Basic knowledge of mental health presentations in children and young people

Basic 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 use (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 mental health problems can disrupt a child's or young 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 the person is not receiving treatment)
An ability to draw on basic knowledge of the symptoms and difficulties in functioning that characterise common mental health problems
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 learning disabilities experience limitations 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 receive 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, often offered in combination

Knowledge of development and developmental transitions in children and young people, and relevance to self-harm and suicide

All young people face the developmental task of moving from childhood to adolescence, and from adolescence to adulthood, a trajectory that is difficult to predict by age. Assuming adult roles and responsibilities will inevitably involve successes and failures, with implications for a young person's wellbeing, mental health and vulnerability to self-harm and suicide.

Although there is no specific set of associations that link self-harm and suicide to development and developmental transitions, it is helpful to hold in mind the developmental 'pathways' that a child or young person who has self-harmed or is suicidal has experienced in the past and is managing currently.

Knowledge of child and adolescent development

- An ability to draw on knowledge of the needs of children and young people in relation to their physical, social, cognitive and emotional development (e.g. the need for attachment relationships, education, appropriate patterns of diet, sleep and exercise)
- An ability to draw on knowledge of normal child and adolescent development and its impact on behaviour, for example:
  - knowledge of theories of child and adolescent development including:
    - physical development; sensory and psychomotor development
    - cognitive development (intelligence, language and symbolisation, the Piagetian model, mentalisation, awareness of self and others)
    - social and emotional development (emotional intelligence, interpersonal competence, identity and moral development at adolescence, compassion and self-management, the impact of the social context)
  - knowledge of age-appropriate and problematic behaviours
  - knowledge of developmental stages, including physical, affective and interpersonal, cognitive, language and social milestones
  - knowledge of the interaction between different aspects of a child's or young person's development and between individual and contextual factors (such as people and life circumstances)
- An ability to draw on knowledge of neurodevelopmental conditions and their impact on cognitive development
- An ability to draw on knowledge of brain development in adolescence and its impact on impulse control and risk taking

Knowledge of the care environment and its interaction with child and adolescent development

Attachment

An ability to draw on knowledge of the importance of the bond that children develop with their parents or carers in early life, and the impact of a problematic relationship on:
child and adolescent development
the development of parent-child, sibling and peer relationships
the development of emotional wellbeing, self-regulation, mental health and mental health problems
the development of resilience (i.e. the ability to cope with stressful and adverse experiences, including difficult interpersonal experiences)

Influence of parents or carers

An ability to draw on knowledge of the impact of the prenatal and perinatal environment on infant and child development
An ability to draw on knowledge of parenting styles
An ability to draw on knowledge that a parent's or carer's communication, interaction and stimulation of their child influences the child's development, attainment and mental health
An ability to draw on knowledge that effective forms of parent/carer engagement change as children and young people develop
An ability to draw on knowledge that the balance of influence from parents, peers, authority figures and others alters as children and young people develop
An ability to draw on knowledge of factors that make it harder for parents and carers to offer consistent or positive parenting (e.g. emotional and cognitive immaturity, mental health problems, particularly substance misuse, neurodevelopmental conditions, loss, abuse, social adversity or negative experience of parenting in their own lives)
An ability to draw on knowledge of the positive effects of parent or carer support on:
attachment relationships
child and adolescent development

Family development

An ability to draw on knowledge that a child or young person and their parents or carers need to be viewed in a number of different contexts including:
their family and other significant relationships
their social and community setting
the professional network(s) involved with them
their cultural setting
the socio-political environment
An ability to draw on knowledge of different family structures and compositions
An ability to draw on knowledge of the family lifecycle and the ways this varies across social contexts and cultures, so as to understand the developmental tasks encountered by specific families
An ability to draw on knowledge of the potential impact on families of social adversity (loss, abuse, social change, socio-economic disadvantage, health inequality)

Developmental transitions

An ability to draw on knowledge that children and young people will inevitably experience a number of significant developmental transitions (from childhood to adolescence), such as:	
	brain development and cognitive maturation
	pubertal maturation
	changes in their perceptions of themselves and their sense of identity
	changes in the salience of peer relationships as the young person attempts to separate and individuate from parents or carers
	the development of gender identity and sexuality
	the development of sexual relationships
	changes in educational environments (such as changing schools or entering college)
	changes in family structure (e.g. births, deaths, marital separation leading to the formation of new parental relationships)
An ability to draw on knowledge that children and young people may find some transitions particularly challenging to negotiate, depending on their prior experiences and their psychological and physical development	

Knowledge of self-harm and suicide

Terminology

An ability to draw on knowledge of definitions of self-harm and self-harm:
‘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 the person intended to die, and believed that the means and method of the attempt would be fatal
‘suicidal ideation’ refers to the 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

Self-harm in children and young people

An ability to draw on knowledge that suicide is the leading cause of death in 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 children and young people who die by suicide have a history of self-harm
An ability to draw on knowledge that:
presentations of self-harm become increasingly common from 12 years onwards
around 10% of young people report having self-harmed
presentation to hospital only occurs in one in eight young people who self-harm in the community (and is more common in those who take overdoses)
although self-harm is more common in female than in male young people (between 12 and 15 years the ratio of females to males is around five to one) this decreases in later adolescence as self-harm becomes more common in males and levels off in females
self-harm rates are higher in young people from lower socioeconomic groups
rates of self-harm in children and young people appear to be increasing
An ability to draw on knowledge that methods of self-injury in children and young people are varied, including self-cutting, jumping from heights and self-battery
An ability to draw on knowledge that while self-cutting is the most common method of self-harm in the community, self-poisoning is the most common presentation in a hospital context
An ability to draw on knowledge that repetition of self-harm is common in younger people, is more likely with self-cutting than with self-poisoning, and that depression, history of sexual abuse, exposure to self-harm, and concerns about sexual orientation are among the predictors of repetition
An ability to draw on knowledge that people who self-harm are 50 times more likely than the general population to attempt suicide, though it is still the case that only a minority will do so (making a history of self-harm a poor predictor of suicide in and of itself)

Knowledge of mental health problems, self-harm and suicide

- An ability to draw on knowledge that self-harm and suicide are expressions of overwhelming and intense psychological distress
  - acts of self-harm and suicide are often (but not always) associated with mental health problems
- 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 such problems never attempt suicidal (and so in itself mental health is a poor predictor of suicide)

Vulnerability

- An ability to draw on knowledge of populations with higher self-harm or suicide rates than the general population, such as:
  - children and young people looked after in the care system
  - children and young people who are carers
  - children and young people who identify as LGBTQ+
  - children and young people with learning disabilities and neurodevelopmental conditions (such as autism spectrum disorder)
  - children and young people from some (but not all) ethnic minority backgrounds (e.g. Indian and East African females)
  - refugees and asylum seekers
  - children and young people in contact with the criminal justice system
  - children and young people from the traveller community
- An ability to draw on knowledge of social factors that are associated with greater rates of self-harm and suicide, such as:
  - social isolation
  - economic problems
  - homelessness and/or insecure or inadequate housing
- An ability to draw on knowledge of factors that could increase or decrease a child's or young person's risk of self-harm and suicide, such as:
  - factors that 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 trauma or abuse
    - experience of childhood abuse and/or maltreatment (including domestic violence)
    - long-term physical health problems
    - 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

- relocations that disrupt the child's or young person's social networks
- factors that may decrease risk:
  - access to social and cultural support
  - support from families, carers and friends
  - engagement with a healthcare practitioner and/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 child's or young person's self-harm or suicidal behaviour on the emotional wellbeing and mental health of parents, carers, siblings, wider family and friends
- An ability to draw on knowledge that some children and young 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 child or young person's social network particularly:
    - within their personal or social media network
    - among peers at school or college
    - where they identify with the person who has died by suicide
  - new methods of suicide are publicised
  - there is a death of a celebrity by suicide
- An ability to draw on knowledge that when a death takes place among children and young people in educational settings (such as schools or universities) some of the deceased's peers 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 with the aim of managing distress after a death by suicide and identifying people who may be at increased risk)

Understanding self-harm and suicidal ideation and behaviour

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

For clarity, models of self-harm and suicide are described separately, but it is important to hold in mind that there are both continuities and discontinuities between these areas, and that in some people there will be close links between them.

Interventions to help people, including children and young 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.

Frameworks for 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 it can be hard to ascribe motivation, and that this can change within and across acts	
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 the 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 engage in self-harm may experience:	
	higher levels of negative affect in general (e.g. depression, anxiety, hostility, anger, negative self-esteem) than their peers who do not self-harm
	emotions more strongly than their peers who do not self-harm and be less comfortable expressing their emotions to others verbally
An ability to draw on knowledge that self-harm is thought to develop through the interaction of both long-term (predisposing) factors and more immediate factors	
An ability to draw on knowledge of factors that may predispose people to self-harm, such as:	
	a genetic predisposition for strong emotional reactivity
	high levels of familial criticism and hostility
	experiencing abuse and/or maltreatment during childhood
	intrapersonal and interpersonal risk factors, such as acute relationship crises and loss
	high aversive emotions
	difficulty tolerating high levels of distress
	discomfort with strong feelings
	difficulty expressing feelings verbally
An ability to draw on interpersonal risk factors for self-harm:	
	poor communication skills
	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
- regulating affect
- 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 of the ways that self-harm can function to help manage intense cognitions, for example, as a way of:

- controlling racing thoughts
- suppressing unwelcome thoughts

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

Frameworks for understanding suicide

An ability to draw on an awareness of models that identify factors associated with the emergence of suicidal ideation and intent

- an ability to draw on knowledge that because these models draw attention to factors which are *generally* relevant they should not be used as indicators of risk in any one person (because of the challenge of predicting self-harm and suicide)
- an ability to draw on knowledge that these are not competing models, but are best seen as complementary and overlapping, with each focusing on different aspects of a person's experience

An ability to draw on knowledge of models that help understand the factors that lead a person to move from a 'motivational' phase (in which suicidal ideation develops) to a 'volitional' phase (in which a decision to act on this ideation is made)

An ability to draw on knowledge of psychological models that emphasise the role of overwhelming thoughts and feelings of hopelessness about oneself, the future and one's capacity to change one's circumstances for the better, a state of mind that has a number of potential determinants:

- long-standing 'dispositional' factors that become more problematic in the presence of stress, such as:
  - a sense that others set a high standard for the self, and that fulfilling these standards is a condition for being accepted by others
  - a restricted ability to apply problem-solving strategies that might ameliorate difficulties
  - a tendency to employ unhelpful ways of thinking (such as overgeneralisation, jumping to conclusions or 'all-or-nothing' thinking) that in turn exacerbates distress

- impulsivity, particularly when combined with a tendency to respond to difficulties with aggression
- processes associated with mental health problems
  - long-standing and unhelpful ways of making sense of the world that become activated when trying to manage challenges, and which:
    - tend to shape unhelpful ways of thinking
    - increase the salience (and presence) of negative thoughts
- processes associated with suicidal acts in which a person intends to die
  - entrapment combined with 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:
    - 'cognitive disengagement' in which 'rational' decision making is impaired by extreme distress, restlessness, racing thoughts and agitation
    - 'attentional narrowing' – a narrow focus on the present that precludes 'rational' thought and problem solving
    - 'attentional fixation' in which suicide appears to be the only option, which in turn reinforces a sense of hopelessness
    - a downward spiral in which hopelessness and attentional fixation interact, and which further promotes suicidal intent

An ability to draw on knowledge of 'psychological' models in which suicidal behaviour emerges from an interaction between suicidal ideation and circumstances that increase the likelihood that a person will act on their suicidal thoughts, in particular:

- a sense of defeat, humiliation and/or entrapment
- the absence of attainable positive expectations for the future, combined with low levels of resilience
- a sense that a need for connectedness has not been met, and so the possibility of social belonging has been 'thwarted' (characterised by feelings of loneliness and the absence of a reciprocal caring relationship)
- experiencing oneself as a burden on others, together with a sense of hopelessness that this is an unchanging state of affairs, made worse by factors such as:
  - adverse childhood experiences, family conflict, unemployment or physical illness
  - an affective state of self-hate, characterised by low self-esteem, self-blame and shame, and a mental state of agitation
- an acquired capability for suicide in combination with factors that increase the likelihood of a person moving from the motivational to the volitional phase, such as:
  - a history of impulsive and aggressive behaviour
  - having access to the means for suicide and plans for acting
  - a lowered fear of death
  - imagining oneself as dying or dead
  - elevated physical pain tolerance
  - cognitive appraisal that the pain involved in the chosen method of suicide is tolerable
  - a diminished fear of pain and death acquired through habituation to painful and fear-inducing life events, such as:
    - previous self-harm and suicide attempts (both attempted and aborted)
    - practising or preparing for suicidal behaviour

An ability to draw on knowledge of models that emphasise the centrality of emotional dysregulation, a state of mind characterised by		
	affective vulnerability, exemplified by:	
		emotional reactivity
		emotional lability
		experiencing intense unbearable negative emotions
	a history of responding impulsively in response to acute negative affective states	
	difficulty in tolerating and regulating emotions (and difficulty experiencing the emotions themselves)	
	difficulty accessing appropriate self-regulatory strategies	
	the experience of hopelessness about being able to effect a change in circumstances	
	a perception that relief will only come though self-harm and suicide	

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 there is an inverse relationship between occupational social class and risk 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:
males are more vulnerable than females to the adverse effects of economic recession, including suicide risk
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
a low level of educational attainment increases suicide risk
people experiencing socioeconomic disadvantage and adverse experiences (such as 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/ negative life events, such as:
adversity
poor mental health
relationship breakdown
social isolation
experience of stigma
emotional distress
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 from the traveller community
looked-after children and young people
people who have been/are in the criminal justice system
people who have been trafficked
refugees and asylum seekers
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