



FINAL REPORT
Suicide Prevention for BME groups in England
Report from the BME Suicide Prevention Project

Centre for Health Improvement and Minority Ethnic Services
(CHIMES)

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Introduction

There are reports of variations in rates between ethnic groups within a country. For example, there are high rates in the aboriginal peoples of Australia and New Zealand compared with the colonists, and in a number of populations from the Indian diaspora around the world (McKenzie et al 2003). The suicide rate in White Americans is double that of African Americans, but this is largely accounted for by the disproportionately higher rates in older White men. Native Americans (including those in Alaska) have rates of suicide that are at least 50% higher than the White population. East Asian American women have the highest suicide rates of all women over the age of 65 years in the USA. Hispanic Americans are half as likely to complete suicide as White Americans, but there are significantly higher rates of suicidal ideation and suicide attempts in young Hispanic Americans at high school which are now being reflected in their suicide rates. Changes in suicide rates have also been reported in African American youths aged 10–14 years: between 1980 and 1995 there was an increase almost double that for the White age-matched population (US Department of Health and Human Services, 2001).

Recent Swedish studies have concluded that first generation immigrants tend to have higher rates of suicide than their countries of origin, but the rate is higher still in their Swedish born children. In addition to cultural factors that mediate suicide rates in ethnic minority groups, the acceptability of suicide in the ethnic majority population and the response of the host culture to the ethnic minority group are important. Though it has been argued that ethnic minority groups will acquire the rates of suicide of the ethnic majority group over time, there have been persistently lower rates of suicide in some groups for instance African-Americans and consistently higher rates in other ethnic minority populations such as the native populations of the US and the antipodes (US Department of Health and Human Services (2001), McKenzie et al 2003).

Suicide is a complex behaviour which is the result of numerous risk and preventative factors acting over a person's life course (Gunnell and Lewis 2005). At an individual level socio-economic stress, thwarted aspirations, racism, acculturation, culture clash with parents, loss of religious affiliation, difficulty with identity formation, and loss of

family and community support may have particular effects on suicide risk in black and minority ethnic groups. However, context is important; all of these risk factors are influenced by the socio-economic situation of the group, their culture, history and mainstream social environment. The institutional deconstruction, decreased collectivism, increased normlessness and helplessness and increased personal risk that characterises a post-modern society may increase the risk of depression in the whole population. This could interact with the particular situation of an ethnic minority group to lead to an increased risk of suicide.

There is no contemporary information on comparative rates and risk factors for suicide in Black and Minority Ethnic groups in England and Wales. It is not clear whether different ethnic minority groups share the same risk profiles as the white British population.

Current suicide prevention strategies in developed countries target high-risk populations. Goal 1 of England's National Strategy (Department of Health 2002) is to reduce the number of suicides in people who are currently in contact with mental health services, to reduce the number of suicide in the year following deliberate self harm, to reduce the number of suicides in young men, to reduce the number of suicides in prisoners and to reduce the number of suicides in high risk occupational groups. BME groups may be considered to be a high risk group because they are more likely to be in contact with mental health services, to be in contact with the prison justice system and to be young.

The National Suicide Prevention Strategy (NSPS) is a wide-based program which covers the promotion of well being, the availability and lethality of suicide methods, improved reporting of suicidal behaviour in the media, research on suicide and suicide prevention and aims to improve monitoring and progress towards the target of reduced suicides set in Saving Lives our Healthier Nation.

The suicide rate in England and Wales in general has fallen since the launch of the National Suicide Prevention Strategy for England (NIMHE 2003) but it is unclear whether these changes are reflected in the rates of suicide in BME groups. In both the

consultation exercise for the NSPS and in the consultation for Delivering Race Equality an Action Plan for Services (Department of Health 2005) suicide in BME groups was considered a cause for concern. Reports of high rates of suicide in South Asian women and increasing rates in some BME youth were noted.

Better information on the rates of suicide in different BME groups, the risk factors for suicide or behaviours which increase the likelihood of suicide (such as a suicide attempt) is needed in order for there to be confidence that targeted initiatives to complement the Strategy are not required for different ethnic minority groups. Moreover more fine grained information on risk factors in different cultural groups within the larger ethnic minority groupings will be required if appropriate targeted initiatives are to be developed.

The Structure of the Report

This report sets out the findings of a study aimed to synthesis existing knowledge on suicide and suicide attempts in different ethnic minorities in England and Wales. This report consists of a summary document that outlines:

- The elements of the suicide and ethnicity project
- Key findings of each of the elements of the study
- Key recommendations that emerged directly for stakeholders.
- The draft publications for each stage of the work are appended for those wishing to read a more detailed account of each part of the study

The Suicide and Ethnicity Project

The project consists of three parts:

- 1) The aim of Part 1 was to assess our current knowledge. We undertook:
 - a. “A systematic review of comparative studies of risk factors for suicide in BME groups in England and Wales”
 - b. “A systematic review of comparative studies of risk factors for Deliberate Self Harm in BME groups in England and Wales” and
 - c. “A systematic review of suicide prevention strategies for BME groups in England and Wales”.
 - d. In addition we undertook a mapping exercise of organisations who stated that they were involved in BME suicide prevention.
- 2) Part 2 aimed to expand the evidence base by undertaking secondary analyses of existing data sets. We made a national call for data on suicide and ethnicity. We collected national and local data sets of relevance and then completed profiles of the data sets, before embarking on secondary analyses if the profiles of the data sets offered potential new insights into suicide and ethnicity, including improved understanding about deliberate self harm and ethnicity. The following data sets were subjected to secondary analyses:
 - a. EMPIRIC: a survey of mental illness in representative populations of six ethnic groups
 - b. Fourth National Survey: data from a national survey of psychiatric morbidity
 - c. National Confidential Inquiry: national data set of suicide in those in contact with mental health services
 - d. Office for National Statistics mortality data: national data set of suicide and untoward injury
 - e. UK700 study: data from a national study of people with severe mental illness
 - f. Other data sets were profiled and found not to offer data for significant statistical analyse to yield new information, or the data owners were unable to suggest methods for further analyses that they considered might advance knowledge.

- 3) In Part 3 of the project we presented the findings from part 1 and 2 (the systematic reviews and the new knowledge from the secondary data analyses) to expert panels of stakeholders. The aim was to describe and discuss possible suicide prevention initiatives that addressed the risk factors identified taking account of strategies that were already in place.

Key Findings: Part 1

Suicide Systematic Review

The clear message from the systematic review of suicide in BME groups is that we know relatively little about this issue for a number of reasons:

- 1) The lack of good ethnic identifiers on death certificates means that proxy measures of ethnicity such as place of birth are used in comparative research on national samples. This leads to error (for instance less than 50% of people of Bangladeshi, Indian or Pakistani origin in England were born in South Asia and 15% of those born in South Asian are White) and in addition the lack of good quality routine data has been an impediment to research;
- 2) There are few good comparative studies of suicide in ethnic minorities;
- 3) The studies that there are have concentrated on identifying differences in rates of illness between ethnic groups and there has been little attention to risk factor analysis ;
- 4) The literature is dominated by investigation of suicides in South Asian groups with relatively little available information on other groups considered to be at high risk such as those of Scottish and Irish origin living in England and refugee and asylum seekers; and
- 5) There are no studies of suicide in children or adolescents from BME groups.

There are some consistent findings from the literature:

- 1) South Asian women have higher rates of suicide, especially young women;
- 2) South Asian men have lower rates;
- 3) Men born in East Africa have high rates of suicide;
- 4) For some age groups of men born in Scotland and Ireland and women born in Ireland are at higher risk, and
- 5) Black and minority ethnic groups are more likely to use violent methods when committing suicide.

However, the literature does not offer a picture of comparative suicide risk and rates that is comprehensive enough to form the basis for suicide prevention.

Deliberate Self Harm Systematic Review

Similar to the literature on suicide there is little good quality information on deliberate self harm (DSH) in different ethnic minority groups in England and Wales. The reasons for this are somewhat different:

- 1) Most of the studies have significant methodological flaws;
- 2) Most of the studies are small;
- 3) Some of the studies did not set out to assess ethnic differences;
- 4) Most of the studies use clinical samples rather than community samples;
- 5) There have only been two national studies and these either investigated one method of DSH or one age group;
- 6) The studies have investigated only on Black Caribbean, South Asian and White samples;
- 7) There are few studies on adolescents and these have contradictory findings, and
- 8) There were no studies of potentially high risk groups such as prison populations or refugee and asylum seekers.

Differences in the findings across the studies may reflect variation of access to services as well as actual differences in rates and risk factors between ethnic minority populations.

The available evidence suggests that:

- 1) Women of South Asian origin are over-represented in DSH samples compared to white women and men;
- 2) Those of South Asian origin and aged under 35 are at higher risk;
- 3) There may be an increasing risk in those of Caribbean origin aged less than 35 years;
- 4) The most common method of self harm is use of analgesics irrespective of ethnic group;
- 5) Previous histories of repeated DSH are reported less often in South Asian and Caribbean adults and they are less likely to have mental disorder and more likely to self harm impulsively, and

- 6) Studies attributing differential rates of DSH in minority ethnic groups to “culture conflict” are difficult to interpret because of methodological problems and their results need to be considered with caution

Follow up studies using validated measures of mental distress and self harm are necessary for better prediction of risk of distinct ethnic groups. Population based studies that follow individuals to evaluate their pathways into care are necessary to fully discern whether ethnic variations of help seeking or access account of the ethnic variations in rates and prevalence in service based studies.

Suicide Prevention Systematic Review

The area of suicide prevention was where there was least literature. No national studies have been undertaken. The empirical literature originates from three studies of South Asian origin women. Only one study had performed a systematic evaluation. The other studies set out a range of recommendations based on small qualitative samples of atypical populations based in inner city areas with large BME populations.

The studies recommend:

- 1) That there is recognition of the importance of the non statutory sector in BME suicide prevention;
- 2) That the non-statutory sector needs to be supported financially for this work;
- 3) However, not too much should be expected from the non statutory sector;
- 4) That there needs to be a range of choices of services and points of access to services to facilitate equitable pathways to care;
- 5) That BME communities need to be provided with better information on suicide and there needs to be an initiative to raise awareness of the issue;
- 6) That there is a need for better and culturally competent commissioning of services;

- 7) That there is a need for training and development of staff to ensure that there is equity of efficacy of services (issues for training should include anti-racism, confidentiality, cultural awareness, cultural competence);
- 8) That services need a whole systems approach to developing equitable services including recruitment and retention of BME staff;
- 9) That suicide prevention in BME groups needs to be seen in context of a broad spectrum of needs, and
- 10) That there need to be improvements in social and primary care to facilitate better treatment of BME groups.

The work was based on reported high rates of suicide in South Asians groups and so had a limited perspective. At the time the recommendations were made there was no wider policy framework or BME mental health strategy within which they could be advanced.

This literature review points to the dearth of evidence for suicide prevention initiatives among BME groups.

Suicide Prevention Mapping Exercise

A mapping exercise was undertaken. All National Institute for Mental Health in England (NIMHE) Development Centres were contacted. Race Equality Leads (RELs) and Suicide Prevention Leads (SPLs) were contacted by e-mail, telephone and face to face meetings were undertaken with their networks if available. All SHAs were contacted. Information on initiatives to improve suicide prevention for BME groups was requested. Using a snowballing technique a list of over 100 groups offering mental health support for BME groups was developed and all of these were contacted by letter and telephone. Again specific strategies or actions considered important for suicide prevention were requested.

The net result of this activity is that there is very little evidence of focused activity taking place, certainly at the level of any development of strategies or prioritising within the

statutory sector. There is however, some evidence of locally based projects within BME communities addressing this issue.

The contacts made through attending meetings of suicide prevention networks within the NIMHE regions affirmed the importance of addressing this issue. However, it is clear that the primary focus on work to date appears to revolve around 'auditing' activities, such as development of environmental audit (West Midlands), hot spots (Yorkshire/North east), PCT audits (NW & SE) with little activity focusing on interventions.

The findings were:

- 1) There are limited projects currently addressing suicide within BME communities, and those that do, do so as part of a wider set of functions not related to BME issues;
- 2) No statutory agencies had identified BME suicide prevention as a priority and there was only limited acknowledgement that this is an issue;
- 3) There has been an uneven response from SPLs and RELs within NIMHE development centres to addressing the issue, for the RELs in part due to their diffuse roles whereby all matters to do with race or ethnicity appear to be directed to them for a response, and
- 4) Suicide prevention was considered an issue by non-statutory organisations offering BME mental health support but these organisations mainly offered direct care.

Key Findings Part 2

Expanding the Evidence Base

The systematic reviews demonstrated how little available information there was in England and Wales about suicide and deliberate self harm in BME groups. For suicide the fact that place of birth, not ethnicity, is recorded on the death certificates, makes national comparative studies from routine data sets difficult. Fifty per cent of the BME population is born in England and Wales and the problem is further compounded by the fact that they tend to be younger and may be at increased risk of suicide compared to their parents. Moreover, suicide prevention initiatives in BME groups are likely to target ethnic groups rather than groups identified by their place of birth. If such initiatives are to be effective then accurate information on the target group is required.

In order to expand the evidence base secondary analyses were undertaken on existing data. Data sets were identified through a national call for data sets, through professional networks and by an assessment of data sets available from the national data archive.

Local and national data sets were offered for analysis. Secondary analysis of national data sets was given priority. The draft scientific papers which have been produced from the secondary data analyses are available in the appendices. Here we will present a short synthesis of the information by ethnic minority grouping for all of the analyses that were undertaken.

Suicide and suicidal behaviour in South Asian origin group

There have been numerous reports of high rates of suicide in South Asian women in England and Wales and in the diaspora around the world. In England and Wales these studies are either based on data that predates proper population monitoring of ethnicity or use information on place of birth on the death certificates to assign ethnicity. Currently, over 50% of those of South Asian origin in England and Wales were not born in South Asia. Moreover 15% of those who were born in a South Asian country are white.

Because of this place of birth is not a good proxy measure for ethnicity. Name

recognition software is an accurate method of ascertaining South Asian ethnicity from routine data sets. We used the South Asian Names and Group Recognition Algorithm (SANGRA) name recognition software to analyse rates of suicide between 1993 and 2003 in those of South Asian origin in England and Wales;

- 1) There were 1438 suicides in the South Asian population between 1993 and 2003
- 2) The (standardised mortality ratio) SMR in South Asian men was low.
- 3) For women as a whole there was no difference in the suicide rate between the South Asian group and the population of England and Wales.
- 4) The SMR was low for all male age groups and the aggregate SMRs for 1993-1998 were generally lower than those for 1999-2003
- 5) Elevated suicide rates in young South Asian women found in the 1993-1998 data decreased so that by 1999-2003 they were no different than England and Wales.
- 6) The suicide rate in older South Asian women increased between 1993-1998 and 1999-2003.

Further research should investigate whether this pattern holds for all South Asian groups or whether specific sub-populations within the South Asian population have different risks. Understanding the reasons for the decrease in suicide rate over time for younger South Asian women and the rise in suicide over time in older women could be the basis for preventive strategies in South Asian diaspora.

An analysis of the National Confidential Inquiry data allowed investigation of a high risk group, those who had been in contact with services in the last year. Good quality data on ethnicity was available because clinical teams were asked to assign ethnicity to those who had committed suicide rather than relying on place of birth;

- 1) People of South Asian origin are less likely to be in contact with mental health services;
- 2) The standardised suicide ratio for those in contact with mental health services in the last year is lower for both South Asian men and women than it is for White men and women;

- 3) For those who have been admitted to hospital in the last year the suicide rate is lower for South Asian women but is no different than White for South Asian men;
- 4) However, there were some differences in risk by age group. In 25-39 year old women the standardised suicide ratio was nearly 3 times higher in the South Asian group if this is coupled with the lack of difference in population rates of suicide we have reported from the SANGRA analysis, it is reasonable to conclude that people of South Asian origin in this age group who commit suicide are three times more likely to be in contact with services in the previous year. Of interest over 50% of female suicides occur in this group. As this group are accessible they may be a possible target for prevention.

No national data sets of deliberate self harm were identified. Data sets which reported information on suicidal ideation produced complex results with few clear patterns:

- 1) Suicidal ideation was found to be less common in South Asian groups, a finding which would support the literature stating that suicidal acts in this group were more likely to be impulsive;
- 2) Risk factors for suicidal ideation were complex and differed by ethnic group. For instance religiosity decreased the risk of suicidal ideation and physical illness increased the risk of suicidal ideation in Pakistani and Bangladeshi groups but not in those of Indian origin groups;
- 3) Low social class was not a risk factor for suicidal ideation in South Asian groups however, housing problems and being unemployed increased the risk of suicidal ideation in Pakistani and Indian origin groups but not in those of Bangladeshi origin;
- 4) This work was significantly hampered by the available data and further refinement of this line of investigation will require specific data collection.

Suicide and suicidal behaviour in the Caribbean origin population

Because of the lack of ethnic identifiers on death certificates other than place of birth, no national population level data on suicide in people of Caribbean origin was available. No

name recognition software was available to interrogate office of national statistics data sets.

The only national data available on suicide was in the group who had been in a contact with services in the preceding 12 months. There were three important findings:

- 1) Black Caribbean people in general were at no higher risk of having been in contact with services in the year before committing suicide;
- 2) Black Caribbean origin men under the age of 25 were nearly three times more likely to have been in contact with mental health services in the year before committing suicide than Whites, and
- 3) For those who were admitted to hospital black Caribbean women were four times less likely to commit suicide.

Young black men in contact with mental health services are a possible target group for suicide prevention.

An investigation of risk factors for suicidal behaviour in those of Caribbean origin with a long term mental illness was undertaken using the UK700 data set. This is a data set of a cohort of patients which entered a case management trial in four centres, three in London and one in Manchester. All patients had to have had at least two admissions to hospital and had to suffer from a psychotic disorder. They were followed up closely over a two year period.

There few differences in risk factors for suicidal behaviour when those of Caribbean origin and British Whites were compared:

- 1) Important risk factors were psychotic symptom fluctuations and depressive symptoms.

Improving general psychiatric care to detect symptoms of depression in psychosis and ensure compliance with treatment may decrease suicidal behaviour in Black Caribbean people.

There was no data on deliberate self harm. National data on suicidal ideation offered a complex picture of risk factors for Black Caribbean people:

- 1) People of Caribbean origin are less likely to report suicidal ideation;
- 2) Within the group of people of Caribbean origin being divorced or separated increased the risk of suicidal ideation;
- 3) Suffering from a common mental disorder is not associated with an increased risk of suicidal ideation in Black Caribbean people, and
- 4) As may be expected those who are religious are less likely to report suicidal ideation.

Suicide and suicidal behaviour in people of African Origin

Because of the lack of ethnic identifiers on death certificates other than place of birth, no national population level data on suicide in people of African origin was available. No name recognition software was available to interrogate office of national statistics data sets.

The only national data available on suicide was in the group who had been in a contact with services in the preceding 12 months. There were a number of important findings:

- 1) Black Africans in general were not at higher risk of being in contact with services in the year before they committed suicide;
- 2) Black African men under the age of 25 are two and a half time more likely to be in contact with services in the year before they commit suicide than Whites;
- 3) Black African women between the ages of 25 and 39 are three times more likely to be in contact with services in the year before they commit suicide than Whites, and
- 4) Black African male inpatients are twice as likely to commit suicide compared to Whites.

There is an increased risk of suicide in sub-groups of Black Africans in contact with mental health services.

Other BME groups

There were very few data on other BME groups to exploit. This is either due to small numbers of other BME groups apart from the African, Caribbean and South Asians origin groups or due to the fact that other BME groups were specifically not sampled. Despite the report of high rates of suicide in those of Scottish origin living in England (mentioned in the literature review) no further data on this group was available. The Empiric data set did offer an Irish origin sample but analysis of this was unremarkable and yielded only the fact that Irish widows were at high risk of suicidal ideation.

Key Findings Part 3

Suicide prevention initiatives

The systematic literature review and secondary data analysis produced evidence of differences in the rates of suicide and deliberate self harm between BME populations in England. However, it was clear that more information would be needed in order to better define these differences, to investigate possible risk factors and to test possible interventions.

We undertook a number of expert consensus panels to help us try to outline what sorts of work maybe needed in the future. These works would be beyond the remit of the BME Suicide Prevention Project, and may require separate funding applications from suitably equipped consortia.

We undertook an initial expert panel of leaders in the field. This indicated that three main areas of activity needed to be developed:

- 1) Public awareness;
- 2) Training for front-line staff, and
- 3) Research and development.

The expert consensus panel offered examples of actions which could be undertaken in each of these areas. These actions were further developed by the BME Suicide Prevention Research Team. Having completed this task we then set up further expert consensus panels.

The aims of these panels were:

- 1) To discuss each of these topic areas in more detail and,
- 2) To see if a wider group of stakeholders with an interest in suicide prevention in BME groups agreed with the suggestions, whether they were workable and how they could be taken forward.

Staff training

The expert panel concluded that there was sufficient information from specialists in cross cultural mental health and from the suicide prevention project to develop teaching materials and training modules. These modules may help to improve the access to services and the assessment and treatment of those from the BME population who are in distress:

- 1) A broad range of staff including statutory, voluntary and community based agencies should be trained.
- 2) Training should be tiered. Three levels of training in cultural competence concerning suicide prevention should be available. The first would be a basic level suitable for all staff (such as policemen, youth workers etc), the second for those having more contact with those at risk (eg. A&E staff), and the third for specialists (e.g. mental health services).
- 3) Training should be available through a range of current in-service channels. Basic training should be part of induction and the other tiers linked to existing courses as additional module.
- 4) Training in BME suicide prevention should be a requirement for employment in the NHS and should form a part of core professional examinations.

Public awareness

An expert panel considered the concept of public awareness in BME populations. Three subgroups discussed prevention in different populations; those of Irish origin, those of South Asian origin and those of African and Caribbean origin. The shape of a public awareness campaign was similar to that which would be expected elsewhere:

- 1) Objectives - Change perceptions and raise awareness of suicide and mental health to overcome stigma of seeking help;
- 2) Actions – Engage with media – national, local and specialist minority to develop simple suicide prevention messages;
- 3) Agencies – governmental, community projects, faith groups, music stations;

- 4) Opportunities – infra structure of community groups and media outlets already exists;
- 5) Obstacles – initiative fatigue within communities, lack of co-ordination among community agencies, media engagement may be short term.

However, the way such a campaign would be deployed generated a model in which non- statutory organisations would be charged with developing local public awareness initiatives. The aim would be to make the message more accessible and bring it closer to local target groups. Rather than try to deploy central messages for diverse populations, a local coalition including statutory and non-statutory organisations but led by community groups would develop local messages through an iterative process and would deploy this through their own networks. The result would be targeted accessible public awareness as well as capacity building (community networks of groups interested in BME suicide prevention). Initial pilots were envisaged to test the model.

Comment:

Research and development

Despite the increased information available due to the suicide prevention project, the panels concluded that much more information on other groups was needed and precise and contemporary information in all groups.

The panels concluded that the evidence base would be better served by the reporting of ethnicity as well as place of birth on death certificates. Further work would be required on how to ensure this was done accurately or whether other types of health data linkages could afford the same outcome.

More innovative methods of ascertainment of ethnicity such as name recognition may be required in the meantime. The dearth of national data which could yield information on differences in risk factors for suicide by ethnic group and the lack of data on deliberate self harm by ethnic minority group is a cause for concern.

A long list of 14 research and development projects was produced by the panel and this was whittled down to three priorities with the potential for most impact:

- 1) With increasing rates of suicide in adolescent groups, quantitative and qualitative studies of risk factors for suicide and self harm and pathways to care in BME adolescents was considered important;
- 2) A number of hidden groups such as people of Irish origin, other white ethnic minority groups and Refugees and Asylum Seekers were a cause for concern, investigation of rates of suicide and risk factors for suicide in such groups was considered imperative; the use of more precise indicators of culture and ethnic origin would also provide more precise information about risks in sub-groups;
- 3) Young African and Caribbean origin men in contact with mental health services and African and Caribbean origin male in patients are at high risk of suicide. Given that they are accessible and therefore could be targets for suicide prevention more research on this group was considered a priority.

There was discussion about how research could be co-ordinated. The panel was of the view that there should be consideration of developing a centre for BME suicide research and prevention of suicide and deliberate self harm. This centre could be virtual but would be expected to pull together expertise in this area. It would be a means of focussing and co-ordinating both research and policy work. The idea of a centre reflected the need for more focussed and in depth qualitative and quantitative work on specific ethnic and cultural groups that would be needed to develop the evidence base on suicide prevention, it also could have a function of offering a continued service of secondary analysis of existing data sets. Linkage of existing with future data sets is also valuable and relatively cost effective as a means to developing the evidence base. Funding would be expected to be sought from a number of different bodies including the MRC, ESRC (project grants and fellowship applications) as well from the lottery with charity partners taking the lead.

Conclusions

The BME suicide prevention project has succeeded in summarising the literature, developing the evidence base, identifying possible avenues for future research and

outlining suggestions for targeted initiatives. The overwhelming message is that we need more information and better information if we are to be able to be confident that services are equitable and BME groups are benefiting from the success of the NSPS. Specific initiatives to improve public awareness, staff skills as well as research and development were proposed by stakeholders.

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Appendices of draft publications as separate documents: Appendix Number

Appendix to Part 1 Contains:

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|--|-----------|
| 1) Systematic review of BME suicide | 1A |
| 2) Systematic Review of BME DSH | 1B |
| 3) Systematic Review of BME suicide prevention in England | 1C |
| 4) Mapping of suicide prevention in England | 1D |

Appendix to Part 2 contains:

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| 5) EMPIRIC | 2A |
| 6) Fourth National Survey | 2B |
| 7) National Confidential Inquiry | 2C |
| 8) South Asian Suicides 1993-2003 using ONS mortality data
and name recognition software | 2D |
| 9) UK700 re-analysis | 2E |

Appendix to part 3 contains:

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|-----------------------------|-----------|
| 10) Consensus Panels | 3A |
|-----------------------------|-----------|