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Developing interventions for prevention of self-harm for British South Asian women: A qualitative study

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Introduction It has been estimated that the global burden of suicide is a million deaths per year (WHO, 2014). Rates of self-harm in British South Asian (BSA) women are higher compared to their white counterparts. Limited evidence is available on effective preventative strategies and culturally sensitive interventions for these patients.
Objective To understand common perceptions about self-harm, identify any barriers to accessing services and service improvement recommendations including appropriate interventions for BSA women.
Aim To examine the views of health professionals on the culturally adapted problem solving therapy (C-MAP) in BSA women.
Methods The design was a qualitative study using focus group discussion. This is part of a larger exploratory trial, to test a culturally adapted problem solving therapy (C-MAP) in British South Asian women who have a history of self-harm (Husain et al., 2011). Three focus groups were held with Asian lay members of the community, health professionals and service users. The data was analysed using a manual content analysis and indexing technique.
Results Results showed lack of identification of self-harm by health professionals. Common self-harm methods reported were serious overdoses, use of household chemicals, burning and cutting. Lack of trust in GP s was one common reason for non-disclosure of self-harm behaviour. Need for increased awareness, working along with local Imams, better cultural sensitivity among health professionals and non-judgmental support were some solutions offered to address these barriers.
Conclusion The results of this study have provided insight into developing strategies to prevent and manage self-harm in British South Asian women.
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Suicide risk assessment and early recognition of risk factors

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Suicide is a common cause of death in people with mental health problems. No specific patient stereotype nor single risk factor can be used to easily identify which person or patient will attempt suicide. Mental health professionals often have to assess or manage suicide risk and this is challenging by reason of accurate methods of predicting remain elusive. Presence of multiple risk factors often suggest the need for additional evaluation for suicidal ideation, but an impending suicide attempt is not always recognized, even after evaluation by healthcare provider. More half of suicidals have seen a psychiatrist or psychologist or other healthcare provider within one month beforehand. The presentation of possible warning signs can be subtle and experience is required. Service provision for suicidal patients is often substandard, particularly at times of highest need such as after discharge from hospital or emergency department. As many as 75% or more of people who die by suicide have a diagnosable mental health disorder at the time of their death. The most common are bipolar disorder and schizophrenia over major depression. Between 25% and 50% of bipolar patients will attempt suicide at least once, and 5% to 20% will die by suicide. In schizophrenia diagnosis, 20% to 40% of patients will attempt suicide and more than 10% will die by suicide. Additional risk factors: alcohol misuse, family history, illegal substance use. The way in which suicide is broached and discussed with patient plays a significant role. Here, a focus on clinical management of suicide risk.
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Who are the suicide reattempters?

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Background History of previous suicide attempts is one of the most important risk factors for a subsequent completed suicide. Suicide reattempters (SR) has been long associated with demographic and clinical risk factors for suicide, such as unemployment and psychiatric disorders, however a recent review of the literature has not supported a specific age and gender profile of SR, but rather underscored that, as far as diagnosis is concerned, SR were more likely to have a personality disorder. According to literature, 16%–34% of the subjects repeat a suicide attempt within the first 2 years after the previous one.
Aim The purpose of our study was evaluating clinical and socio-demographic characteristics and the outcome of psychiatric consultation among subjects referring to an emergency room for recommitting a suicide attempt.
Methods We considered a sample of SR aged > 16 years. We extracted data from the database including all patients requiring psychiatric evaluation in the emergency room, and eventually compared the features of SR and patients with a single suicide attempt. For each patient, we gathered socio-demographic features, psychiatric history and current clinical issues, suicidal intent and suicidal behaviors.
Results Data collection and statistical analyses are still ongoing. Preliminary results show that, compared to patients with a single suicide attempt, SR were more frequent female, unmarried, employed, with a low level of instruction; they had a psychiatric disease (axis I – anxiety disorder, somatoform disorder; axis II – histrionic personality disorder); they are under the care of mental health services and under psychopharmacological treatment.
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