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ORIGINAL ARTICLE

Black and minority ethnic groups (BME) suicide, admission with suicide or self-harm: an inner city study

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Abstract
Aim The aim of the study was to identify trends of suicide or undetermined injury, admission with suicide or self-harm among black and minority ethnic (BME) groups in an inner city area of London.
Subjects and methods Retrospective data was obtained between 2009 and 2012; 2010 and March 2013 from the Office of National Statistics and Public Health Mortality files for suicide and undetermined injury and for admission with suicide or self-harm respectively. Descriptive analysis was done by charts, graphs and percentages.
Results 192 people died of suicide or undetermined injury between 2009 and 2012. 59 % of these were born in the United Kingdom (UK) but outside London, while 55 % were born in London. Of those born outside the UK, Eastern and Western Europeans had the highest suicide rate of 51 %. In relation to admission with suicide or self-harm, 996 BME groups were admitted between 2010 and March 2013. Those of Arab origin, North and South Americans had the highest number of admissions (28 %), while Eastern and Western Europeans had 26 %.
Conclusion Suicide and admission with suicide or self-harm among BME are issues that should be addressed. Rates among those from Eastern and Western Europe are of particular concern. Improved training is needed for primary-care workers in screening at risk groups and better referral to psychological therapies. This will enable better interventions in addressing BME needs.

Keywords BME suicide and self-harm · Suicide prevention · Psychiatric assessment · Primary care · Psychological therapies

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Background

According to Cooper et al. (2010), there are ethnic differences in rates of self-harm, suicide, attempted suicide, characteristics and service provision. These are highest in young black females of 16–34 years. Arguably black and minority ethnic (BME) groups are less likely to receive specialist psychiatric assessment and to represent with self-harm following discharge/assessment in comparison to whites. Black males have been identified to be less likely to be referred to their GP with South Asian males being less likely to be referred to any other service(s). The Care Quality Commission (CQC 2011) suggest that people who belong to ethnic minority groups in the United Kingdom (UK) are not only at risk of developing mental health problems, but are also at risk of having poor outcomes from their treatment and be admitted to hospital. They are equally more likely to be socially excluded as a result of deterioration in mental health, separate themselves from conventional mental health services and not engage at an early stage with services. Self-harm or attempted suicides do not in themselves constitute mental illness per se; they are arguably experience of difficulties with life events beyond one's control. Trigger factors to suicide or self-harm among BME have been suggested by several authors (Griffiths and Baldwin 2009; Rethink 2012; Gervais 2008; Joseph Rowntree Foundation 2007; Karlsen et al. 2005; Erens et al. 2001; Kirmayer et al. 2011; Bhugra 2004; Cooper et al. 2006; Chew-Graham et al. 2002; see Table 1).

A further study by Keating (2007) discusses BME male experience of mental illness and concludes that wide-ranging accounts of causes of mental ill-health surrounds the stressful impact of unrealistic social expectations on individual identity and mental health. They identify three themes as affecting BME men in particular. These include racialization leading to undermining negative and positive stereotypes, hegemonic masculinity that exerts immense pressures on males to attain

Table 1 BME possible trigger factors for self-harm, suicide or suicide attempt

Thwarted ambition	Difficulty with identity formation
Racism	Loss of close knit family
Acculturation	Loss of social network
Domestic violence	Housing-overcrowding or unsuitable
Language difficulty	Culture clash with the host nation
Differences with children growing up in Western culture	Arranged/forced marriage
Different expectations between immigrants and host communities	Loss of status
Poor economic status	Interracial relationships
Family conflict	Living in poorer inner city areas
Existing mental health issues	Ethnocentricity
Immigration	Exclusionary policies that place barriers to integration/success
Lack of information on the health care system	Unrealistic expectations
Loneliness due to being in a new environment	

ideals and acculturation that may challenge males with contradictory and sometimes unattainable customary and economic expectations. These expectations are dictated by factors such as how BME people are treated in society, their perceptions of mental health services, how they are viewed by mental health services and how BME men are viewed and view themselves in their host society. The assertion here may be that BME men face difficult expectations: to assimilate within the new culture including sex role change or to continue with traditional values (thereby maintaining perceived masculinity), whilst also attaining economic achievement. Similarly, BME women may face several strands of expectations: to continue being a traditional partner/wife, assimilate within the new culture, attain economic independence or remain economically dependent on the spouse. Coupled with domestic abuse which may ensue if no positive coping mechanisms are employed by both men and women, these factors may be a major contribution to the development of a sense of hopelessness and mental illness leading to self-harm and or suicide attempt(s). Some authors add that common concerns affecting BME men as well as issues specific to particular BME groups are high rates of schizophrenia, psychotic disorders and low levels of confiding in professionals leading to lack of emotional support for BME men with mental health difficulties. It may well be that due to cultural background, some BME people may not be forthcoming with information because they think that issues they have are inappropriate and undeserving of help or just that they may not be understood. On the other hand, previous studies (Galloway and Gillam 2006; Keating 2007; Cooper et al. 2010; National Institute for Mental health (NIMHE) 2008) indicate that possible reasons for such outcomes could be mistrust of services by BME groups which is reinforced by experience of racism, perceived lack of culturally competent staff or service providers, gender attitudes to health and stigmatisation of mental ill-health.

Over the years, rates of suicide have been reported to be high among ethnic minority groups in the UK (Neeleman and Wessely 2001; Mackenzie et al. 2003; Ougrin et al. 2010). In response to such studies, policies have been developed by subsequent governments to ensure reduction in the number of those committing suicide (DOH 2005). Since the inception of such policy documents, much has been done to identify those at risk of suicide (NSPS 2011). There is an indication that there is a fall in suicide rate in England and Wales; however, there is lack of clear data regarding statistics among BME groups. The aim of the study was to identify trends of suicide or undetermined injury and admission with attempted suicide or self-harm among BME in an inner city area of London.

Methods

Data sources and collection

Retrospective data on suicide or undetermined injury and admission with suicide or self-harm was obtained between 2009–2012 and 2010-April 2013 from the Office of National Statistics (ONS) and Public Health Observatory Mortality files respectively. Data obtained for suicide or undetermined injury incorporated place of birth and whether the victims were resident or resident with GP registration. Data was collected in line with International Classification of Diseases (ICD-10) description and ONS classification of suicide and undetermined injuries (Table 2).The area of study of inner North West London was selected due to its ethnic diversity and significant number of immigrants, in particular those from Eastern and Western Europe.

Analysis

Data collection did not include variables that would have enabled analysis by statistical significance; therefore, the analysis is descriptive. Secondly, ethical approval is acknowledged but not indicated in this study as statistics had already

Table 2 ICD-10 classification of suicide and undetermined injury (source ONS)

Definition	ICD-10 codes
Death with a definite suicide	x60-x-84
Injury/poisoning of undetermined intent	Y10-Y34[2]

been collected at primary source by the Public Health Observatory and Office of National Statistics.

Results

Inner North West London has a total population of approximately 505,447 of which 235,748 is BME, almost half the population (47 %). Broken into individual ethnic groups, white other (Eastern and Western Europeans) make up the largest group of 21 % and white Irish form 4 %, while mixed white and black Caribbean, mixed white and black African, mixed white and Asian, other mixed, Asian Pakistan, black other British accounts for 6 % (each being 1 %) of the total population. Asian and Asian British, Asian British Bangladesh, Chinese or other ethnic groups: Chinese 6 % (each being 2 %) and other Asian British, black/black British African, black/black British Caribbean and Chinese/other ethnic group Chinese accounts for 12 % of the total population (each being 3 %; Table 3).

BME suicide statistics

Recording of ethnicity on death certificates is not routine in the UK and, therefore, data that links ethnicity to suicide or death is limited. Data presented below makes conclusion from place of birth. There were 164 (ONS) 192 (PHO) deaths by suicide and undetermined injury in inner North West London between 2009 and 2012 (Fig. 5). In this study, London Public Health Observatory figures (192) are used as it is likely to be more accurate than that of ONS. BME death by suicide and undetermined injury is expressed as a percentage of the total deaths of 192 (Figs. 1 and 2). There were 167 deaths in the resident population and 126 in both resident and GP registered population. Higher percentage of deaths by suicide and undetermined injury occurred among BME born in the UK and living in inner North West London. This figure is high for both resident and GP registered population (55 and 59 % respectively). Of those born outside the UK, West and East Europe had the highest number of suicide (23 % for resident and 18 % GP registered population). Africa had 6 % for resident and 7 % GP registered, Asia 7 % for both resident and GP registered, South America 2 % resident and 3 % GP registered, North America 2 % resident and 1 % GP registered and Middle East 5 % for both resident and GP registered population (Figs. 1 and 2).

Table 3 Ethnic composition

Ethnicity	Percentage
White Irish	4
Other white	21
Mixed white and black Caribbean	1
Mixed white and black African	1
Mixed white and Asian	1
Other mixed	1
Asian and Asian British Indian	2
Asian British Pakistan	1
Asian British Bangladesh	2
Other Asian British	3
Black/black British African	3
Black/black British Caribbean	3
Black British Other	1
Chinese Ethnic Group	0
Chinese or other ethnic groups: Chinese	2
Chinese/other ethnic group Chinese	3
White British	53

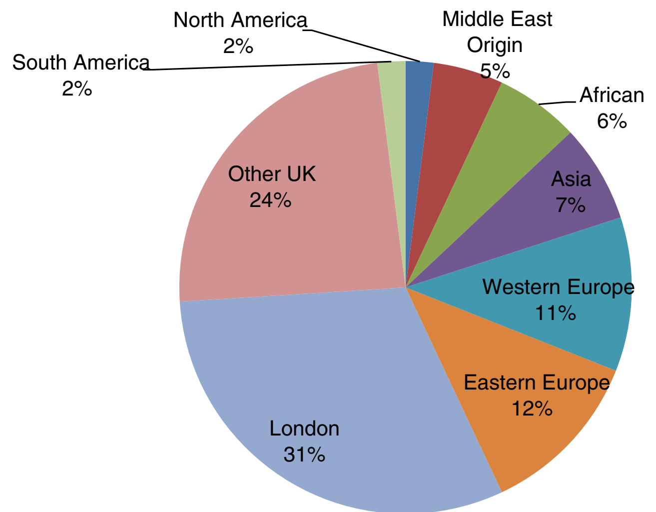

Fig. 1 Resident BME place of birth and percentage of suicide or undetermined injury 2009–2012. Total number of deaths by suicide or undetermined injury: 192 (source: PHO)

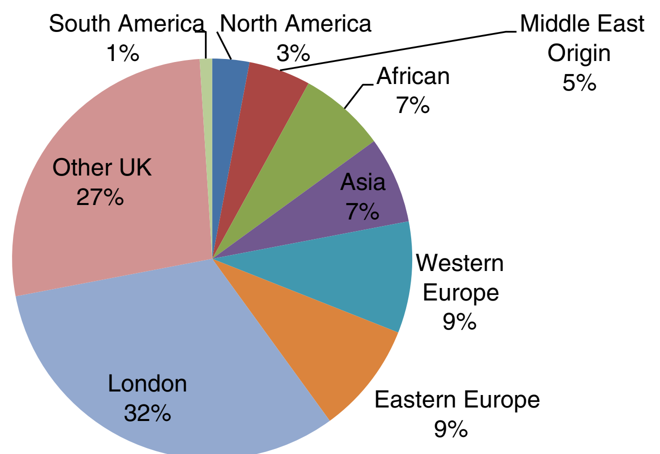

Fig. 2 BME GP registered place of birth and percentage of suicide or undetermined injury: 2009–2012. Total number of GP registered deaths by suicide or undetermined injury: 126 (source PHO)

Admission by suicide, self-harm or both

Total BME number of admissions into the local acute psychiatric wards for the period 2010–April 2013 was 996. Taken per year, the figures were: 2010–2011 (380), 2011–2012 (367) and 2012-April 2013 (249; Fig. 3). Broken into BME groups, those of Arab origin and South Americans had the highest number of admissions with history of attempted suicide, self-harm or both (28 %). Eastern and Western Europeans had an almost equal percentage of 26 %, while black Africans had 7 %, white Irish 6 %, black other 6 %, Asian other 5 % and black Caribbean 4 %. The rest of the BME population had admissions of less than 2 % with mixed white and black Africans having no admission (0 %; Fig. 4).Possible inaccuracy in record keeping meant that 9 % of those admitted were not allocated to any particular ethnicity. Table 4 gives the breakdown per year.

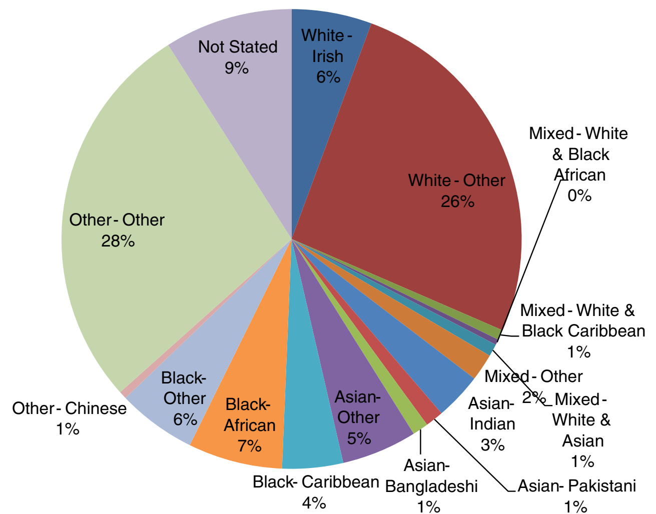

Fig. 4 BME cumulative percentage breakdown, admission for suicide or self-harm: 2010–2013

Discussion

The main findings of this study are the high number of suicides and undetermined injury among UK born BME. This figure is particularly high in BME born in other parts of the UK and living in Inner North West London (59 %), while for those born in London, the figure is 55 %. Equally high and perhaps significant is death by suicide in those from Eastern and Western Europe. This number is higher than the national average and is reflective of the number of admissions in those with attempted suicide, ideations or self-harm. Studies involving European immigrants in relation to suicide, attempted suicide and self-harm in the UK is limited. Understanding their health behaviour therefore warrants further investigation. Given the relatively high number of suicides among UK born BME, Eastern and Western Europeans, emphasis may need to be put on their needs when designing suicide prevention strategies. Death occurring among BME groups outside Europe (Africa, Asia and Middle East) though relatively small could still be considered important when designing preventive or treatment services. There were a combined total of 34 deaths in these groups in the 3-year period: 2009–2012 (Fig. 5). Previous studies have identified high suicide rates in those from Africa and Asia (mainly female; Mackenzie et al. 2003; Hunt et al. 2003; Cooper et al. 2006; Bhui et al. 2007; Bhui and McKenzie 2008).

53 % of those who died by suicide and undetermined injury had no General Practitioner (GP) registration. By implication, this is indicative of inability to access mental health services via the GP or otherwise. Within the UK and most Western

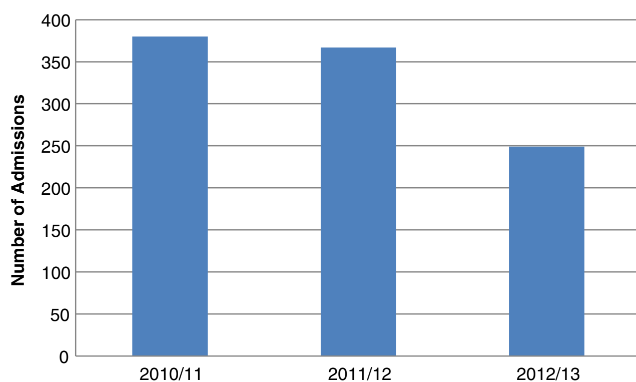

Fig. 3 BME admission by suicide or self injury: 2010–2013

Table 4 BME admission by suicide and self-harm: 2010-2013

	2010/11	2011/12	2012/13	Total
Unknown	19	30	15	64
White - other	101	100	60	261
Mixed - white and black Caribbean	4	3	1	8
Mixed - white and black African	4	1	0	5
Mixed - white and Asian	5	4	1	10
Mixed - other	11	7	3	21
Asian - Indian	10	4	13	27
Asian - Pakistani	5	7	2	14
Asian - Bangladeshi	3	5	2	10
Asian - other	17	16	16	49
Black - Caribbean	25	19	5	49
Black - African	25	23	17	65
Black - other	24	21	12	57
Other - Chinese	4	3	0	7
Other - other	98	88	77	263
Not stated	25	36	25	86
Total	380	367	249	996

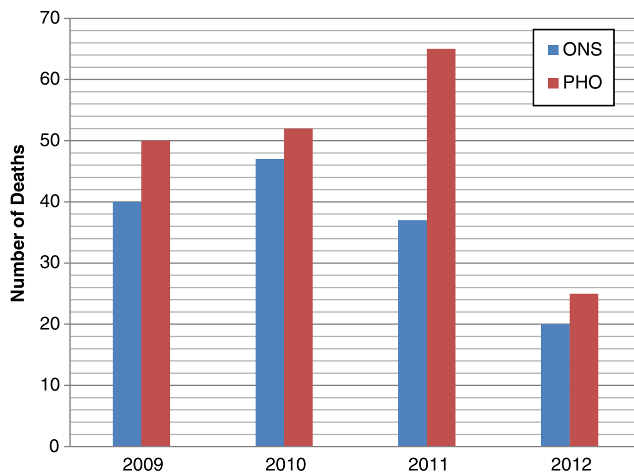

Fig. 5 Number of deaths by suicide and undetermined injury: 2009–2012 (source: ONS and PHO)

countries, the role of the GP cannot be overemphasised as they play a major role in preventive, referral to curative or specialist services. Reasons for non GP registration in BME groups are not clear; however, in a previous study by Ougrin et al. (2010) on suicide in one of the London Boroughs, immigration was suggested as having some influence on GP registration. This may be due to lack of knowledge of the health-care system, fear of discovery of illegal immigration, transient nature of GP registration or frequent moves triggered by lack of accommodation or rent increments. Other studies (Cooke et al. 2007; Aung et al. 2010; Palmer and Ward 2007) give more elaborate reasons for non GP registration as being overseas born, being a refugee or asylum seeker, not having English as first a language, being in the UK less than 5 years and the interpretation of the health-care system including role of doctors by immigrants. For instance, in some countries the GP concept may not exist and therefore one does not require registration with a doctor in order to be treated. This poses difficulty in health-seeking behaviour in countries where this is the norm. It is therefore important for immigrants to be educated on the importance of not only GP registration upon arrival in the host country, but also how the health-care system operates.

In relation to admission with suicide or self-harm, larger percentages presenting with either suicide or self-harm were those of Arab origin and South Americans (28 %), Eastern and Western Europeans (26 %). Irish, black Africans, black other and Asian-Indians had admissions of almost 7 %, while those of Chinese origin or with Chinese Background had fewer admissions of 1 %. Observation in this investigation is the number of suicides and undetermined injuries in those from Eastern Europe, Western Europe and Africa being in relative proportion to the admission rates. This is surprising given the high profile nature of clinical risk assessment and management in the UK (policy document: NSPS 2011). Reasons for high levels of suicide in relation to discharge as Galloway and Gillian (2006), Cooper et al. (2010) explain, may be due to less frequent specialist psychiatric assessment relating to false low expectations regarding the risk of suicide or attempted suicide, the likeliness of not being referred for follow up and cultural differences in communicating distress. Taking the argument further, Kirmayer et al. (2011) discusses how culture can influence all aspects of an illness, patterns of coping, seeking help and response, adherence to treatment, methods of emotional expression and communication. This is echoed by Bowl (2007) who explains how cultural differences can lead to poor care and engagement with clients of different cultures. Edge and Rogers (2005) for instance explain how black expectant women had a lower score on depressive scales in comparison to white expectant women despite experiencing social adversities. The expectation among black women was of being strong and that admission of an inability to cope would be an admission of weakness. The end result of such cultural discourse may lead to crisis of which self-harm and attempted suicide could be a symptom and suicide an outcome.

Socio-economic status (SES) that includes measures of social exclusion or deprivation has been associated with suicide. For example previous studies on occupation level (Kivimaki et al. 2007; Rubenowitz et al. 2001), educational achievement (Qin et al. 2000) employment status (Cubbin et al. 2000; Kposowa 2001) and income level (Blakely et al. 2002; Qin et al. 2003) have all indicated higher predictor of suicide in those from lower SES than in the higher groups. Socioeconomic factors are also linked to mental disorders, with prevalence being evident in lower SES in comparison to higher SES groups (Taylor et al. 2004). In addition to suicide or self-harm, socioeconomic factors have also been associated with mental disorders, with higher prevalence found in lower SES compared to higher SES groups (Taylor et al. 2004). Though not always the case, BME groups tend to be in the lower SES mainly due to lower education attainment, unemployment, low income level, social exclusion and are disproportionately over represented within the mental health-care system. Evidence within inner North West London suggests a substantial difference in life expectancy between residents living in the most deprived and more affluent areas. BME groups are disproportionately affected by deprivation as is evident in its profile. They tend to live in the most deprived areas and as such live in poverty. Although the link between suicide and deprivation cannot be concluded with certainty, studies such as the ones mentioned previously indicate an association between low SES, deprivation and suicide. For this reason, a link between BME, low SES and suicide or self-harm can be inferred.

In terms of gender, there are considerable differences in suicide rates between male and female, which is 4 to 5 times higher in males than in females (Hawton and Van Heeringen 2000; Heller et al. 2003). There are also differences in

prevalence of mental disorders and SES by gender (Taylor et al. 2005; Qin et al. 2003; Qin and Nordentoft 2005) with males being more affected. Such differences are considered to be due to males being more inclined to engage in substance abuse than females and more likely to be unemployed. Data collection within the current study did not include socio-economic variables that would have enabled analysis of socio-economic factors and gender differences in relation to suicide and self-harm. A further study is warranted in this aspect.

Preventive/clinical interventions

Until recently, place of birth rather than ethnicity has been used in recording deaths within the UK. This not only makes comparative studies difficult, but could also lead to difficulties when designing ethnic-specific treatment plans or prevention strategies as cultural differences are wide and varied within a continent. Kirmayer et al. (2011) indicate how better treatment outcome is inextricably linked to culture and that it may be better if ethnic identity rather than continental identity approach to understanding culture is adopted.

Although this study has not focused on age, previous studies have identified high risk of self-harm or suicide in young black African and Afro Caribbean females in those between 25 and 39 (Mackenzie et al. 2003; Bhui and McKenzie 2008; Cooper et al. 2010). Figures in the older generation as high-risk groups in terms of self-harm, attempted suicide or suicide tend to be lower. Though this may be the case, it could give a false impression because culturally older BME groups could be unwilling to engage in positive health-seeking behaviour. Crawford et al. (2005) argue that the reasons for such non-health-seeking behaviour could be related to stigmatisation, social isolation following contact with services, services not being accessible at all and consideration of health seeking as inappropriate. Aung et al. (2010) for instance indicate how priority is given to issues around immigrations status, housing, employment and child care rather than mental distress.

Non-fatal self-harm (Sun 2011) is a common phenomenon that places a significant burden on care services. When considering this phenomenon, it is often difficult to ascertain the degree of suicidal intent. Studies however suggest that repeated behaviour of deliberate self-harm with intent is often a precursor to suicide (Carter et al. 2005). Although there are studies on ethnicity and self-harm, few have been on how cultural influence(s) relate to deliberate self-harm among BME population. To this end it can be asserted that cultural understanding of self-harm is vital if there is to be effective provision of services to BME communities (Kleinman et al. 2006). Justifiably it can be concluded that such understanding of cultural influence on self-harm needs to acknowledge variability within BME groups. Similarly, Aisenberg (2008) indicates that evidence base is not accessible or synthesised to guide practitioners or policy makers in taking into consideration ethnic differences in rates of harm and risk factors. More therefore needs to be done in carrying out specific needs analysis for each BME group with the aim of putting in place effective culturally sensitive treatment/intervention programmes.

Suicide is multidimensional and requires a multidisciplinary approach rather than just one service component. At public health/prevention level, it is advisable that services such as the police, coroners, faith or community leaders, schools, GPs and non-governmental organisations(NGOs) come together to address preventive measures. In broad terms, preventive measures should embrace targeting at risk BME groups taking into account age, gender sensitivity and individual circumstances. This can be done at two levels—population- and intervention-based strategies. Population-based strategies could include measures such as psychological education geared towards specific BME communities so they can better access to services and in the recognition of mental health issues (this can be done via targeted community projects). Secondly, it may include training primary-care workers in the screening and detection of those at risk of suicide (see Table 5).

Table 5 Possible risk assessment areas that may help suicide prevention among BME. List is not exhaustive and can be included with existing risk-assessment formats

Perception of racism	Level and source of support
Self-harm behaviour	Language barrier and ability to cope if cannot speak the host country's language
Level of coping with stressful life events	Level of integration in a new environment/perception of inclusiveness
Help/health seeking behaviour	Existing mental illness
Illness perception	Gender and age
Religious practices	Employment
Level of education	Marital status-relationship within marriage
Perception of gender roles	Experience of violence or abuse
Perception of new culture/environment.	
Drug use and alcohol dependence	

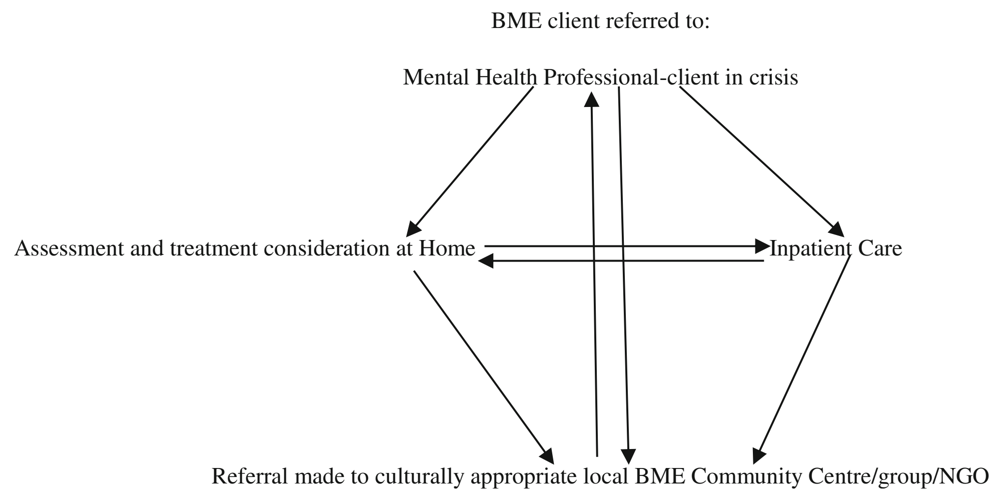

Fig. 6 Possible collaborative working relationships between statutory, voluntary and non-Governmental organisations

Intervention for high-risk groups could include access to cultural sensitive psychological therapies such as problem-solving cognitive behaviour therapy (CBT), solution-focused therapy and similar interventions after self-harm or suicide attempt. Generally, there needs to be ongoing education on the influence of culture on mental health. Such programmes should embrace an understanding of how health is explained and understood in different cultures. Other general preventive measure could be development of survival guides for all ethnic groups, especially new arrivals, which could be in the form of information booklets that contain information on where to find help and how, the link between stress and mental health, the importance and process of GP registration and of community support groups. The booklets could be made available in schools churches, mosques, community centres and hospitals including accident and emergency departments which are often the first port of call for crisis presentation.

Other preventive measures specific to BME groups should include developing an unambiguous collaborative working partnership between statutory services and community voluntary organisations or NGOs with interest in BME and mental health (see Fig. 6). Arguably such collaborative partnerships would bring together distinct approaches and experiences in equal terms aimed at improving the mental health of BME groups. Such collaboration could include referrals to and from each other and sharing of knowledge (Fig. 6). Employment of health professionals with similar backgrounds to specific BME groups should be considered in areas where suicide or mental health problems are deemed to be high. In this instance, it may be worth employing or training nurses, doctors, psychologist, social workers from Eastern and Western Europe, which would enhance understanding in dealing with specific factors affecting mental health and wellbeing in this BME group.

As has been argued in the foregoing sections, BMEs fail to re-engage with services following initial contact. To improve re-engagement, aggressive follow up upon discharge or assessment should be put in place. A mechanism needs to be in place whereby a key person ensures client contact with the next service they have been signposted to. This will in no doubt facilitate continuity of care, treatment and understanding of the reasons for disengagement if any, and above all, it will help to prevent relapse or escalation of symptoms.

Limitations

A number of factors influence suicide or self-harm behaviour among BME groups. Analysis of statistical significance has not been possible due to the lack of associated variables from the source of data collection. Secondly, the discrepancy between ONS figures and that of public health observations implies caution in interpreting the results, as the figures could be less or more than what has been presented. Further research is required to better understand the relatively high number of admissions among those of Arab origin, South and North Americans and the relatively high level of admission and suicide in those from Western and Eastern Europe.

Conflict of Interest None

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