Basic knowledge of mental health presentations

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 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 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 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

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 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 years
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:
5% of the population report attempting suicide
9% of the population experience suicidal ideation
3% of the population make plans to end their lives
5% of the population make non-lethal suicide attempts
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)
An ability to draw on knowledge that suicide is the leading cause of death in younger people (partly reflecting the fact that other causes of death, such as serious illness, is less common in this age-groups)
An ability to draw on knowledge that over half of younger people who die by suicide have a history of self-harm
An ability to draw on knowledge that rates of self-harm in younger 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 problems, 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 such 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 with higher self-harm or suicide rates than the general population, such as:
  - certain groups depending on their gender
    - men in mid-life and older men (who are at greater risk of completed suicide)
    - divorced men and single men and women
    - younger women (who are at greater risk of non-suicidal self-harm, but not suicide)
    - men in the construction industry
  - young people looked after in the care system
  - both men and women aged between 35 and 54
  - 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 of abuse
  - people from some (but not all) ethnic minority backgrounds (e.g. such as Indian and East African females)
  - refugees and asylum seekers
  - occupational groups with greater access to means of suicide
  - people within 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 associated with greater rates of self-harm and/or 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 person's risk of self-harm or 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 loss
    - access to potentially lethal means of harm
    - bereavement by suicide
    - experience of current or past abuse and/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 and cultural support
    - support from family, carers, significant others 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 person's self-harm or suicidal behaviour on the emotional wellbeing and mental health of their family, carers, significant others and wider family 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:
    - among peers, in the context of educational settings such as schools or universities (and where there can be a risk of 'suicide clusters')
    - within their personal or social media network
    - where they identify with the person who has died
  - 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 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 our 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 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, 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 or 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 suicide and self-harm
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 combination of low level of educational attainment and no home ownership increases a person's risk of suicide
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
difficulties accessing welfare benefits or other financial support
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
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