home. Although home is often considered to be a safe space, the pandemic highlighted the vastly disparate home environments in which children and adolescents live. In the USA, the effects of racism and racial discrimination on the mental health of Black and Latinx youth were evident long before the pandemic, but in the absence of the support and structure offered by the school environment, mental health challenges have become even more apparent.

The imbalance of power and privilege among and between ethnic groups contributes to differences in access to resources and opportunities,² and pandemic-related school closures disproportionately limited access to resources for Black and Latinx children and adolescents in the USA. The academic deficits will most likely plague a generation, and school closures have engendered social isolation, food insecurity, and increased susceptibility to neglect and abuse, with no clear outlet for reporting.³ Moreover, young people whose mental health needs were addressed through school-based resources did not have access to these services. Taken together in a context of increased stress due to economic hardship, fear of contracting or spreading a deadly virus, and threats of racially motivated violence, increased rates and intensity of mental health presentations are to be expected.⁴

Self-harm, more formally termed non-suicidal self-injury, is fairly common among children and adolescents, with lifetime prevalence rates ranging from 17% to 60%.⁵ Self-harm is a concerning psychiatric phenomenon both as a predictor of increased suicide risk and in its own right. Evidence suggests that the main function of self-harm behaviour is to regulate intense negative emotions, heightened stress, and feelings of numbness or emptiness;⁶ all of which

are events a child or adolescent may experience and attribute to the COVID-19 pandemic.⁷

In *The Lancet Child & Adolescent Health*, Bushra Farooq and colleagues⁸ leverage data from the Multicentre Study of Self-Harm in England to examine rates of self-harm in children and adolescents aged 10–19 years, from various ethnic groups, who presented to hospital emergency departments between 2000 and 2016. Although rates of self-harm were highest among White children and adolescents (10211 [85.8%] of 11906 individuals who presented at hospitals with self-harm and had data for ethnicity), findings highlight inequities in assessment, wherein Black, South Asian, and other non-White children and adolescents were less likely than their White peers to receive a psychosocial assessment upon presentation to the hospital (179 [52.0%] of 344 Black children and adolescents, 330 [53.3%] of 619 South Asian, and 405 [55.3%] of 732 other non-White children and adolescents [including those with Chinese and Arab backgrounds] received a specialist psychosocial assessment, compared with 6679 [65.4%] of 10211 White children and adolescents; $p < 0.0001$). Despite these seemingly discriminatory assessment practices, the model suggested an annual increase of 2% in the rates of self-harm in White groups, 7% in Black groups, 5% in South Asian groups, and 11% in other non-White groups. This increase might be attributable to more accurate reporting in recent years, but another plausible explanation is that rates of self-harm among these ethnic groups are increasing.

Other studies⁹ have also shown that lower rates of formally diagnosed mental health concerns can misrepresent actual mental health burden among minoritised ethnic groups. The danger is that undiagnosed mental health conditions go untreated, and untreated conditions could become more intractable over time. Moreover, young people who do not feel safe or heard by providers are not likely to seek mental health services; youth from minoritised ethnic backgrounds, in particular, are less likely to feel safe or heard by their care providers.²

Considering what we know about risk factors for self-harm behaviours among young people in minoritised ethnic groups, it is crucial that we act. A key first step suggested by Farooq and colleagues⁸ is to identify and

address conscious and unconscious bias among staff who will encounter these children and adolescents. Training in diversity, cultural humility, and anti-racism often aid in the introspection needed to identify such bias in oneself. Next is development, implementation, and evaluation of culturally appropriate methods of prevention, assessment, and treatment. For example, the authors⁸ identified difficult family dynamics as a precipitant for self-harm among Black and South Asian children and adolescents. Inquiring about and addressing familial issues might garner greater buy-into treatment from these young people. Equitable assessment and treatment also require a more nuanced examination of intersecting identities such as race, ethnicity, gender, social class, disability status, and religious beliefs. Understanding these aspects of identity can also aid in identifying protective factors.

It is very likely that children and adolescents in minoritised ethnic groups will continue to present with self-harm behaviours. As schools reopen, stressors will shift to reacclimatising to schedules and routines, social and academic pressures, and concerns about staying safe and healthy. Some relief might come from social reintegration and some semblance of normalcy. However, the COVID-19 pandemic is still very much

active, and the long-term effects are yet unknown. We will be untangling the effects on child and adolescent mental health for years to come.

I declare no competing interests.

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Early targeted heart rate aerobic exercise for sport-related concussion



The highest prevalence of sport-related concussion is seen in adolescents aged 14–19 years, with an estimated 10% reporting a concussion each year in North America and an even higher prevalence in collision or contact sport participants.¹ Research suggests that many adolescents remain symptomatic for months after concussion.² Evidence-informed sport-related concussion treatments are limited, and treatment options to prevent consequences of sport-related concussion and enable more rapid return to learning and sport are urgently needed.

In *The Lancet Child & Adolescent Health*, by focusing on sport-related concussion in adolescents aged 13–18 years, a multicentre randomised controlled trial (RCT) by John Leddy and colleagues³ has potential for substantial public health effects by reducing youth sport-related

concussion burden. This RCT primarily aimed to evaluate the safety, efficacy, and adherence to early targeted heart rate subsymptom threshold aerobic exercise compared with a stretching exercise control group. Efficacy was based on clinical recovery following sport-related concussion (ie, return to baseline symptoms, normal exercise tolerance, and a normal physical examination) within a 4-week study period with participants who were recruited within 10 days of injury. Studies examining the efficacy of treatment strategies following youth sport-related concussion are surprisingly scarce, are not RCTs, are of low quality with small sample sizes, and often focus on prolonged recovery.⁴ Thus, the need for RCTs to examine early treatment implementation approaches aimed at reducing recovery time after sport-related concussion are clearly needed.



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