Cross-cultural attitudes to help-seeking amongst suicidal persons: a new perspective for policy-makers

Alexandra Pitman and David P.J. Osborn

Summary:

World Mental Health Survey data demonstrate that a high proportion of suicidal persons receive no treatment and that, contrary to previous assumptions, attitudes to treatment constitute greater barriers to help-seeking than do stigma or structural/financial constraints. We explore how suicide prevention policy-makers might respond to Bruffaerts et al's findings.

Author information:

Alexandra Pitman is an MRC Research Fellow in the Department of Mental Health Sciences, University College London, where she is investigating the impact of suicide bereavement. David Osborn, is a Senior Lecturer in community psychiatry and psychiatric epidemiology in the Department of Mental Health Sciences, University College London, and is an honorary consultant psychiatrist

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Introduction

Analysis of World Mental Health Survey data by Bruffaerts et al in this issue describes healthcare use by suicidal individuals in 21 countries. Only 39% of suicidal respondents had sought treatment of any type in the past year. This low rate ranged from 17% in low- to 56% in high-income countries, and is alarming given the association between self-harm and completed suicide (1). Yet the leading reason for not seeking help was not stigma or structural/financial constraints, but low perceived need, with 58% of those respondents endorsing the statement *The problem went away by itself, and I did not really need help*. The second most common barrier (ranked first in high-income countries) was respondents' attitudes; identified as the

low perceived efficacy of treatments, the desire to handle the problem alone, and (in only 7%) stigma. Structural barriers, for example lack of access to treatment, ranked third overall.

These findings develop our understanding of help-seeking in suicidal crises, challenging the conventional wisdom that stigma and structural/financial constraints are the major barriers to accessing mental healthcare. Although the household residents sampled probably under-represents those with more intense suicidality, the majority who had felt suicidal did not believe that services offered tangible benefits. If such attitudes constitute a genuine obstacle to the delivery of suicide prevention interventions, each nation must rethink its suicide strategy. Rather than pushing evidence-based interventions blindly, we must determine what suicidal individuals would find helpful and therefore seek out.

Perceptions of the need for care amongst suicidal persons

The authors warn that low perceived need for care, as well as attitudinal barriers, cause delays in treatment and the risk of clinical deterioration. However delays in accessing healthcare only increase the risk of progressive suicidality if effective treatments are available. We should challenge three key assumptions in suicide prevention: a) that demand is the same as clinically-determined need, b) that healthcare services provide the most appropriate setting for managing medically-determined need (2), and c) that available interventions are effective for all clinical sub-groups. There are many possible reasons for low perceived need, including an individual's strong sense of self-efficacy and a containing social network. Indeed self-care and informal care manage a key proportion of healthcare need in all societies. Yet given the high personal, societal and political cost of completed suicide, policymakers and practitioners are certain to feel uneasy about the extent of care being provided outside mainstream auditable services.

Low perceived need is alarming when it arises from past contact with uncaring practitioners, experiencing ineffective interventions, or perceptions of services being ineffective. Systematic reviews indicate that people who self-harm report negative experiences when using clinical services, including stigmatising attitudes (3).

Evaluations of interventions to reduce the repetition of self-harm have developed minimally a decade on from the initial Cochrane review (4). Generalisability of interventions is questionable, with most studies confined to secondary care, specific clinical sub-groups (5), and high-income countries (6). Looking beyond the dominance of western healthcare models many of these interventions would be impossible to implement on any large scale in low- and middle-income (LAMI) countries (7), and consequently are not supplied.

Figure 1 here – see below

Bruffaerts et al feel they have identified a high level of unmet need (with negative connotations ascribed to attitudinal barriers), however the relationship between need, supply and demand represented in Figure 1 suggests an alternative interpretation: a low level of demand for formal healthcare (with positive connotations of self-efficacy). Patient satisfaction exerts a powerful force where consumers use their right to exit the mainstream healthcare market in favour of competing services (8), and is increasingly evaluated as part of service planning. What we learn about patient choice in this survey is that self-help, primary care and alternative practitioners are key competitors to secondary care, the very setting in which the evidence base is most developed. This is particularly marked in LAMI countries where, for reasons of cost, cultural-appropriateness, and feasibility, evaluations of informal care and alternative practitioners have yet to be conducted. Given that absence of evidence is not evidence of absence, and that many consumers express a preference for managing suicidal crises outside healthcare settings, we need to understand the nature of help which suicidal people value. If mainstream services for people with suicidal behaviour are not attractive to their target market, resources may need to be shifted into other settings.

Suicide prevention is a public health priority for the World Health Organisation, which recommends improving access to health and social services. For most disease areas health policies will fail if the target population do not utilise designated services. However there are three reasons why suicide requires a different approach to other public health problems. Firstly, as the responses to this survey suggest, notions of clinical need may differ in the case of suicidality. Secondly suicidality is not a distinct

diagnosis but a behaviour with diverse underlying aetiologies, and one blanket intervention is unlikely to be effective for all (5). This lies in contrast to strong evidence of effectiveness in treating specific mental health diagnoses (6). Thirdly, the evidence base for suicide prevention programs remains poor, apart from restricting access to lethal methods and training primary care physicians to evaluate suicide risk (9). Policymakers must decide whether to use marketing principles (and scarce resources) to attract suicidal people into existing services, or invest in culturally-appropriate interventions in more acceptable settings. Bruffaerts al's findings suggest the latter may be a more promising way of meeting suicide prevention targets, especially in a global context.

Taking a country-by-country approach

Cross-cultural variations in suicidal behaviour are not well-understood, particularly given the under-resourcing of suicide research in LAMI countries (10). As Bruffaerts et al discuss, cultural factors are involved throughout the help-seeking pathway. The studies they cite describe the impact of stigma and cultural distrust on service utilisation for suicidal persons within different ethnic groups, suggesting there might be some overlap in the barriers to treatment their survey defines. The majority of this literature relates to ethnic minorities in higher-income countries, with questionable applicability to communities in LAMI countries. Nevertheless their data clearly show that stigma associated with suicidal behaviour is a disincentive to seeking care in all countries surveyed, adding to the evidence for stigma associated with mental disorders (11). The myriad cultural differences within and between nations suggest that instead of a global 'one size fits all' solution to suicidal behaviour, a very different policy approach would need to be taken within each country.

The first step is to expand the quantitative and qualitative evidence base on the views of consumers, particularly in LAMI countries. This would determine cultural influences on help-seeking preferences, and the value consumers place on primary care, traditional healers and the informal sector. Bruffaerts et al highlight primary care and non-mental healthcare providers as key entry points for suicidal people, but they are also care delivery points (9). The current Western focus on secondary care interventions (4) should shift towards gatekeeper training programs for primary care

practitioners, religious leaders, and traditional healers (12). Consumer surveys would yield suggestions for acceptable care which could then be evaluated. Settings might include schools for provision of psycho-education, primary care or community centres for delivering a range of psychotherapeutic approaches, and the home for use of manualised self-help packages.
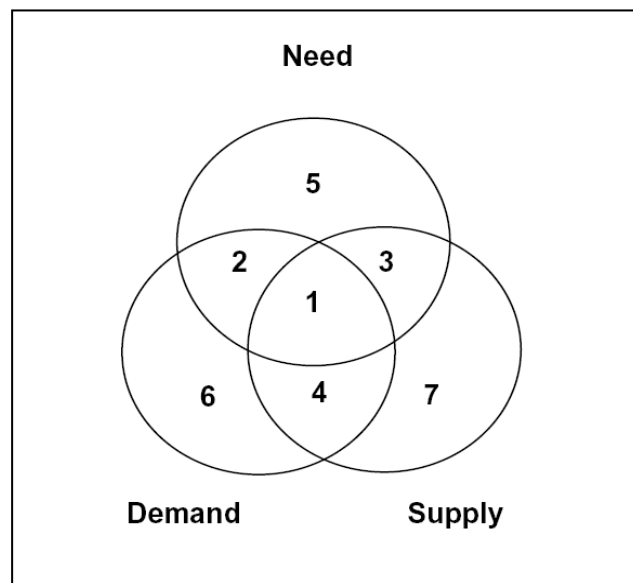
Using cost-effectiveness data on a specified range of acceptable interventions each country should then identify its national strategy. This set of interventions would cater for each key sub-culture and clinical sub-group, and include services outside mainstream healthcare. Substantial resource and feasibility implications are obviously involved in establishing individualised national suicide policy based on evidence of acceptability and effectiveness. This may require the use of innovative research designs, wider outcome measures (5;12), and international research collaborations.

Conclusions

This international survey of suicidal people suggests that policy-makers need to address an apparent rejection of mainstream services. Yet without knowing which interventions actually work, or how cultural values and differences influence acceptability in different settings, adhering to traditional specialist mental health models may prove unsuccessful. Cultural competence is as important at the macro-level (research design and policymaking) as at the micro-level (individual patient-practitioner interactions). Future research should deliver an international evidence base on the preferences of suicidal persons, and evaluate tailored interventions for each clinical sub-group in a range of settings. Policy-makers will then have a more realistic chance of matching supply to need and demand in the marketing of suicide prevention services.

Figure 1: Venn diagram showing how need, demand and supply overlap in relation to suicide prevention interventions

(adapted from Stevens, Andrew & Raferty, James Eds. Health care needs assessment: The epidemiologically based needs assessment reviews. Oxford: Radcliffe Medical Press. 2nd Edition, 1997).

Examples of interventions in each section:

1. provision of evidence-based and culturally-acceptable interventions to reduce suicide risk
2. service gaps for provision of evidence-based and culturally-acceptable interventions to reduce suicide risk
3. suicide means restriction policies; media blackouts on reporting suicides
4. psychosocial interventions which increase risk by reinforcing self-harming behaviour
5. evidence-based but culturally-unacceptable interventions for suicidal persons; evidence-based interventions for suicidal persons who prefer to handle the problem alone
6. internet-acquired benzodiazepines to palliate suicidal distress
7. non-utilisation of ineffective psychosocial interventions

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