Basic knowledge of mental health presentations

Knowledge about mental health

An ability to draw on knowledge that mental health problems can affect people of any age, class, ethnicity, religion or income
An ability to draw on knowledge that mental health problems and problems with substance misuse (including alcohol) are a leading cause of disability
An ability to draw on knowledge that mental health problems are important risk factors for physical illnesses, as well as unintentional and intentional injury
An ability to draw on knowledge that physical illness (especially long-term conditions) are a significant risk factor for mental health problems, particularly anxiety and depression
An ability to draw on knowledge that mental health problems can disrupt a person's thinking, feeling, mood, ability to relate to others, daily functioning and quality of life
An ability to draw on basic knowledge of the prevalence of mental health problems, for example that:
in each year approximately one in four people experience a mental health problem
the most frequent problems are depression and anxiety disorders (with mixed anxiety and depression the most common presentation)
bipolar disorder and psychosis are relatively uncommon presentations, but can be associated with significant additional health problems (especially if a person is not receiving treatment)
An ability to draw on knowledge of the symptoms, difficulties in functioning and likelihood of recovery that characterise:
common mental health problems such as depression and anxiety
serious mental illness, such as psychosis and bipolar disorder
An ability to draw on knowledge of the distinction between mental health problems and learning disabilities (the former affects a person's thinking, mood and behaviour, whereas people with a learning disabilities experience limitation in intellectual function and difficulties with certain skills)

Help-seeking and treatment

An ability to draw on knowledge that fear (and sometimes experience) of stigma and discrimination can prevent people from seeking mental health care
an ability to draw on knowledge that only about one in eight people with mental health problems are receiving active treatment
An ability to draw on knowledge that for most people experiencing mental health problems or suicidal feelings, the initial acknowledgement that they have a problem (and seeking help) is a major life event/transition
An ability to draw on knowledge that treatments for mental health problems are effective and help to reduce symptoms and improve quality of life
An ability to draw on knowledge that there are a range of psychological, psychosocial and medical interventions for mental health problems and that:
treatments may be offered independently, sequentially or in combination
access to treatments in all modalities may be limited by availability and local service provision
public awareness of treatment options can be low

Knowledge of self-harm and suicide

Terminology

- An ability to draw on knowledge of definitions of self-harm and suicide:
  - ‘self-harm’ refers to an act of self-poisoning or self-injury in the context of overt or covert emotional or psychological distress, with or without an intent to die
  - ‘suicide’ refers to the intentional act of taking one’s own life
  - ‘attempted suicide’ refers to an act of self-harm in which a person intended to die and believed that the means and method of the attempt would be fatal
  - ‘suicidal ideation’ refers to a person having thoughts about suicide (but not necessarily acting on these thoughts)
  - ‘suicidal intent’ refers to an intention to act on suicidal ideation

Knowledge of potential interventions

- An ability to draw on knowledge that self-harm and suicide are preventable and amenable to a range of public health, population-based and individual clinical interventions

Frequency of self-harm and suicide

- An ability to draw on knowledge about the frequency of self-harm and suicide in the general population, for example that:
  - suicide is the leading cause of death in males aged 20–49
  - suicide is the 14th most frequent cause of death (responsible for around 1% of all mortality)
  - between 1 in 5 to 1 in 7 people have self-harmed by age 20
  - at some point in their life:
    - 3% of the population make plans to end their life
    - 5% of the population report attempting suicide
    - 5% of the population make non-lethal suicide attempts
    - 9% of the population experience suicidal ideation
- An ability to draw on knowledge that people who self-harm are 50 times more likely than the general population to attempt suicide, although only a minority will do so (making a history of self-harm a poor predictor of suicide in and of itself)
- An ability to draw on knowledge that suicide is the leading cause of death in children and young people (partly reflecting the fact that other causes of death, such as serious illness, are less common in these age groups)
- An ability to draw on knowledge that over half of young people who die by suicide have a history of self-harm
- An ability to draw on knowledge that rates of self-harm in young people appear to be increasing

Knowledge of mental health, self-harm and suicide

- An ability to draw on knowledge that self-harm and suicide are expressions of overwhelming and intense psychological distress, and that:
  - acts of self-harm and suicide are often (but not always) associated with mental health difficulties, such as:
    - depression
    - psychosis
    - personality disorders (particularly emotionally unstable personality disorder)
    - anxiety disorders
    - anorexia nervosa
    - comorbidity of the above disorders (e.g. with alcohol and substance misuse or with long-term physical health conditions)
- An ability to draw on knowledge that although more than 90% of people who die by suicide have a history of mental health problems, most people with mental health problems never attempt suicide (and so in itself mental health is a poor predictor of suicide)

Vulnerability

- An ability to draw on knowledge of populations who have a higher rate of self-harm or suicide than the general population, such as:
  - gender groups:
    - men in mid-life and older men (who are at greater risk of completed suicide)
    - divorced men
    - younger women (who are at greater risk of non-suicidal self-harm, but not suicide)
    - men in the construction industry
  - children and young people in the looked-after care system
  - people who identify as LGBTQ+
  - people with learning disabilities and neurodevelopmental conditions (such as autism spectrum disorder)
  - people with long-term physical health problems and limitations in daily living
  - people from socioeconomically deprived backgrounds
  - people who are in debt or unemployed
  - people with low educational attainment
  - people who misuse alcohol or drugs
  - people from some (but not all) ethnic minority backgrounds (e.g. Indian and East African females)
  - refugees and asylum seekers
  - occupational groups with greater access to means of suicide
  - people in contact with the criminal justice system (including newly disclosed sex offenders) especially early in incarceration and immediately after release
  - military veterans
  - people from the traveller community
- An ability to draw on knowledge of social factors that are associated with greater rates of self-harm and/or suicide, such as:
  - social isolation
  - economic problems
  - homelessness and insecure or inadequate housing
- An ability to draw on knowledge of factors that could increase or decrease a person's risk of self-harm or suicide, such as:

- factors which may increase risk:
  - presence of mental health problems (particularly depression)
  - previous self-harm or suicide attempts
  - family history of suicide
  - feelings of hopelessness
  - isolation and a sense of being cut-off from people
  - exposure to the suicide of another person in an institutional setting (e.g. school, university, workplace or hospital)
  - impaired capacity for problem solving (and so being unable to generate a solution or a way out of difficulties)
  - experience of major losses
  - bereavement by suicide
  - access to potentially lethal means of harm
  - experience of current or past abuse or maltreatment (including domestic violence)
  - long-term physical health problems (particularly in women)
  - history of alcohol and/or drug misuse
  - impulsive or aggressive tendencies
  - unwillingness to seek help (e.g. because of perceived stigma about accessing mental health services)
  - transitions in care
- factors that may decrease risk:
  - access to social or cultural support
  - support from families, carers, significant others and friends
  - engagement with a healthcare practitioner or healthcare services

Knowledge of the impact of self-harm and suicide on others

- An ability to draw on knowledge of the impact of bereavement by suicide on individuals and communities
  - an ability to draw on knowledge that the impact of a death by suicide will be an interaction between a person's circumstances and the nature of their relationship to the deceased
- An ability to draw on knowledge of the impact of a person's self-harm or suicidal behaviour on the emotional wellbeing and mental health of their family, carers and friends
- An ability to draw on knowledge that some people may react to knowledge of (or news about) a suicide by becoming suicidal themselves, and so there can be an increased risk, for example when:
  - a suicide occurs within a person's social network, particularly:
    - within the personal or social media network of young people
    - among peers at school or college
    - where they identify with the person who has died by suicide
  - new methods of suicide are publicised in the media
  - there is a death of a celebrity by suicide
- An ability to draw on knowledge that when a person dies, some of their peers (such as at school or university) may be at increased risk of suicide through a process of 'social contagion'
  - an ability to draw on knowledge of the role of 'postvention' (interventions whose aim is to manage distress after a death by suicide and identify individuals who may be at increased risk)

Knowledge of the impact of social inequalities on self-harm and suicide

An ability to draw on knowledge that social inequalities are associated with increased rates of self-harm and suicide
An ability to draw on knowledge that people living in areas of higher socioeconomic deprivation tend to have higher rates of suicide and that:
hospital admissions following self-harm are twice as high in the most deprived neighbourhoods compared with the most affluent
males in the lowest social class who live in the most deprived areas are up to ten times more at risk of suicide than those in the highest social class living in the most affluent areas
An ability to draw on knowledge that the greater the level of deprivation experienced, the higher the risk of suicidal behaviour
An ability to draw on knowledge that:
unemployed males are two to three times more likely to die by suicide than those in employment
those in the least skilled occupations (e.g. construction workers) have higher rates of suicide
people experiencing socioeconomic disadvantage and adverse circumstances (e.g. unemployment and unmanageable debt) are at increased risk of suicidal behaviour, particularly during periods of economic recession
An ability to draw on knowledge that people who are socioeconomically disadvantaged are thought to be at increased risk of self-harm and suicide because they are more likely to experience ongoing stressful experiences and negative life events, such as:
adversity (including adverse events in childhood)
poor mental health
relationship breakdown
social isolation
experience of stigma
emotional distress
difficulties accessing welfare benefits or other financial support
debt
poor housing
An ability to draw on knowledge that some populations may be at greater risk of self-harm and suicide, such as:
people who identify as LGBTQ+
people who have been/are in the criminal justice system
people from the traveller community
people who have been trafficked
refugees and asylum seekers
looked-after children and young people
An ability to draw on knowledge that while some ethnic minority groups are at greater risk of self-harm and suicide, others show a reduced risk or no greater risk than the population as a whole
an ability to draw on knowledge that within ethnic minority groups there may be differences in vulnerability between males and females

Understanding self-harm and suicidal ideation and behaviour

This section describes our current understanding of factors that can lead to self-harm and suicidal ideation and behaviour.

Interventions to help people who self-harm or are suicidal are based on the principles set out in this section; as such, these guide the practice set out in other areas of this framework.

Understanding self-harm

An ability to draw on knowledge that while there are many motivations for self-harm, the goal is not usually death (and it is this that distinguishes it from suicidal behaviour)
An ability to draw on knowledge that (whatever the motivation) self-harm is associated with a greater probability of suicide
An ability to draw on knowledge that it is unhelpful to view self-harm as 'attention-seeking' or manipulative, and so dismiss its potential significance and its meaning to a person
An ability to draw on knowledge that the function of self-harm is best determined by looking at specific incidents that led up to and followed the self-harm
An ability to draw on knowledge that people who self-harm may:
experience high levels of negative emotions (e.g. depression, anxiety, hostility, anger, negative self-esteem)
experience emotions strongly
An ability to draw on knowledge that self-harm is thought to develop through the interaction of both long-term (predisposing) and more immediate factors
An ability to draw on knowledge of factors that may predispose a person to self-harm, for example:
a tendency towards being emotionally reactive
high levels of criticism and hostility from family members
experiencing abuse or maltreatment during childhood
social factors, such as acute relationship crises and loss
difficulty tolerating high levels of distress
difficulty expressing feelings verbally
poor social problem-solving skills
An ability to draw on knowledge that before self-harm, a person commonly experiences:
feelings of rejection
overwhelming negative feelings directed to the self (such as anger, shame, disgust or guilt)
feeling numb
strong negative feelings directed toward others
An ability to draw on knowledge of the ways that self-harm can function to help manage intense emotional states, for example:
releasing a sense of unbearable tension
stopping bad feelings
reducing the experience of emotional pain
communicating the level of distress being experienced (and so drawing attention to its presence)
relieving a sense of frustration
relieving the experience of emotional numbness (e.g. feeling something, even if it is pain)

- An ability to draw on knowledge that while immediately after self-harm there can be a sense of relief, this is often followed by negative feelings, such as guilt and shame
- An ability to draw on knowledge that self-harm may become a habitual response to feeling overwhelmed or stressed, reinforced by the experience of:
  - increased positive feeling (immediate but short-lived)
  - decreased negative emotions (immediate, but short-lived)
  - increased attention to distress from others

Understanding suicide

- An ability to draw on knowledge that research has led to models that help identify factors that:
  - are often associated with the development of suicidal ideation and intent
  - that lead from a preoccupation with suicide to a decision to act
- An ability to draw on knowledge that psychological models emphasise the impact of feeling overwhelmed by feelings of hopelessness about oneself, the future and one's capacity to change one's circumstances for the better. This state of mind arises from:
  - long-standing factors that become worse in the presence of stress, such as:
    - a restricted ability to apply problem-solving strategies that might resolve difficulties
    - a tendency to employ unhelpful ways of thinking (such as jumping to conclusions or 'all-or-nothing' thinking) that in turn worsen distress
    - impulsivity, particularly when combined with a tendency to respond to difficulties with aggression
  - mental health problems
  - a long-standing sense of hopelessness about the future (a sense that the current situation cannot be changed and is intolerable), leading in turn to:
    - impaired decision-making
    - a narrow focus on the present difficulties
    - a downward spiral which further promotes suicidal intent
    - a focus on suicide as the only option, which in turn reinforces a sense of hopelessness
    - a downward spiral which further promotes suicidal intent
- An ability to draw on knowledge that suicidal behaviour emerges from an interaction between thoughts about suicide and factors that make it more likely that a person will act on their suicidal thoughts, in particular:
  - a sense of being trapped by problems
  - the absence of positive expectations for the future
  - a sense of loneliness and of being denied a caring relationship
  - experiencing oneself as a burden on all significant others, combined with a sense of hopelessness that this is an unchanging state of affairs, made worse by factors such as:
    - difficult childhood experiences, family conflict, unemployment or physical illness
    - feelings of self-hatred, low self-esteem, self-blame and shame
  - factors that make suicide seem more of a possibility, such as:
    - a history of impulsive and aggressive behaviour
    - having access to the means for suicide and plans for acting
    - imagining oneself as dying or dead
    - judging that the pain involved in the chosen method of suicide is tolerable
    - a diminished fear of pain and death as a consequence of previous self-harm and suicide attempts

An ability to draw on knowledge of the link between ‘emotional dysregulation’ and suicide, which is a state of mind characterised by:
experiencing intense unbearable negative emotions
a history of responding impulsively to negative emotions (because it is hard for a person to develop more constructive strategies to manage feelings)
hopelessness about being able to effect a change in circumstances
a perception that relief will only come though self-injury or suicide

Knowledge of pharmacological interventions

Knowledge of psychopharmacology

An ability to draw on knowledge on the use of pharmacological interventions for coexisting mental health problems in people who self-harm and/or are suicidal
An ability to draw on knowledge that there is no clear evidence for the benefit of pharmacological interventions specifically for self-harm and suicidal behaviour in the absence of a coexisting mental health problem
An ability to identify individuals with sufficient knowledge of psychopharmacology to whom to refer when necessary (usually a psychiatrist or other medical practitioner)
An ability to direct a person to a GP, psychiatrist, other medical practitioner when there are concerns that relate to psychotropic medication(s) that are currently being prescribed
An ability to draw on knowledge that all medications have benefits and risks