Ethnicity and suicide

Introduction

This paper explores suicide among minoritised ethnic groups in England. It gives an overview of existing evidence around unequal rates of suicide between ethnic groups, key themes from research, the current policy context, and recommendations.

What is the evidence about prevalence of suicide across ethnic groups?

Ethnicity is one of many different lenses that reveal inequalities in suicide and suicide prevention. However, evidence about suicide rates across ethnic groups is hampered by issues in the collection, recording, and presentation of data. These limitations include the categorisation of groups, with diverse groups often merged into homogenous categories such as 'BAME', inconsistent approaches to merging groups, or omission of ethnicity data. Moreover, evidence suggests that suicides among some minoritised ethnicity groups may be underreported, partly due to stigma and issues in recording of deaths.[1] Research also suggests that misclassification of ethnicity can occur when based on an observer's (such as a coroner) classification, rather than self-reporting.[2]

In 2021, the Office for National Statistics (ONS) published data on suicide in different ethnic groups in England and Wales for the first time.[3] These figures provide insights on the rates of suicide across ethnic groups between 2012 and 2019. They show that suicide rates vary between ethnic groups, with the highest rates among the White and Mixed ethnicity groups.[4] Importantly, these data also show a more complex picture when considering other characteristics alongside ethnicity, with disparities in suicide rates between ethnic groups varying depending on an individual's sex. Among males, rates of suicide among the White (14.9 per 100,000) and Mixed ethnicity (14.7 per 100,000) groups were similar. Among females, suicide rates in this period were consistently higher among the Mixed ethnicity group than others (7.1 per 100,000). However, these data rely on linkage to GP registers, meaning people who were not registered with a GP are not included. Moreover, as this analysis relied on linkage to the 2011 Census, anyone who migrated to England and Wales after 2011 is also not included, and this is a group in which minoritised ethnicities are overrepresented.[5]

These findings echo other research which suggests that rates of suicide differ between ethnic groups. For example, research exploring deaths by suicide within twelve months of

contact with mental health services found that the highest rate of suicide was among White patients.[6] There were differences between the four other ethnic groups included in the study, with higher rates in Black Caribbean patients and the lowest rates in Chinese patients. These findings again highlight the impact of considering other factors alongside ethnicity; when considering ethnicity, sex, and age together, these data reveal new trends. For example, the researchers found that male Black African patients younger than 25 years old were more likely to die by suicide than any other ethnic group except White. The available evidence therefore suggests that suicide rates between and among ethnic groups can only be fully understood when considering a range of intersecting factors together.

Racism and ethnic discrimination as risk factors for suicide

Experiences of racial or ethnic discrimination can refer to both major, acute experiences of unfair treatment, such as harassment or bullying, and chronic daily injustices. There is international evidence that experiences of racism and ethnic discrimination contribute to suicidality, and their impact on mental health is well-established.[7] [8]

Evidence is also growing of an indirect relationship between racism and suicide, with experiences of discrimination associated with known risk factors for suicide, such as depression, harmful substance use, and unemployment.[9] [10] [11] [12] Racism can have intergenerational effects, with associated trauma also affecting children.[13] The relationship between discrimination, mental health and suicide may be exacerbated for people with multiple minoritised identities. For example, LGBTQ+ people in minoritised ethnic groups may experience a kind of double disadvantage, being subject to discrimination related to their sexuality or gender identity, and ethnicity.[14] [15] [16]

The way in which these experiences may influence suicidality is not currently well-understood. The Integrated Motivational-Volitional Model of suicide suggests that a sense of burdensomeness and thwarted belongingness are associated with suicide, via a feeling of entrapment.[17] Research has found limited evidence confirming this association to date, and the limitations of applying models of suicidal behaviour or risk across different cultural contexts and ethnic groups are discussed below.[18] However, a sense of belonging can help us to manage stress and trauma, and may act as a protective factor against suicide.[19] It is hypothesised therefore that disruption to this sense, such as the 'othering'[20] experience of discrimination, may contribute to suicidality.[21] Conversely, self-defined ethnic and racial identities can also be a way for people to organise and assert themselves, offering social support and belonging.[22] It has been suggested that these factors may provide a source of resilience or identity which could be a protective factor.[23]

Accessing treatment and support for people in minoritised ethnic groups

There are inequalities in access to services involved in suicide prevention between ethnic groups, affecting individuals' ability to get support for suicidal thoughts and feelings and their wider mental health. However, these inequalities do not exist uniformly – different studies suggest people from minoritised ethnic groups are more, less, or equally as likely to access various services.[24] For example, people in Black British, Black Caribbean, Black African and Black Other groups are more likely to use specialist mental health services than the White British group, while Chinese, Indian, and Mixed White & Asian ethnic groups are least likely.[25] The overrepresentation of some groups within secondary care mental health services may be due to poorer accessibility and outcomes in primary care, which lead to people's mental health deteriorating before they are able to get support.[26]

These variations may be partly explained by mistrust of services as well as a fear of being discriminated against, sometimes based on previous negative experiences of support.[27] Research around suicidality amongst South Asian women found that a fear of experiencing racism, cultural misunderstanding, and oversimplified views of their problems all acted as deterrents to seeking help.[28] For non-English speakers in minoritised ethnic groups, language barriers or reluctance and difficulty in communicating distress via an interpreter may compound these difficulties.[29] Some people may worry that support involving an interpreter would involve other organisations in their family life or lead to breaches of confidentiality.[30]

Stigma around suicide has been suggested as another contributor to inequalities in access. This may involve stigma about mental health conditions which are risk factors for suicide; limited awareness of relevant support services; cultural norms, including those associated with gender; or conceptions of shame and honour.[31] [32] A study of experiences of bereavement by suicide found that experiences of stigma were more common among minoritised ethnic groups and people felt this stigma affected their ability to get support.[33] Stigma around suicide has been posited as one explanation for the fact that deaths among minoritised ethnicity individuals are less likely to be recorded as suicide.[34]

Receiving treatment and support for people in minoritised ethnic groups

People in some minoritised ethnic groups experience unequal treatment from services involved in suicide prevention. For example, records of mental health patients who died by suicide shows minoritised ethnicity patients were less likely to have been receiving care

from crisis resolution home treatment teams, more likely to have shorter inpatient admission periods, and more likely to have a Community Treatment Order (CTO) upon being discharged.[35] [36] Some people in minoritised ethnic groups are more likely to experience more coercive forms of treatment; Black patients specifically are much more likely to be detained under the Mental Health Act.[37] Young people from minoritised ethnicity backgrounds have also been found to be less likely to receive specialist psychosocial assessment following self-harm, compared to White young people.[38]

Evidence suggests that minoritised ethnicity patients who died by suicide were generally seen by practitioners to be at lower risk of suicide compared to White patients before they died.[39] Their records were less likely to show previous self-harm and depressive illness, but more likely to show markers of social adversity, such as economic deprivation or unemployment. These findings build on previous research which suggested minoritised ethnicity patients that died by suicide were less likely to have had suicidal ideation or depressive symptoms noted in health records.[40]

A wide range of organisations are involved in suicide prevention, so these issues extend beyond considerations of healthcare systems or suicide prevention researchers. For example, the police often act as first responders following a suicide or suicide attempt. A study with people from minoritised ethnicity backgrounds who have been bereaved by suicide found the police were often reported as providing insufficient support, and that this contributed to some people's sense of isolation and abandonment following a death by suicide.[41]

Some of these inequalities are caused by institutional racism in suicide prevention, defined in this context as 'processes, attitudes and behaviour(s) which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people'.[42] For example, this evidence suggests that suicidality may be expressed or developed in different ways in different cultural contexts and across ethnic groups, and that clinicians' approaches may not always capture this diversity or recognise expressions of mental distress from people with different cultural backgrounds to them.[43] It may also suggest that existing models of suicidal behaviour and risk assessment are biased towards White groups, resulting in worse aptitude for recognising suicidal behaviour among minoritised ethnicity individuals.

Samaritans' work on suicide among minoritised ethnic groups

The work of the whole of Samaritans is underpinned by our commitment to equity, diversity, and inclusion (EDI). We are committed to breaking down barriers to make Samaritans more diverse and inclusive, both through our people, but also in who we connect with and support, making sure that we are responding to people's needs in a way

that is relevant and meaningful to them and their circumstances. There is more information about our commitment, including our five key EDI goals, on our website.

In 2020, Samaritans carried out research with people who had used our helpline to understand their experiences and find out what difference calling had made to them. We found that, compared to all other callers, callers from minoritised ethnicity backgrounds were more likely to be younger, more likely to raise certain concerns such as physical health issues, and more likely to have had a better experience than they were expecting. Importantly, these callers were less likely to have sought help from other organisations. This highlights the importance of the helpline as sometimes the only source of support people use, and raises questions around information, accessibility, and barriers for support services.[44]

In 2022, Samaritans published a new five-year strategy, *Tackling suicide together*. A core priority of this strategy is 'Reach', and we have laid out an ambition to be more visible and relevant, particularly to a more diverse range of people and communities. This includes assessing the needs of specific communities and taking action to reach a more diverse range of people who could benefit from Samaritans' support. Another priority of our strategy is 'Access', which includes a commitment to undertake targeted recruitment campaigns to attract a more diverse range of people so that our branches reflect their local communities.[45]

Policy context

National suicide prevention policy

In the 2012 suicide prevention strategy for England, 'Black, Asian and minority ethnic groups and asylum seekers' are highlighted collectively as a group which may require tailored approaches to improve mental health.[46] Subsequent progress reports include actions related to these groups. The fifth report, released in 2021, includes efforts to improve the use and collection of data and work to develop a framework for more culturally appropriate care for people in mental health services.[47]

The Minister of State for Care and Mental Health has committed to refreshing the 2012 Suicide Prevention Strategy in 2022-3, alongside developing a new cross-government Mental Health Plan.[48]

Improving data and reporting

In 2020, Government committed to mandating the recording of ethnicity on death certificates in England.[49] The Government has stated that this change 'will probably require legislation', and that its effectiveness is dependent on the accuracy of data within health

records. [50] [51] To support this, updated guidance will also be issued to healthcare providers and GPs about coding patients' ethnicity.[52] In late 2021, it was announced that these efforts would be led by the Department for Health and Social Care (DHSC), with work ongoing to make it mandatory for healthcare professionals to ask patients their ethnicity and for this data to then be transferred to a new digital Medical Certificate Cause of Death (MCCD).[53]

Wider developments

Structural changes to the healthcare system in England, such as the dissolution of Public Health England and creation of the Office for Health Improvement and Disparities in late 2021, may facilitate further focus on ethnic inequalities. The NHS also established the Race and Health Observatory (RHO), an independent expert body, in 2020 in the context of concerns about the unequal impact of COVID. In its landmark report, the RHO concluded that: 'ethnic inequalities in access to, experiences of, and outcomes of healthcare are longstanding problems in the NHS, and are rooted in experiences of structural, institutional and interpersonal racism.'[54]

In 2022, the Government published its response to the 2020-21 Commission on Race and Ethnic Disparities, laying out a plan with 74 actions.[55] The plan contains no actions specifically focused on addressing inequalities in suicide prevention, with the section on health predominantly focusing on physical health. The plan does include a requirement for the Care Quality Commission to measure healthcare workforce diversity and inclusion, using a newly developed framework. The Cabinet Office's Race Disparity Unit will also consult on new standards on how to record and communicate ethnicity data by the end of 2022.

What is Samaritans calling for?

It is impossible to fully understand suicide across different ethnic groups without better recording, collection, and communication of the data. It is unacceptable that we still do not have a complete picture of suicide across ethnic groups.

- There is an urgent need for more detailed and standardised reporting of suicides by ethnic group. Government must deliver on its promise to record ethnicity on death certificates as soon as possible, to facilitate a more robust and ongoing evidence base for suicide. This change needs to be based on previously collected self-reported ethnicity, rather than ethnicity as observed by practitioners, to ensure accurate recording.

- The planned linkage of death certificates with medical records will still not allow for data to capture suicides among people who are not registered in the healthcare system, a group in which people from some minoritised ethnic groups may be overrepresented. DHSC's work on this should therefore explore how MCCDs can be linked to other official records, such as migration data held by the Home Office.

- Considering other factors alongside ethnicity is the only way to build a full picture of suicide rates and risk factors. Future analysis by the ONS and others exploring ethnicity and suicide should also consider other factors, such as age, place of birth, and migration status.

- The Race Disparity Unit's work on ethnicity data should put an end to using amalgamated ethnicity categories which obscure the diversity among groups (such as the merging of White Gypsy, Roma and Traveller people into the White category).

- Recent years have seen a promising growth in Government and independent bodies exploring ethnic inequalities in healthcare, but disappointingly little activity related specifically to suicide prevention. The NHS Race and Health Observatory should commence a programme of work to further explore, understand, and prevent suicide among minoritised ethnicity groups, with a specific focus on how statutory services involved in suicide prevention can better support people from minoritised ethnic groups.

There are clear and concerning inequalities in the access to and receipt of services involved in suicide prevention for people in minoritised ethnic groups. Racism and ethnic discrimination undoubtedly play a role in creating and perpetuating these inequalities.

- Service providers, charities and researchers need to re-examine the evidence base for suicide prevention that informs their practices, to consider whether this is genuinely

applicable for people from minoritised ethnic groups. A range of further work is needed, alongside people from minoritised ethnic groups with lived experience, to better understand risk factors and effective interventions, and to raise awareness of the existing inequalities in services involved in suicide prevention.

- Trauma-informed care is central to suicide prevention. Services involved in suicide prevention must consider experiences of racial and/or ethnic discrimination when providing care of people from minoritised ethnic groups, including the possible role played by intergenerational trauma or the experience of multiple minoritised ethnicities.

- The inequalities in care received by young people in minoritised ethnicity communities following self-harm are unacceptable. Anyone who self-harms and visits a healthcare setting should receive a psychosocial assessment, in line with NICE guidelines, and should be given the option of receiving a suitable community-based or NHS-provided service, in line with their needs.

- A wealth of local suicide prevention work is done by community-based organisations who have the experience, knowledge, and trust to engage with people in minoritised ethnic groups. Community-based organisations can play a particularly vital role in addressing stigma associated with suicide through their outreach work. Government must provide long-term funding to these groups to put them on a sustainable footing and maximise these existing relationships and abilities.

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