National Suicide Prevention Leadership Group

Suicide Prevention Action Plan
Action 7

RESEARCH

Experiences of Adversely Racialised People In Scotland Related to Suicide Ideation

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Summary and context

Scottish Government's National Suicide Prevention Action Plan – Every Life Matters. The plan was published in 2018 and has an ambitious goal of reducing the rate of suicide by 20% by 2022. The research reported is part of Action 7 of Every Life Matters plan.

Action 7 aims to identify and facilitate preventative actions targeted at risk groups of suicide. An initial phase of activities to support Action 7 was completed between December 2019 – October 2020. However, analysis of the engagement identified a number of gaps which found little involvement of people from minority ethnic communities, including migrant and refugee communities. This research has come about because of an "intervention" in the development of the Every Life matters plan to address this omission.

Therefore, this second phase of activities has been developed to ensure the perspectives of minority ethnic communities are included in the analysis of suicide risk groups within the development of the National Suicide Prevention Plan.

The COVID 19 pandemic has become an important "tool" to clarify the mechanisms and outcomes of systemic inequality not just in Scotland, the UK, USA, but globally. The experiences of those racialised by society and the injustice and impact of systemic, institutional and interpersonal racism has become clearer -at least for a moment- to those who do not experience it. There has been an outpouring of statements to support the #BLM movement and although often met with scepticism by those racialised, it does remain an unprecedented moment of global reflection on inequality and in particular on racialised inequity.

This research was undertaken during this time of insight and reflection. The people who participated are entrusting their thoughts and their reliving of traumatic experiences to support the ambition of the national strategy. We thank them all for their expertise, efforts and their trust.

Racism, immigration, mistrust of services and community stigma in relation to mental health, suicide ideation and completion were dominant issues and are the focus of much of the reported findings.

Participants wish to see the implementation of creative, solid, sustainable systemic processes. People, particularly young people who are the demographic change that has already happened in Scotland, want services which understand and respond to their needs as people who have migratory histories, people who face racism and live racialised within society.

Dr Ima Jackson and Judy Wasige

1 Introduction

This report is a presentation of the research commissioned by the Scottish Government to support the second phase of Action 7 of the National Suicide Prevention Action Plan. Action 7 seeks to identify and facilitate preventative actions targeted "at risk" groups. An initial phase of activities to support Action 7 was completed between December 2019 – October 2020.

Analysis from this initial phase of engagement identified a number of gaps in the work to date. One such gap was a lack of engagement with people from racialised communities, as well as migrant and refugee communities. This paper sets out work undertaken as part of Action 7, highlights the key insights identified and proposes next steps.

The report begins by setting the context within which the research was carried out, followed by the methodology. The findings are then presented.

2 Context

The initial phase of activities to support Action 7 was completed between December 2019 – October 2020. However, analysis of the engagement identified a number of gaps which found little involvement of people from minority ethnic communities, including migrant and refugee communities. Therefore, this second phase of activities has been developed to ensure the perspectives of ethnic minority communities are included in the analysis of suicide risk groups.

Scottish Association of Mental Health (SAMH) is responsible for the delivery of Action 7.

The Training Research Education and Engagement Management (TREEM) Consultancy was commissioned by SAMH to carry out the second phase of the research with ethnic minority communities.

TREEM are not experts in mental health. We are a collective of community engaged scholars and activists with a combined more than 30 years' experience of working with communities and individual people racialised in our policy and service provisions processes. Our main objective is to support racialised communities' perspective to become evidenced and incorporated into research and policy decision making.

Our wide experience of community engaged research and activism has built trust and extensive networks in diverse racialised groups in Scotland. Our research approach involves academics working with racialised communities and policy decision makers to explore a collaborative understanding of the challenges experienced by racialised groups, and to translate the findings into policy relevant solutions. This approach has been recognised and applied in key strategic organisations across sectors in Scotland to support the need for systems change.

TREEM recognises that the labels used by researchers and policy-makers often shape racialised groups' experiences in the community and in the work place (Bunglawala, 2019; Black British Academics, 2020; Aspinall, 2020; Aspinall, 2021) (Black British Academics, 2020). People are racialised differently at different times. However, irrespective of their experiences of racialisations, the experiences and outcomes of racialisation are largely similar.

We do not use the terms BAME or BME unless it has already been used in the reports and documents we cite from. Minority Ethnic people, people from minority ethnic backgrounds and people racialised has been used in this report. The ethics and politics within shifting terminology to categorise those racialised by society is complex. There is not capacity in this report to explore this issue, however we strongly suggest it should be formally engaged with for any future research and policy developing national strategies.

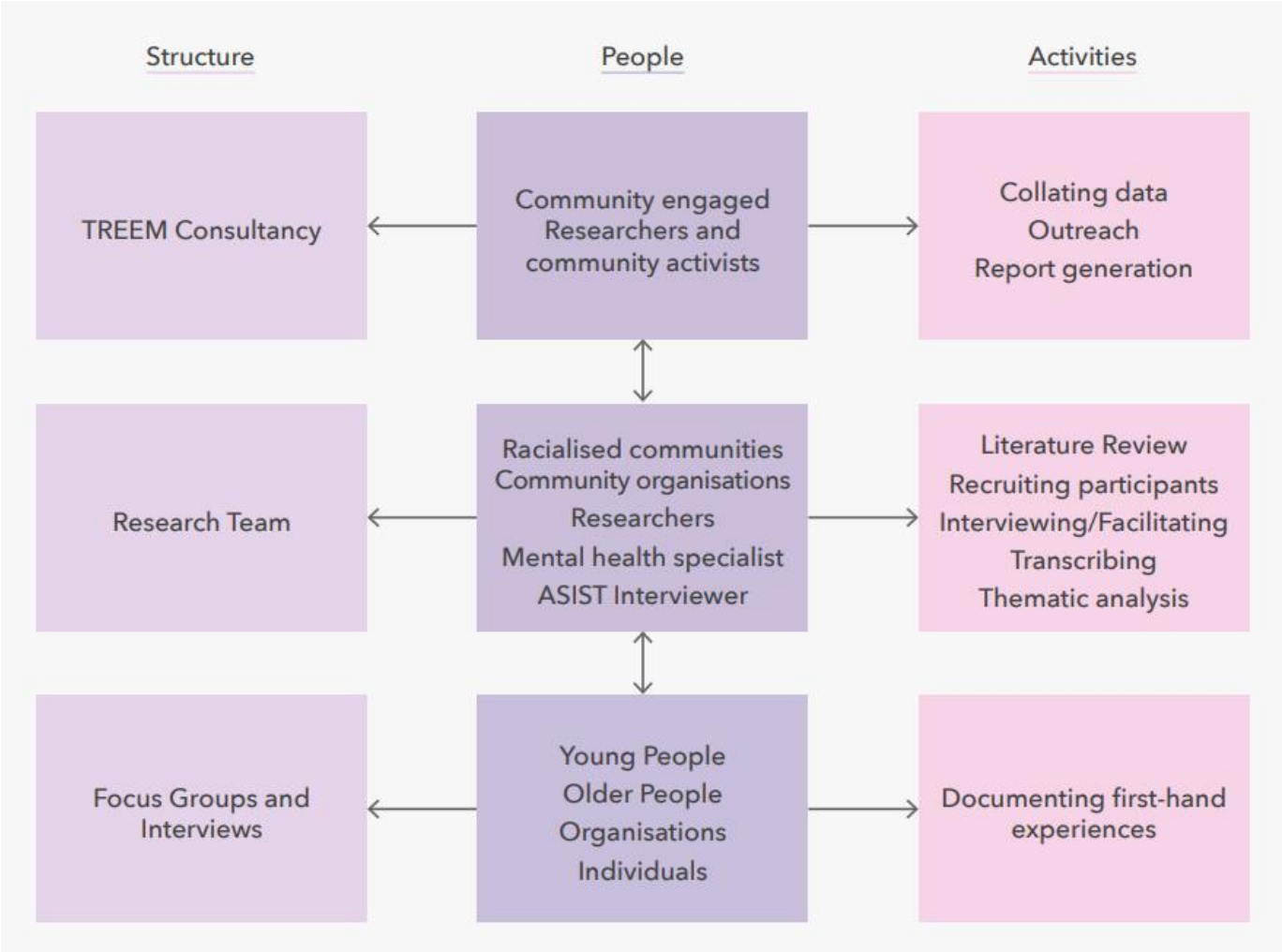
3 Methodology

The research was shaped and guided by TREEM as outlined in Figure 1 below. TREEM is composed of community engaged researchers and community activists with wide experience of working with racialised communities in Scotland.

In line with the specifications from SAMH, TREEM set out to recruit participants, collect the data and generate a report from the findings. The work began in January 2021 and the report was to be submitted by 31 May 2021. Due to this short time scale, it was important that all activities happened almost simultaneously, and critical that the people involved had the right skill-set and experience.

Using TREEM's networks, a core research team was set up. The team included a mental health professional and an interviewer who had successfully completed Applied Suicide Intervention Skills Training (ASIST).

Figure 1: Outline of Approach Taken in the Research



3.1 Literature review

A literature review was undertaken to inform implementation of the study (see Appendix 1). As stated previously, we are not mental health experts. The expertise of our work is with engagement with racialised communities. The literature review was to support our learning of the mental health landscape in Scotland as we undertook this piece of work.

A rapid review was also requested from the Scottish Government's National Suicide Prevention Leadership Group Academic Advisory Group, a specification of which is in Appendix 2. The request was for a literature search on suicide ideation in 'BAME' communities in Scotland and the UK in the last 10 years.

We approached the AAG to include the terminology - racism and racialisation, individual, institutional and systemic - in the search criteria in order to explore what has been evidenced in relation to risk and protective factors associated with suicidal thoughts and behaviours among the target group. However, as indicated by the AAG doing this was inconsequential as including these terms returned only the three publications outlined in Box 1 below and none of them in the context of the UK. As indicated by our literature review in Appendix 1, prevalent literature largely focuses on ethnicity and not racism as an analytical concept.

Given these results, it was agreed that the review keep its broad focus on risk and protective factors for suicide, suicidal thoughts and behaviours within BAME communities.

The rapid review had not been received by the time of writing this report.

Box 1
Publications on suicide ideation with racism and racialisation, individual, institutional and systemic included in search criteria

Bowden, M., McCoy, A., & Reavley, N. (2020). Suicidality and suicide prevention in culturally and linguistically diverse (CALD) communities: A systematic review. International Journal of Mental Health, 49(4), 293-320.

Hamilton, S. M., & Rolf, K. A. (2010). Suicide in adolescent American Indians: Preventative social work programs. Child and Adolescent Social Work Journal, 27(4), 283-290.

Christson Adedoyin, A., & Nicole Salter, S. (2013). Mainstreaming black churches into suicide prevention among adolescents: a literature review. Ethnicity and Inequalities in Health and Social Care, 6(2/3), 43–53. doi:10.1108/eihsc-10-2013-002.

(Scottish Government's National Suicide Prevention Leadership Group Academic Advisory Group, 2021)

3.2 Using Participatory Ethnographic Evaluation and Research (PEER)

From a methodological perspective this research was informed by Black feminist thought (Hill Collins, 2009), with Participatory Ethnographic Evaluation and Research (PEER) (Hawkins, et al., 2009; Heslop & Banda, 2013; O'Brien, et al., 2016; Elmusharaf, et al., 2017) methodology used for data collection and intersectional analysis for interpreting the data (Cho, et al., 2013; Hill Collins & Bilge, 2020). This orientation made both the research process and the research outcomes equally important in assessing the contribution of this work.

PEER is based on members of a community (PEER researchers) being trained to carry out in-depth conversational interviews with friends in their social networks. Building on the established relationships of trust between people who are socially networked, PEER is acknowledged to generate rich insights into the lived experiences in relation to the issues being researched. Thus, it is recognised to be highly effective in generating insights into sensitive issues in communities where stigma and marginalisation often makes traditional research methods difficult to implement. For example, it has been demonstrated to be effective in obtaining young people's perspectives on transitions from care to adulthood (Lushey & Munro, 2015). PEER has also been used successfully in Scotland to engage with communities potentially affected by Female Genital Mutilation (FGM) to inform the development of policy and the design of services (O'Brien, et al., 2016).

In this research, however, because the target participants were expected to have lived experiences related to suicide, it was a prerequisite for the interviewer to have successfully completed ASIST. Thus, the PEER approach was altered slightly; the interviews were carried out by an ASIST trained interviewer, with the support of someone socially connected with the interviewee.

TREEM also considered the ethical and process issues that might arise from this work. As SAMH had already made an exploration of these issues in the first phase and a framework agreed, we build on it by incorporating PEER ethics guidelines (Options, 2007) throughout the research process.

3.3 Multi-sited research sites capture intersecting issues

The literature review undertaken by TREEM (Appendix 1) emphasises that exploring the experiences of suicide ideation and attempts in racialised groups is incomplete without exploring the full diversity of the mental health experiences of racialised groups in Scotland. Furthermore, it suggests that effective suicide prevention in racialised groups cannot be addressed in isolation, but rather in conjunction with addressing the prevailing systemic issues that perpetuate unequal access to mental health services for racialised communities.

This research therefore acknowledged that ethnic minorities in Scotland experience multiple intersecting challenges, of which vulnerability to suicide ideation is potentially one of the outcomes. Hence, a multi-sited approach to data collection was sought in attempt to capture the interrelated and intergenerational issues impacting on the lives of people with experience of suicide ideation in these communities.

Intersectional analysis is founded on Black feminist thought which emphasises centring participants lived experiences in making sense of the interlocking systems of power that impact on those who are most marginalised in our society.

In this regard, data was collected from four sites: five one-to-one interviews were carried out, and focus group meetings held with young people and older people. The fourth site involved a group discussion with representatives from organisations that support people from ethnic minorities with mental health.

3.4 Participants

The study recognised the term 'ethnic minority' encompassed a wide range of communities with multiple diverse experiences. However, due to the short timescale, it was agreed that for effective capture of the

rich data, participants be drawn from TREEM's embeddedness in communities hence participants are largely from the African diaspora. The organisational focus group had representation which encompassed more diverse minority ethnic variation.

In addition, Appendix 1 signposts existing literature of research carried out in some 'ethnic minority communities' living in Scotland which can be used towards meeting Action 7's research objectives. For example, several studies on suicide ideation in Polish communities living in Scotland already exist (Gorman, et al., 2018; McArdle, 2018; Kopeć & Czarnecka, 2020).

Critically however, intersectional analysis emphasises that the day to day experiences of racialised communities are largely shaped by societal structures. Hence, irrespective of the diverse racialisations that the diverse ethnic minority communities might be subjected to, the experiences at personal level are largely similar. For example, this study's focus is an exploration of the risk of 'experiences of suicide'.

As defined by the Action 7 research framework, 'experience of suicide' in this research designates someone who has had thoughts of suicide; past suicide attempts; supported someone with thoughts of suicide; and/or bereavement by suicide. Due to the stigma surrounding mental health, careful consideration was made in framing the issue when approaching potential participants. It was agreed that interviewees had to be emotionally stable enough to participate in the research. This information was shared with all our contacts.

The study recognised that interview and focus group discussions were may cause upset and/or to "trigger" participants and arrangements were put in place to mitigate this. The participant information sheet shared contained information about support organisations to contact should this happen and useful activities/ techniques to help in the moment. For each interview and focus group a trusted person was on standby to "reach out" for support.

Initial exploration of how to get access to potential participants for this sensitive research was made through telephone conversations with TREEM's trusted networks – this was the most effective approach as the research took place during lockdown. Once links had been made with a potential participant, a researcher with experience of managing difficult conversations reached out to provide more information about the study and explore the possibilities for engagement. The best leads were made from community organisations already working with people from the African diaspora, especially those tackling mental health issues.

The participants involved in the research at the four sites were as follow.

3.4.1 Site 1 – One-to-one interviews (1-1)

Specifications from SAMH indicated that up to five individual interviews be held. The five interviews were carried over a two-week period, from 19 – 26 February 2021. Participants were mainly from second-generation migrant families who had schooled, gone to university in Scotland, and were in employment. Two of them had set up mental health community organisations to address the lack to access to information and culturally sensitive services. One was a parent of refugee background whose child had completed suicide and was keen to raise awareness about the issue.

3.4.2 Site 2 – Young Peoples' Focus Group (YPFG)

There was an overwhelming interest in the Young People's Focus Group (YPFG). Despite a request for up to 6 people aged 18 – 30 years to attend, fourteen turned up. Children and young people under the age of 18 years were excluded from the study due to the short time scale and the need to seek more rigorous ethical approval required for this group. The participants were generally second and third-generation immigrants from diverse backgrounds including refugees.

3.4.3 Site 3 – Organisations' Focus Group (OFG)

Representatives from ten organisations The Organisation Focus Group (OFG) included organisations that delivered mental health advocacy, education and awareness workshops for racialised communities, and one-to-one and group counselling. All organisations played a signposting/referral role, in which they referred clients to specialised mental health services.

The mental health support services were often combined with other key support services, including housing and employment support. The organisations emphasised that due to the intersecting challenges experienced by racialised communities, it was difficult to prioritise their mental health when there were key areas of day to day life that often required more urgent attention.

The organisations involved in the research were:

African Caribbean Society Scotland
African Caribbean Women's Association
Afro Caribbean Elders' Society
Baba Yangu Foundation
Jones&us
Hwupenyu African Health and Wellbeing Project
Information and Learning for All Project (ILFA Project)
Mental Health Foundation
Pachedu Health and Wellbeing
Waverley Care African Health Project

3.4.4 Site 4 – Elders' Focus Group (EFG)

The six participants in the Elders' Focus Group (EFG) generally ranged from forty years onwards with some having worked in Scotland for more than thirty years and retired. Most elders had experienced suicide ideation and completion through engagement with their grandchildren and teenage nieces and nephews who struggled to communicate their challenges and feelings.

3.5 Documenting first hand evidence

As the research happened during a lockdown period, the focus groups and interviews were an online video discussion using a Zoom platform. The framework for the conversations was set in phase 1 of the study, and focused on the following topics.

1. Participants' experience of suicide
2. Participants' experience of interventions/services that helped when they experienced suicide
3. Participants' experience of interventions/services that did not help when they experienced suicide
4. Things that participants believed would help people experiencing thoughts of suicide

The 1 -to-1 interviews were carried out by an ASIST interviewer with the support of a TREEM researcher socially linked with the interviewee. The interviews lasted about an hour each. The focus group discussion took up to 2 hours and were facilitated by a mental health professional. Both the interviewer and facilitator were of African descent, and the meetings were recorded.

3.5.1 Safe spaces

PEER ethical guidelines[1] and Black feminist thought (Hill Collins, 2009) both emphasise the need for safe spaces during research with marginalised groups, especially when the research focuses on sensitive issues like suicide ideation.

An important first step of PEER is to ensure a comfortable informal environment. An online video platform offered the informality of the venue in terms of participants being in their home environment.

Like with all research with vulnerable groups, it was recognised that participation may carry risks for participants and arrangements put in place to mitigate them. Firstly, it was identified that involvement in the research might trigger negative memories for participants. Provisions were made for access to support before, during and after the research - see Appendix 3 for the details. In addition, a mental health professional facilitated the focus groups and an ASIST interviewer the interviews. This was to ensure potential triggers were picked up and support sought timeously.

In addition, the literature review highlighted the stigma around mental health in racialised communities. This highlighted the potential risk of participants being inadvertently labelled and further marginalised in their communities because of participating in the research.

In depth knowledge by researchers of the community being researched was helpful in making the relevant arrangements to mitigate this risk. In particular, working with community organisations already working with the target group was helpful in both identifying participants who felt able to speak out, building their confidence regarding their personal information being safe with us.

In this regard, the potential risk of participants being identified for participating in the study was also identified, Participants were reassured that all data shared in the research would be anonymised such that it would not be traced to participants. This point is addressed in the data analysis below.

Issues of cultural sensitivity were highlighted by our literature review. Thus, the benefits for participants speaking to someone who looked like them were acknowledged. Hence, both the facilitator and interviewer were people of African descent, just like the participants themselves.

3.5.2 Managing expectations

Racialised communities are often bombarded with research requests, but often, the research results are not shared with the communities nor do they see much change as a result of the research. It is therefore important for the research objectives to be shared with the research target group upfront.

Most participants were happy that this research was bound to directly influence the Scottish Government's Every Life Matters Action Plan and keen to see change in policy for their communities.

3.5.3 Compensation for time and contribution

Participants in this research were offered a small honorarium.

3.6 Data analysis

The interviews were transcribed and thematic analysis carried out by different research team members. Transcribing the two-hour long focus group discussions was particularly challenging due to the multiple voices involved. All the data was anonymised during transcribing and data from each site conflated, such that all submissions made in the 1-to-1, YPFG, OFG and EFG, are treated as one entry, respectively.

[1] Ethics and the use of PEER

The findings from the research are presented in the next section.

4 Findings

4.1 Introduction

The following sections report from the focus groups and individual interviews which were undertaken to explore how individual racialised people and community organisations understood experiences related to suicide ideation and completion within the broader context of mental health.

4.1.1 A brief overview of the conversations

Similar to the general population, people spoke about the comorbidity of health illnesses as a factor contributing to poor mental health and suicide ideation. A few organisations supported clients who are living with a combination of HIV, Hepatitis, Diabetes and high blood pressure. The combination of medication that clients are on was reported to lead to the onset of their poor mental health. Some clients experienced a double burden, stigma in their communities for being HIV positive and having poor mental health, which may increase their propensity to suicide. There was discussion about mental health issues in conjunction with organisations who are providing support for key social issues related to employment, housing, education and poverty, disability, and adverse childhood experiences.

The increase in prevalence of drug and alcohol addiction during the COVID-19 pandemic was identified by some support organisations as a key factor to the worsening of mental ill health conditions and severity of suicide ideation in clients. And gender-based violence was discussed as a contributing factor for poor mental health and suicide ideation in some female clients who sought support. Some suggested that women's experiences were further compounded by the stigma against reporting cases of gender- based violence because this was frowned upon in some racialised communities. As a result, some female clients sought support when their mental health had worsened or after the onset of suicide ideation. These issues seem to reflect more general understanding of mental health.

However, beyond the areas outlined above there were four key themes, found through analysis of the data and discussed below.

Four key themes

1. Racism
2. Immigration
3. Mistrust of services
4. Stigma and lack of knowledge within racialised communities.

Each thematic area is discussed using direct quotes from the transcriptions to help us understand how each issue was expressed by those who spoke about them.

4.2 Racism a trigger and a constant presence

Racism is trauma and is the lived reality for racialised people and their communities in Scotland. There is interpersonal, institutional and systemic racism and each can impact in different ways at different times throughout people's lives (Stephanie, et al., 2016; Royal College of Psychiatrists, 2018; Nazroo, et al., 2020). It has taken generations of grassroots activism, research, scholarship and now a pandemic or as many understand it a syndemic for the local, national and global conversation to finally name and openly discuss racism and its impact on people's lives (Horton, 2020).

There is a growing body of evidence that demonstrates how racism leads to mental ill health, depression, prolonged grief and periods of adjustment, and difficulty processing traumatic events. Research highlights a strong association between racism and suicide ideation and attempts in racialised groups.

Engagement through the focus groups and individual interviews found that significant emphasis was placed by the participants who took part, on the effect of the racism they or their clients experienced and how it exacerbates their mental health illnesses that increased propensity towards suicide.

"And, it's just everything, like I think, it's just everything that triggers, me mentally. Like I get affected by, you know, racism, I get affected by... the justice system, the government, Africa, my family. You know, so it's like a whole build-up...." (participant 2)

The organisational focus group (OFG) reported how experiencing racism was very frequently mentioned as a key factor that perpetuated poor mental health and suicide ideation in client's from racialised communities. In particular experiencing racism at their workplace. Racism made their working environment hostile and toxic. Their client's reported feeling overwhelmed by trying to endure racist treatment alongside high workloads. As result, this leads to the onset of the poor mental health they experienced and often suicide ideation.

"I was not even outside of work, not even, they couldn't even wait for me to get to the car park or wherever but they actually did it in work, on-site. So, I'm like, yeah, those type of things just like bewildered me. It just- when you combine all of that like, you know, like yeah. It kind of leads you to know not wanting to live anymore, you know, because it wasn't just one incident. It's like a combination of so many things so many things. And then yeah, just boom. Then when that happened I just didn't want to live anymore. But [sigh] yeah, to be honest that's that." (1 to 1 participant 3)

The constant threat of racism and biological weathering it causes is openly discussed in the interviews and focus groups.

At a recent Glasgow Centre for Population Health (GCPH) seminar, Global scholar Professor David Williams presented to the Scottish Public Health landscape his 20 years of evidence about "How Racism Shapes Our Health". 1-1 participant 3 continues…

"And this starts to make me paranoid ... I had to leave that place. because that place wasn't, wasn't affecting me in the right way at all. It was just- was messing my head, you know, I started questioning, umm, my my non-black friends. You know, I start I start looking at them some type of way like differently like…. I'm like, are all white people like this"

Similarly, to the OFG racism was identified as a trigger of mental health distress and suicide ideation in the elders focus group (EFG). For instance, EFG participants who have supported their teenage nieces and nephews who have experienced suicidation or attempted suicide completion. Reported that one of the key factors influencing suicide ideation in this age group is peer pressure and racist bullying, especially at school.

4.2.1 Sense of belonging disrupted by racism

Racism played a key role in participants' feeling a lack of a sense of belonging coupled with what they felt was their inability to easily feel part of Scotland and Scottish culture.

"...When I was here, when I was in Scotland and went to school, I was the only black person so already like I was really suffering with identity. Because everybody around me didn't look like me, and didn't share experiences like me." ...I like the idea of being mixed race. It was two cultures and stuff. But I remember my mother warning me very early.... they're just going to see you as black and you're probably going to be treated as black so you have to be strong" (1-1 participant 5)

It is recognised that the social capital that normally accompanies an individual's sense of belonging, serves as protective factors that help individuals to manage stressful and traumatic events in their lives (Garner, 2012). Kwansah-Aidoo and Mapedzahama (2018) suggest that when individuals feel supported, they often cope more effectively with traumatic experiences. Furthermore, that one factor that influences an individual's sense of belonging is how similar or different they feel to others in their community.

Some spoke of how racism is the trigger to serious challenges to their sense of self and sense of belonging not only within their relationship to Scotland but with the disconnect living in Scotland created about their heritage.

"You know like, the problem is, I'm mixed so, even in Africa, I was discriminated against. I came here, I was a discriminate against, so that was also another factor is just like everywhere you go you're getting a beating. You're not allowed to be in this group, you know allowed to be in that group" (1-1 participant 5)

The lack of feeling a sense of belonging in Scotland, based on their race, family environment and social class was recognised by the participants as a factor that contributed to their mental health distress. Participants expressed being shamed and feeling embarrassed because they did not grow up in a traditional family structure with a mother and father in comparison to some of their peers. This, perpetuated feelings of anger, depression and not belonging.

The issue of loss of a family members and premature deaths is increasingly documented as a key issue in racialised people's lives (Umberson, 2017). For some participants, this compounded their depression and anxiety and resulted in them feeling lost and unsupported which led them to believe that suicide was their only option. For instance,

"as a child I was going through so much like I was going through immigration, I was going through racism, I was going through body image, I was going through daddy issues, everything like being even in a different environment because I left Africa where I had all my cousins around me for support, I had so many people around me, and I came here, and it's just me and my mom. And on top of that, my mom's not even available for me...I felt I didn't belong…". (1-1 participant 4)

4.3 Immigration – a destabilising experience in family life

Participants felt there is a lack of understanding or acknowledgement on the effect of racism in the immigration processes in the UK on the mental health of racialised groups. Participants mentioned experiencing the effects of racism through the experiences of their parents as they went through the immigration process as it was felt to affect their whole families' mental health. The immigration process can be stressful, financially exorbitant and complicated but it was more than that. Participants felt that seeing the racism their parents experienced going through this added to a sense of family vulnerability. The tense home environment affected the ability of their parents to be supportive when they were going through traumatic experiences. Thereby, leaving them to process their emotions and these events in a more harmful manner, through suicide completion or self-harm. It was a sense of lack of control and injustice and a feeling that these processes are not even scrutinised as a potential mental health stressor for their communities. A sense that there were no safeguards for racialised groups when going through immigration to prevent them from being victims of racism and discrimination.

"Like I'll put it in this way. immigration immigration immigration is a big issue. I found myself in a situation where anything I could have done for myself to live a good life. Has been taken away from me. From my coffee shop. How am I supposed to eat if I don't work? The system has deprived me, taken away my power to work. Taken away my power to study, took away everything from me. So, every effort I make to get better, there are barriers everywhere. No matter how hard we try…back in my country where I'm from... it wasn't good. I left that country for a purpose. And then I came here, I find myself in a very worst situation" (EFG participant)

Several participants within the EFG reported these feelings of hopelessness, powerlessness and defeat after engaging with immigration services.

The uncertainty of the immigration process and at times enforced economic inactivity has led to an onset in poor mental health that worsened and increased the elderly's propensity to suicide ideation and attempts at completion. There was no direct mention of the hostile environment evidenced through the Windrush scandal (Wardle & Obermuller, 2019; Gentleman, 2020; Hewitt, 2020) but it may be of relevance to the broader feelings of immigration uncertainty expressed by those in the EFG, despite having lived full lives in Scotland.

Most of the organisations in the OFG identified negative social factors influenced by immigration processes and status, as the primary factor that perpetuates poor mental health in racialised communities. As a result, participants in the OFG suggest that it is difficult to expect racialised communities to prioritise their mental health when there are key areas of day to day life that may require more urgent attention and this puts them at greater risk.

Participant 4 who had lost her son through completion of suicide said

"Especially for us, as people who've come here, your new you don't know your way around. You're still trying to find yourself, you're still trying and all- in all this you're trying to make sure that your family is fine. That they've settled okay, that they are, you know, independent responsible citizens. Yet, if this is what's coming up because you've trusted the system."

4.4 Mistrust of services

"You know, usually what happens, especially in the black community is that when somebody gets to crisis point, then they'll end up in an inpatient ward. And then it means that their only experience of services is being dragged into an inpatient ward, probably under some sort of order, they've been sectioned, you know. And then they don't have a great experience because they're still going into an area that they're underrepresented in, there's a lack- there's complete inequality in it, there's a lack of cultural understanding, religious understanding." (1-1 participant 5)

The first point of support when individuals makes suicide completion attempts are normally the NHS through the hospitals. As a result, people generally look to healthcare providers to provide them with guidance on pathways to care and support after their admission in hospital. However, most of the participants in the focus groups and interviews felt that they did not receive adequate support from healthcare providers. Especially once they were discharged from healthcare facilities.

"The first time I tried to commit suicide I just took pills and alcohol and ended up in hospital...I never received support from services...I just got one phone call from the hospital after and that was it…" (YPFG participant)

And another YPFG participant explained…

"All three times I have tried to take my own life, I did not get any support from health services…" (YPFG participant)

Similarly, participants who had been in the social care system from a young age stated receiving satisfactory mental health support from their carers who facilitated for them to get therapeutic support. However, once they were out of the social care system and living on their own all support stopped.

"...at 17 actually they gave me the flat I'm in now. And I feel like from then, soon as they gave me this flat, everything just kind of went, well, you're on your own. you need to deal. you're an adult now. your mental

health is yours. You need to deal with your depression and suicidal thoughts. You need to find a way…". (1-to-1 participant)

The lack of mental health support or guidance on how to access support from services was consistently mentioned by all participants. For people who did not have any support from personal social structures, they suggested this increased their propensity to suicide ideation and led to them having multiple attempts at suicide completion.

Participants who sought and gained support from therapists felt that these sessions were not always helpful and they were not provided with tools to overcome their challenges. Participants felt there was a lack of understanding of what they were going through or their varying backgrounds. The lack of cultural competence and understanding of the experiences of racialised groups posed an additional barrier to the mental health support participants received from counsellors/therapists. Furthermore, participants expressed the frustration of having to constantly explain their experiences as racialised people to their service providers, and felt that they were participating in research rather than being patients, and getting the help they desperately need.

"with the health professionals as well, they have to be sensitive to our culture, and not look at us as an experiment because the first time that I ever went for counselling, my counsellor was just like I'm going to use you for research. I was like wow, I was stunned…" (YPFG participant)

For participants who have experienced traumatic events, these encounters they suggested can result in them feeling re-victimised and vulnerable.

They also felt that individuals attempting suicide completion because their feelings of being unsupported are compounded by the notion that even mental health professionals would not understand their experiences. When accessing services, most participants wanted to see a counsellor, therapist, mental health expert who looked like them and who would be able to understand their culture, recognise and sympathise with their experiences.

"I do have Suicidal thoughts hundred percent. I'm not saying they've gone, they probably got worse since Covid, but I'm finding my own ways to, to deal with it because the route that I found to get support was medication…. having to talk to a therapist who, at a times like this …I think that therapist needs a therapist themselves." (1-1 participant 2)

Another concern emphasised by participants is the lack of alternative options of therapy offered to them besides medication. Participants mention often not receiving any other options besides medication that left them feeling worse off due to the negative side effects. They felt there was a need for mental health professionals to be educated on the pathways of mental health care for racialised patients and alternative therapies for patients in need and more diverse mental health work forces and cultural competency training (Memon, et al., 2016; Rethink Mental Illness, 2020).

Distrust of mental health as a system was frequently identified within the OFG as a factor that negatively affected client's help seeking behaviour.

"It comes from a history of not being able to, you know, trust the system, and rightfully so, because you know, there were experiments that were done, and they did focus on us people as black. You know, they were done with ill intention and all these things." (OFG participant)

This stance is well documented and increasingly recognised as a significant factor in health behaviours of racialised people (Anstiss & Ziaian, 2010; Robinson, et al., 2011; McConnell, 2017; Batelaan & Krystal, 2021)

The OFG also mentioned that the root cause of client's feelings of distrust towards mental health practitioners is due to the high number of mental health sectioning of racialised people and the over prescription of medication offered to this group. To avoid falling into either category clients often allow their mental ill health conditions to worsen which has they felt increased their propensity to suicide ideation.

This was felt to be compounded by a sense of a lack of cultural competence of mental health practitioners and GP's that may contribute to a reluctance in clients to seek support because of the lack of understanding of their cultural experiences, which is reflected in their inability to sympathise with the diverse realities of racialised groups. A few clients reported positive experiences with GP's and psychologists they were signposted to by organisations. Their positive experiences highlighted by clients was the ability of some GP's to take the time to get to the root cause of the mental health distress and suicide ideation they experienced. This allowed for clients to explore alternative treatment options besides medication, and fast tracked their waiting time to receive psychiatric support.

4.5 Lack of awareness of services for and by racialised communities

There was a general sense of a lack of awareness in racialised communities of mental health services and how to access them (BBC Scotland, 2018; Barnett et al, 2019). Participants suggest that this is one of the key factors that perpetuates the worsening of mental health conditions in racialised communities. As people feel helpless because they don't know where to get help. Resulting in them not acknowledging their mental health illnesses at all. Participants who did seek guidance on how to access mental health support from their GP, felt that even GP's are not aware of minority ethnic community organisations that patients can be referred to. This was an additional source of frustration for some participants that exacerbated their feelings of helplessness.

Some participants felt strongly that key mental health organisations do not make enough effort to engage with racialised communities to conduct mental health awareness campaigns or promote awareness/access to services because of communities' lack of knowledge.

"You know, and it's always like the mental health posters it's quite stereotypical and it's always someone with their head in their hands and they're like that, you know, "Are you struggling? Call this number", but it's always a white person that's in it. So, people always look at that and go on "Oh well, I'm not welcome there. I don't feel part of", and that was one of my biggest barriers of to getting into recovery" (1-1 participant 5)

This disconnect from the need to address service change because Scotland's demographics have changed is well documented in other sectors (Young, 2016; Arshad, 2016; Mohammed, 2020). Similarly, growing community mental health organisations reported a lack of support and willingness to collaborate on mental health initiatives by key mental health organisations when community organisations are still at a grassroots level.

"It's like they only want you when you're up there when you're known as an organisation but when you're still growing nobody really wants to know you." (OFG participant)

Participants from grassroots organisations felt that this lack of support and engagement by key third sector and public health sector organisations is a major contributor to the rising mental ill health and suicide rates in racialised communities. They suggested that collaboration with key organisations would increase the resources to ensure mental health initiatives in these communities have more reach and make a greater impact as a way of reducing negative mental health outcomes in racialised groups. This disconnect or lack of engagement with the reality of Scotland's changed demography was recognised as existing across the whole landscape of key statutory agencies (Hopkins, 2016; Lyle, 2016).

Well documented barriers to communication (Cleland, et al., 2012; Crowther & Lau, 2017; Martzoukou & Burnett, 2018) were identified as a factor that negatively affected client's help seeking behaviour. As many

clients from racialised communities are from countries where English is not their primary language. The inability to communicate comfortably with mental health practitioners results in clients choosing to endure worsening mental health conditions that may increase their propensity to suicide ideation.

4.5.1 Adverse experiences accessing mental health support

In the OFG it was explained that experiences of institutional racism in mental health services were consistently reported by clients. Clients reported feeling unwelcome and having rushed consultations at mental health facilities, a generalised approach and being prescribed high doses of medication irrespective of clients' attempts to express their reluctance of taking medication to treat their symptoms. Furthermore, clients reported to them that the severity of their mental health distress is not treated with a sense of urgency due to the stereotypes that racialised groups have high pain or distress tolerance. As a result, specialised treatment for clients from racialised communities is not felt or seen as prioritised and clients feel they are put on longer waiting lists in comparison to their white counterparts. One organisation reported that this is reflected in partner services that clients are referred for mental health and suicide support to. This organisation stated:

"Services are still kind of advising things like, black people have a higher threshold for pain than white people. That's still something that's being taught in the medical community, which is complete nonsense, you know and then they wonder why black women are having more complications and death through childbirth, it's because of pains not being taken seriously. So how do we expect our mental health to be taken seriously when we access these Services. When I look at addictions there's one Community Addiction Team that deals with BME. I've not seen one referral from them. Not once. In the two years I've been there, I have not seen one black person come in for a detox. When we looked at their 2019 number, it was 11,500 white people who were admitted for a detox, White Scottish people. But when it came down to BME people they say their services are targeted at, it was 36 people from the Asian Community, 9 from the Caribbean community, and 6 from the African Community…"

Similarly, an elder who sought support from a GP on behalf of her granddaughter at the initial stages of her mental health decline, before her first attempt at suicide completion reported receiving support that was dismissive and lacked a sense of urgency.

"So, I went with my granddaughter to the GP and she was more or less dismissed, you know, and told that there wasn't very much wrong with her and she was just maybe missing her friends. It took another three to four months before she was seen again…" (EFG participant)

A lack of support and follow up after suicide completion attempts was frequently reported amongst elders in the study. Most reported that their family members or themselves were discharged the next day and prescribed a lot of medication to deal with their conditions. This was concerning for elders whose family members attempted suicide completion by taking pills. Elders reported expressing an interest in alternative options out of fear that the large supply of pills would encourage more attempts. However, they were not provided any other options.

The elders shared concerns that the lack of support and care shown to individuals who already made attempts at suicide completion increased their propensity to more severe attempts. Due to the fact that in some cases individuals with severe mental health distress are desperate for support outside of their families. As a result, when they feel unsupported and not understood by experts who are supposed to be better positioned to support them. They feel hopeless and attempt suicide completion again, in more severe manners.

Another elder echoed the same concern as discussed in the OFG and stated that some GP's and mental health service providers promote an unfounded stereotype that racialised individuals have higher pain thresholds. This perpetuates a sense of a lack of urgency provided to racialised individuals even after they have made attempts at suicide completion.

"Well for me, all my attempts before, I spoke to a doctor, and it was just falling on deaf ears, you know. It is almost like I felt like I needed to convince the doctor, and then I began to doubt myself, like, maybe I am exaggerating. I was made to feel like I was attention-seeking, you know, even up until the third attempt. The doctor just says, it's okay, it's okay. We are taking care of it and nothing is done…"
(EFG participant)

An elder suggested that the more general lack of concern by mental health services for racialised people with mental health conditions is demonstrated through patients who have committed suicide completion while in mental health support facilities.

"this is a 23 year- old boy or man who committed suicide in hospital. What concerns me is that those who are in charge of the hospital and where he was actually...The nurses, doctors who were supposed to be taking care of this boy. I mean letting him go that far to just kill himself... So, I'm just concerned. I don't know whether most of the people there have experience with somebody with that mental state... individuals not being cared for... " (EFG participant)

4.6 Stigma

In addition to the systemic barriers to accessing mental health support that racialised groups face, the lack of knowledge and ease to be open about mental health illnesses and channels of accessing support within communities was seen as a significant problem. Researchers suggest this has resulted in the worsening of mental health conditions and an increased rate of suicide completion cases within racialised communities (Hamilton & Rolf, 2010; Adedoyin & Salter, 2013; Armstrong, 2019; Gunson, et al., 2019; Bowden, et al., 2020)

Some participants suggested that the lack of knowledge of mental health illnesses in racialised communities results in an inability in individuals to recognise symptoms of poor mental health.

"...first of all, I just didn't even have any education about mental health, you know, I just felt like, you know, this is life. It's hard but you push through because like that's what we're taught from a young age…" (1-1 participant 2)

Participants felt that this may lead to worsening mental health conditions and increases their propensity to suicide ideation and completion.

"...I just never took a moment to stop and actually observe what was even happening with me, what was going on with me...I didn't even know what mental health was until I went through my own mental health breakdown. (YPFG participant)

Another participant echoed the same feelings stating

"...racialised people often have no clue what is happening until they go through a mental health breakdown...".
(YPFG participant)

Participants also suggested that in racialised groups where there is more awareness of mental health illnesses some community members are not aware of mental health conditions like anxiety, depression, post traumatic disorder etc.

"some black communities only understand mental health to be schizophrenia and extreme cases of bipolar, many are not aware that there are many other mental health illnesses.". (EFG participant)

This lack of community knowledge of mental health illnesses was frequently mentioned within the OFG as a key barrier to reducing the burden of mental health illnesses in racialised communities. Stigma towards mental health illnesses was viewed as a persistent barrier to their clients' poor help seeking behaviour.

"… those are the challenges we have as a community to make sure that, you know, people understand that there's mental health issues mental health issues like any other illness. And, yes with our communities [it will be] hard work, it would take a while to make sure, I mean to, to make people realise that actually, it's an illness that can be treated like any other like a physical illness" (1-1 participant 4)

It was frequently reported in the OFG that clients typically sought mental health support when their conditions were more severe, which often increased their propensity to suicide ideation. They also mentioned that the age range of clients typically accessing services from organisations are 16 - 35. They suggested that this may be due to the mental health stigma in the older generation in racialised communities.

We tend to keep, we tend not to want to know, anything outside our surroundings, our cultures. And that affects, the way we are going to definitely erm access Services. Because if we don't if we don't openly, say issues, then who's going to know that you have issues? So, we, we can't, we need to be em, self-aware. We need to, you know, to make our community, em, aware, of issues for instance (1-1participant 4)

Among the OFG, it was suggested that clients from racialised communities seldom report that they are experiencing suicide ideation during their initial visit. Clients who have expressed experiencing suicide ideation are often reluctant to expand on their experiences or simply tell key personnel that they don't want to talk about it.

They agreed that most clients reported their experiences of suicide ideation to their GP's and that clients are mainly referred on for suicide prevention through their GP. However, in some cases clients are prescribed medication to cope with these experiences. According to the organisations, some racialised communities were more likely to engage in discussions if mental health was not the sole focus, due to stigma against mental health issues (Plaistow, et al., 2014) (Gary, 2005; Knifton, et al., 2010; Memon, et al., 2016; Linney, et al., 2020). Although it is not usual practice to include YouTube chat references in a research report, Trevor Noah[1], the popular US TV host of the Daily Show, recently released a piece discussing the issue of mental health, space and place for racialised people.

There was sense from some that the act of seeking help is in itself a racialised experience. That their own communities along with society's racial ideas of them may increase stigma.

"It is a stereotype that you must be a strong black woman. And it's not just them seeing you are a strong black woman, it's almost like behind it is that you must be, or you're less than. So, for that it was just, for me all that did was create walls, you know, and that stopped me from accessing help. Going and getting treatment things like that." (1-1 participant 5)

"You know, I feel like my white friends are more... errr, more open, to listen to it- to talk about it compared to my black friend. You know, once a once I try to open up to some of my friends, and they start making fun of me. "Aw you really. You are acting white"", and what they heck what does it mean? You know, I mean like yeah, this type of things. This type of stigma, those type of nonsense statements" (1-1 participant 3)

[1] Trevor Noah - Instagram Video

5 Conclusion

The preceding sections have outlined the issues and the process that was undertaken to engage with those who are racialised in Scotland. We were invited to undertake this work as it was recognised that the suicide prevention strategy had not managed through the usual consultation process to engage with racialised people. This work is to support strategies that develop.

Racism was only recognised as an urgent threat to health in November 2020 by the American Medical Association. This is significant, not only in how long it has taken which is likely an indicator of systemic racism itself, but what it actually means for the public health landscape and for our collective understanding of the social determinants of health more generally. There is no Scottish exceptionalism.

When engaging with people who are racialised in Scotland for this research it was found that racism permeates many aspects of their life and is understood as deeply affecting their mental health. The harm racism causes seems intensified because people and services who are there to support them do not seem to understand how racism functions in society and health. This seemed of particular significance when participants spoke of suicide. Intergenerational immigration experiences were also reported as a significant factor impacting on people's health and well-being, individually, families and communities.

Finally, it seems important to note that there was a sense that the learning needs for health services and for families and communities seemed somehow similar in relation to mental health, suicide ideation and completion and the factors which impact on those who are racialised within society.

"And in a population as a whole - yes, we as I know we are small, number in the community yes - but I think, the policies, have to start thinking, how they are going to include us not as an extra not as an equality issue. Otherwise, we are going to see, the impact of not reaching to us is going to be immense. In every way we need- they need to engage with us… they need to stop excluding us and putting us on the side and start accepting that we are there, we exist there's generations are coming up and they need to understand us" (1-1 participant 4)

In summary

This small piece of qualitative research, undertaken with care but also with some haste with people and community organisations who have first-hand experiences of providing, getting, wanting or losing support in relation to suicide prevention, ideation and completion. The report has outlined the context, the process and the issues which were evidenced through this research. Racism, immigration, mistrust of services and community stigma in relation to mental health, suicide ideation and completion were dominant issues and are the focus of much of what was reported.

The research team were not asked to formulate specific recommendations, it was asked to engage with and report from those who are racialised about their experiences in relation to suicide. However, it is clear that racism in all its forms is a key factor which is viewed by those who experience it as misunderstood and often not even seen by the systems of health support in Scotland. This reflects the current global conversation about systemic racism, how it operates in society and how living a racialised life in a predominately white society needs to be engaged with and understood in order to develop appropriate services. The need for the mental health workforce to reflect the people it serves is clearly expressed in the research and again reflects the wider global conversation highlighted during lockdown and expressed through #BlackLivesMatter. All the issues reported are already well documented and this fact and the current challenges for mental health are explored in expert detail by Kinouani (2021).

This work has been undertaken to support the strategic development of service and policy implementation. What is clear is that individual people in the communities and the small, often fragile, support organisations want the Scottish mental health landscape established NHS, third sector and well-

established supportive charity funders to engage with them and those they support in a more meaningful and centring way.

The conversation and knowledge of the experiences of those racialised in society has been changed by the global pandemic. A moment of understanding seemed to be shared. This work contributes to the spirit and ambition of that conversation and the channels for engagement are open if the Scottish Government wishes support to develop implementation strategies for mental health services.

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7 Appendices
7.1 Appendix 1 – Literature review

Exploring Suicide Ideation and Completion in Racialised Groups in Scotland

Introduction

Since 1990, Scotland has had a higher suicide completion rate in the UK overall (ScotPho, 2020). In August 2018, the Scottish Government published the national suicide prevention plan: Every Life Matters. The plan lists ten actions that partners in mental health and suicide prevention, leaders at local, regional, and national level must take to transform Scotland's response and perceptions towards suicide. Through the successful implementation of these ten actions, the plan sets to reduce the rate of suicide in Scotland by 20% by 2022. The plan adopts a multi-sectoral approach that extends beyond social care and healthcare agencies. By recognising the need for collective action to prevent deaths by suicide in the country.

To support the successful delivery of the plan the Scottish Government instituted the National Suicide Prevention Leadership Group (NSPLG) that oversees the plan's ten actions. This piece of work will support Action 7 of the plan. Action 7 seeks to identify and facilitate preventative actions targeted "at risk" groups. During the completion of initial activities under action 7, several gaps in engagement in the work to date were identified. One such gap was engaging and exploring the experiences of suicide ideation and completion in racialised groups. As a result, this piece of work seeks to explore the factors that influence the suicide ideation or attempts in racialised groups in Scotland. Summers (2018) reports that racialised groups in Scotland face unequal access to mental health services and lack specialised support. However, there is a lack of research on the mental health experiences in racialised groups, in Scotland. As a result, a furthermore objective of this work is to explore the appropriateness and perceived barriers to access of mental health services for racialised groups in Scotland.

Perceptions of Mental Health in Racialised Groups

Mental Health Stigma

Developing suicide prevention interventions, and exploring suicide ideation, attempts and completion in racialised groups. Is incomplete without understanding the perceptions of mental health held by this group. Stigma towards mental health illnesses remains a constant feature in some racialised groups (Knifton, 2012; Gunson et al, 2019). Whether it is mild cases of depression and anxiety or severe cases of schizophrenia and bipolar, and in the worst cases suicide. In some racialised groups, there are long standing beliefs that mental health illnesses are a taboo or perceived a concern for the western world (Gunson et al, 2019; Gervais et al, 2010). Some racialised groups believe that enduring tough or traumatic experiences are a sign of strength and resilience.

Anything less is considered weakness, and the onset of mental health illnesses are considered punishment for breaking spiritual or moral laws (Armstrong, 2019; Gervais et al, 2010).

Stigma towards mental ill health has created a reluctance in individuals from racialised groups to seek support to treat mental ill health symptoms (Memon et al, 2016). Dr Asif Khan, a GP in West Scotland, reported to BBC Scotland, that over a fifth of his workload is mental health related, and patients he supports from racialised groups always show an initial reluctance to seek mental health support. Once they have overcome their initial fears, they will describe their challenges by listing everything they are experiencing, like family stress, financial difficulties, housing stress etc, besides acknowledging that they may be experiencing symptoms of mental ill health (BBC Scotland, 2018).

Ethnic variations define what acceptable responses and coping mechanisms to mental health illnesses are for racialised groups. For some racialised groups, issues of mental ill health are ignored or perceived as a socially unacceptable topic of discussion. In instances where the topic is discussed, individuals with mental health illnesses are labelled “mad” or “crazy” or “psycho” (Memon et al, 2016; BBC Scotland, 2018). For example, a patient in Glasgow reported to BBC Scotland that she kept quiet about her mental health challenges because mental health issues are not spoken about or accepted in her community (BBC Scotland, 2018). Suggesting that discussing pertinent issues like suicide would be more difficult.

Mental health issues remain a least discussed topic in some racialised groups because the consequences of mental health stigmatisation extend beyond the individual and can affect an individual’s entire family Memon et al, 2016; Armstrong, 2019; Choo et al, 2017). For example, negative mental health framing that results from cultural myths asserting that mental ill health is a sign of bad luck. Result in individuals ignoring mental health distress. To prevent their social stigmatisation in their communities (Memon et al, 2016; Gervais et al, 2010).

Research suggests that Scotland’s current public education programmes have been slow to transform perceptions towards mental health in racialised groups (Brook, 2018). Owing to this research, improving mental health education and support has been one of the top priorities on the policy agenda of the Scottish Government and related agencies (See Me Scotland, 2020). With a key priority being to diversify the pathways for public mental health education and awareness. That ensures that programmes engage with “hard to reach” communities in the country, like racialised groups (Quinn and Knifton, 2014).

For example, the Scottish Mental Health Arts Festival (SMHAF), launched in 2017, that has been effective in engaging with diverse groups to challenge stigma towards mental health. The reach of these festivals has led to the Scottish Government, NHS boards and other mental health agencies incorporating these festivals as a central part of their mental health improvement strategies and anti-stigma campaigns, i.e. the SMHAF is a central part of the Scottish Government’s national anti-stigma “see me” campaign. However, to ensure transformative change, Turakhia and Combs (2017) suggest there is a need for the Scottish Government, NHS boards and other mental health agencies to prioritise co-producing mental health awareness campaigns and services with service users from racialised groups. Involving service users in the planning and implementation processes has the potential to improve mental health outcomes and service experiences for racialised groups.

Perceived Factors Driving Suicide Ideation or Completion in Racialised Groups

Socio-Cultural Factors

Intergenerational strife, marriage, sexism, cultural factors, domestic and substance abuse, and adverse experiences in the host country have been identified as key triggers of mental ill health in racialised groups (BBC Scotland, 2018). McLaughlin (2016) and Mental Health Foundation (2020) report that socio-cultural factors like gender-role expectations and domestic violence are key mental ill health triggers in South Asian communities. For example, research by Forte et al (2018), Bhui et al (2011) and Barnett et al (2019) reports high levels of anxiety and depression in South Asian individuals attributed to stressful family environments. While Rethink Mental Illness (2020) and Bamford et al (2020) suggests that risk factors like poor housing, homelessness and social deprivation perpetuate mental health illnesses and suicide ideation in African and Caribbean migrants.

Hate Crimes

Studies have suggested that there is an increased risk of mental ill health such as depression, anxiety and psychotic disorders in immigrants as compared to native individuals of a host country (Bamford et al, 2020). In Scotland, post migration stress and experiences of hate crimes are key triggers of mental ill health, self-harm, and suicide ideation and attempts in racialised groups (Hate Crime Scotland, 2020).

Racial crime was the most reported hate crime in Scotland, in 2019-20, accounting for 3,038 charges (BBC Scotland, 2020). With many more cases believed to go unreported. Hate crimes exacerbate mental health conditions in individuals and make it increasingly difficult for individuals to assimilate into Scottish society and live a high-quality life.

Hate Crime Scotland (2020), Penrice et al (2019) and Hall (2017) report that crimes motivated by discrimination and prejudice have damaging effects for survivors, their families, and communities. Feelings of anger, shame, mistrust, fearlessness, depression, and anxiety are all common effects experienced by survivors of hate crimes. These in turn may negatively impact on many areas of a survivor's life including education, employment, health, and relationships. For migrants without close family or friends in Scotland, experiencing hate crimes compound feelings of isolation, not belonging, or being accepted in society seem to perpetuate mental ill health and suicide ideation and attempts.

Racism

Racism is a trauma and an unpleasant and unfortunate reality of racialised groups in Scotland. Racialised individuals experience racism in society and through systems. There is a growing body of evidence that demonstrates that racism leads to mental ill health like severe depression, prolonged grief and periods of adjustment, and difficulty processing traumatic events (Kwato and Goodman, 2015). Research highlights a strong association between racism and suicide ideation and attempts in racialised groups.

Furthermore, the repeated experience of suicide and discrimination reduces an individual's ability to overcome suicidal behaviour (Mental Health Foundation, 2009).

Institutional racism in mental health organisations has been a growing concern in Scotland. For example, the inequalities seen in mental health service delivery provided to racialised groups. Institutional racism in mental health services is seen through the consistent pattern of unequal services and outcomes for racialised groups for decades (The Synergi Collaborative Centre, 2018; BBC SCotland, 2018). Demonstrated through greater involuntary detentions of racialised individuals made by unevidenced criteria, and harsher psychiatric diagnosis and treatment options in comparison to White counterparts (Barnett et al, 2019; BBC, 2019). The fear of racism that would be reflected in unequal mental health services is a real concern for racialised groups and has created a reluctance in these individuals seeking support.

In Scotland, mental health organisations like Saheliya, Mental Health Foundation Scotland, VOX, REACH, CRER, BEMIS, SAMH and Rethink Mental Health Illnesses are some of the organisations that have been vocal about the need to for the Scottish Government and mental health agencies to acknowledge the diverse factors experiences of racialised groups that increase an individual's propensity to mental ill health and suicide ideation. Furthermore, through mental health awareness campaigns, events and reports, these organisations have advocated for the need of specialised mental health services for racialised groups to be created.

Through desktop research of these organisations. REACH, Saheliya, Rethink Mental Health Illnesses and the Mental Health Foundation Scotland appear to be the only organisations that acknowledge racism as one of the key factors that lead to mental ill health in racialised groups. With REACH and the Mental Health Foundation Scotland being the only organisations that have published reports that expand on the effect of racism on the mental health of racialised groups (REACH, 2008; Mental Health Foundation, 2009). Suggesting that there is a need for all mental health organisations that aim to provide mental health support to racialised groups to fully explore the factors that result in mental ill health and suicide ideation or attempts for this group, like racism. Furthermore, this would suggest as racism may be experienced interpersonally and structurally, providing appropriate mental health support for racialised groups in Scotland is incomplete without exploring and addressing racism in mental health services.

REACH published a report titled Mental Health Issues amongst Muslim Women Residing in

South East Glasgow Community Health and Care Partnership Boundary: A Study of Their Beliefs, Knowledge and Service Access Issues in November 2008. The report has a brief section on racism and discrimination. In which it highlights that racism negatively effects the mental health and suicide behaviours of the individuals. Furthermore, it explores the experiences of racism the individuals have endured and highlights that racism has made the participants reluctant to seek mental health support (REACH, 2008).

The Mental Health Foundation published a report titled Model Values? Race, values, and models in mental health in 2009. The report repeatedly highlights the fact that racism negatively affects mental health of individuals and may negatively affect mental health diagnosis/treatment and various aspects of an individual's life (King et al, 2009). This suggests there is a need to further explore the association between racism and suicide ideation/ completion in racialised groups.

Migration

In recent years, the Scottish Government and mental health agencies have been concerned with exploring the health and mental health needs of racialised groups like asylum seekers, refugees and migrants in Scotland (Scottish Government, 2020; Mental Health Foundation, 2016). Research has highlighted mental ill health as a prevalent issue for refugees and asylum seekers in Scotland. Furthermore, research has identified worsening of mental health among refugees since arriving in the UK. With pre- and post-migration stress identified as one of the key factors of mental ill health among these groups (Mental Health Foundation, 2016; BBC, 2017).

Pre-migration experiences that some refugees and asylum seekers have endured like torture, various forms of violence and other traumatic events in their home counties have negatively impacted on their mental health. These issues are compounded by the asylum and refugee processes. Key stresses of the process are the uncertainty of an individual's case, enforced economic inactivity and dependency on charities or government for everyday needs while seeking asylum (Mental Health Foundation, 2016; ScotPHN, 2016). Often, an asylum seekers or refugees stress does not end there. Once an individual is granted leave to remain in the UK, they face additional barriers accessing employment due to ethnic variations. As a result, this compounds their feelings of insecurity and uncertainty, which increases the severity of their mental health illnesses and propensity to suicide (Mental Health Foundation, 2016).

Refugees and asylum seekers that are not granted leave to remain and do not appeal their cases are faced with deportation and held in deportation detention centres around the UK. Research by the BBC's Victoria Derbyshire programme found an unequal appeal process for racialised asylum seekers and refugees. In that the success of their appeal cases are dependent on which centre their application is lodged to. Some legal supervisors have expressed similar concerns by reporting that there could be numerous cases that have merit for success, but still each could have a different outcome depending on the location of the centre, cultural differences between applicant and decision makers, and based on different judges. The stress and uncertainty caused by these unjust processes compound mental health distress in asylum seekers and refugees and have the potential to lead to suicide ideation and attempts (BBC, 2017; Mental Health Foundation; 2016).

Research by Rubin (2020) states that according to the Home Office's policies, vulnerable individuals and survivors of torture and traumatic events should not otherwise be detained. Such as refugees or asylum seekers. Furthermore, following concerns about the high suicide rate in the UK detention centres and the detention of vulnerable individuals. The Home Office developed a new Adult at Risk policy for people held in detention under immigration. Rule 35 underpinning the policy intends to ensure that potential vulnerable individuals are examined by a medical practitioner and detention is maintained only if it is necessary. However, evidence suggests that many adult asylum seekers and refugees who had a rule 35 report were still detained and are classified as vulnerable adults across the UK's deportation detention sites. The stress of detention and pending deportation has worsened mental health conditions of detainees and increased their propensity to suicide ideation and attempts. It is reported that suicide attempts have

become more common in the UK deportation detention centres, with two attempts being recorded every day in 2018. 56% of which were committed by detainees who were classified as vulnerable adults (Rubin, 2020; The Guardian, 2018).

In Scotland organisations like the Mental Health Foundation Scotland, Saheliya, REACH and Rethink Mental Illness have focused on providing mental health support to asylum seekers, refugees and racialised migrants in other categories. These organisations have focused on creating awareness of the unequal immigration processes these groups face and the pre-migration adverse events these groups experience. For example, discrimination and racism experienced by migrants at immigration facilities or through immigration decisions. Furthermore, they have focused on improving health education campaigns to reduce mental health stigma in these groups and provide specialised mental health support for racialised individuals in need (Mental Health Foundation, 2020; Saheliya, 2020; REACH, 2020; Rethink Mental Health Illness, 2020). However, migration stress and challenges do not seem extensively explored by most mental health agencies that seek to support racialised groups. There seems a need, for organisations to acknowledge the effect of hostile immigration processes in the UK on the mental health of migrants, and how the worsening mental health conditions and propensity to suicide occurs because of these.

Housing and Homelessness

Housing issues and homelessness are identified as key factors of mental ill health in racialised groups (Mental Health Foundation, 2020). Although there is considerable diversity in the circumstances of racialised groups with regards to housing issues. The common housing problems include obtaining information about housing options and rights due to language needs, a lack of familiarity and access to the system and institutional discrimination (Anderson, 2019; The Migration Observatory, 2019). In Scotland, racialised groups are underrepresented in social housing and overrepresented in privately rented properties (Joseph Rowntree Foundation, 2020; Netto et al, 2011). However, these houses tend to be poor quality housing. There is a need for social housing agencies to be more representative in their lettings, to ensure that racialised individuals are not inadvertently or consciously disadvantaged in social housing allocations (Joseph Rowntree Foundation, 2020). This suggests a need to prioritise racialised groups in activities to improve access to quality housing. Evidence suggests that poor housing and various housing issues increase an individual's propensity to mental ill health (Anderson, 2019). Suggesting that housing stress has the potential to lead to suicide ideation and attempts.

Perceived Barriers to Accessing Mental Health Support for Racialised Groups

Cultural Competence

To implement effective suicide prevention strategies for racialised groups, it is important to explore the availability of appropriate mental health services and perceived barriers of access for this group. Access to appropriate mental health services for racialised groups in Scotland has been a cause for concern. Evidence suggests that racialised groups are less likely to obtain appropriate mental healthcare services in the country. Furthermore, fewer individuals from racialised groups are referred for specialised psychiatric services, and individuals who are referred tend to be over treated or sectioned under the Mental Health Act. (BBC Scotland, 2018; Barnett et al, 2019).

Adverse experiences with mental health services are consistently reported by racialised service users in Scotland (BBC Scotland, 2018). With the lack of cultural competence by services providers, considered a key barrier to accessing mental health services for racialised groups (Gunson et al, 2019; Memon et al, 2016). It seems a significant proportion of service providers have had limited ability to deliver mental health support that meets the social, cultural and language needs of patients from racialised groups. Evidence suggests that racialised individuals are reluctant to seek support from mental health specialists because they lack an understanding their cultural experiences, which is reflected in their inability to

sympathise with the diverse realities of racialised individuals (Memon et al, 2016; Choo et al, 2017). Thereby affecting the appropriateness of services provided to racialised groups.

Research suggests that the cultural competence of mental health service and practitioners may be one of the key factors that can improve mental health help-seeking behaviour in racialised groups (Royal College of Psychiatrists, 2020). Evidence suggests that racialised individuals are less likely to seek support for mental ill health at an early stage due to a lack of culturally appropriate services (Barnett et al, 2019; Memon et al, 2016). As a result, many individuals seek treatment much later, when their conditions are more severe. Worsening mental ill health conditions, compounded by additional daily stresses an individual may experience, increases an individual's propensity to suicide ideation and attempts (Choo et al, 2017).

The literature suggests it's imperative for mental health agencies to acknowledge that delivering culturally appropriate services extends beyond an organisation ensuring that their staff attends mandatory trainings on cultural competency in mental health. There seems an urgent need to for mental health organisations and related agencies to prioritise ensuring an ethnically diverse and representative workforce of psychologists and psychiatrists. The literature suggests an ethnically diverse workforce is imperative for improving the mental health help-seeking behaviour and overall experiences of mental health services for racialised groups in Scotland (York, 2020). Furthermore, it seems imperative for addressing the unequal clinical outcomes for racialised groups in the country (Haigh et al, 2014; York, 2020). A similar study in the field, conducted in the UK, reported that when accessing mental health services the majority of the study participants would prefer to see a practitioner of the same ethnicity, who would understand their culture and experiences (Memon et al, 2016). Therefore, suggesting that ensuring a diverse workforce to deliver suicide prevention interventions should be a key component of incoming strategies.

Communication and Responding to Patient Needs

Language is a common barrier to access for racialised groups. The inability of some individuals to communicate effectively with mental health practitioners prevents individuals from clearly articulating their challenges and could lead to misdiagnosis (Memon et al, 2016; Forte et al, 2018). Although interpreter services are better provided for in recent years and have helped with miscommunication. There is a lack of interpreters available to support the full body of patients with language needs, and practitioners need to be aware of the potential challenges for their use (Haigh et al, 2014; Ahmad and Tabassum, 2009). For example, Green et al (2007) suggests that patients are less likely to discuss their health challenges through an interpreter. Languages needs may result in individuals being reluctant to seek mental health services for those who have barriers in communication and may result in patients withdrawing from support facilities, mainly because patients feel they are not receiving their desired support (Memon et al, 2016; Forte et al, 2018).

Barriers to communication do not only arise from linguistic challenges of racialised groups. The perceived inability of practitioners to listen to the concerns of service users pose additional barriers to access of appropriate mental health services for racialised service users (Choo et al; 2017). For example, in the UK, it has been reported that when engaging with mental health practitioners racialised patients were often treated with a generalised approach and prescribed higher doses of medication, irrespective of the patients' attempts to express their reluctance of taking medication to treatment their symptoms and their desire to explore alternative therapies (Memon et al, 2016; Mind, 2020). Similarly, it has been suggested that racialised groups in Scotland are given unequal mental health support and harsher treatment options, that lead to worse mental health outcomes (BBC Scotland, 2018). Therefore implying that to avoid unfavourable outcomes, there is a need for targeted and person-centred mental health support to be provided for racialised groups.

Mental Health Sectioning

Evidence suggests that racialised mental health patients are at risk of being given harsher psychiatric diagnosis's and are more likely to be sectioned under the Mental Health Act (Barnett et al, 2019). Professor Sashi Sashidharan, a consultant psychiatrist in Scotland, reported to the BBC Scotland that racialised groups have the worst experiences with mental health services in Scotland. Furthermore, service providers either do not take the challenges of these groups seriously or section individuals and provide them with extreme forms of treatment (BBC Scotland, 2018).

Research suggests that patients from racialised groups are disproportionately at risk of involuntary psychiatric detention in the UK (Barnett et al, 2019). Studies in the field that assessed the effect of location as a predictor of involuntary psychiatric detention of racialised groups. Reported a significantly higher probability of involuntary psychiatric detentions of racialised individuals who are UK based in comparison to other countries (Ajnakina et al, 2017; Barnett al, 2019). In March 2019, black people were four times more likely than white people to be sectioned under the Mental Health Act in the UK (Scottish Government, 2019).

The main explanation for the high prevalence of involuntary sectioning in racialised groups is an increased prevalence of psychosis in these groups (Mann et al, 2014). While unevidenced explanations for involuntary psychiatric detentions are increased perceived risk of violence and demographic assumptions of racialised groups (i.e. greater drug use) (Pheobe et al, 2019). However, according to the Mental Health Act, psychosis alone is not a criterion for involuntary detention. Furthermore, using unevidenced assumptions to enforce involuntary psychiatric detention of individuals who could have benefited from more appropriate treatment options, results in worse mental health outcomes. Due to the trauma of sectioning or harsher treatments (Mind, 2020; Mann et al, 2014; Bignall et al, 2020). Suggesting that there is a need for further investigation into mental health consultations of racialised individuals that resulted in involuntary psychiatric detention.

These frequent adverse experiences of racialised groups with mental health services, has built distrust in the services for these groups, and created misconceptions in some racialised groups that seeking support from mental health services "will not result in recovery by could result in death" (Fanin, 2017). This results in individuals suffering in silence and presenting for mental health treatment late, when their cases are more severe (Bignall et al, 2020).

Due to the concerns that practitioners have the power, with the simple stroke of a pen, to decide whether an individual will be sectioned or receive appropriate treatment (Memon et al, 2016). For example, Fanin (2017) reports a case where a woman from a racialised group, in the UK, reported to the hospital to seek support for mental distress and suicidal thoughts she was experiencing. However, her case was not taken seriously, and instead she was sectioned which compounded the mental distress she experienced. Such cases may highlight deeper systemic issues and subconscious racial bias, that perpetuate unequal access to mental health services and unfavourable mental health outcomes for racialised groups.

To improve mental health help-seeking behaviour and implement effective suicide prevention strategies in racialised communitiesthe literature seems to indicate that mental health practitioners and agencies should begin to acknowledge the genuine and realistic fear of being sectioned or receiving harsher psychiatric treatment as a key barrier to access for racialised groups. Furthermore, to prioritise changing this narrative and building trust in racialised groups, through addressing the persistent systemic issues that result in unequal mental health services and mental health outcomes for this groups.

Data and Literature

Suicides are among the most preventable causes of death if the risk factors are identified early and appropriate interventions are applied promptly (Forte et al, 2018; NICE, 2012). One of the greatest

dangers is that of not recognising the “red flags” or treating the absence of traditional risk factor signs, as confirmation of the absence of the risk of a suicide ideation or possible attempt (Bhui et al, 2011; NICE, 2012). Research suggests that effective suicide prevention strategies targeted at racialised groups are those that are culturally informed and understand the ethnic variations of expressing mental distress (Choo et al, 2017; NICE, 2012). For example, Choo et al (2017), NICE (2017) and Forte et al (2018) suggest that while depressive symptoms may be a key risk indicator of suicide ideation and attempts for one ethnicity, sudden consistent social isolation may be a risk indicator for another. Suggesting that exploring the ethnic variation of expressing mental distress should be a focus of mental health agencies prior to designing and implementing suicide prevention interventions targeted at racialised groups.

In Scotland, the lack of systematic data on the use and experiences of mental health services by ethnicity prohibits mental health practitioners and agencies, health boards and the Scottish Government from understanding the true extent of barriers faced by racialised groups (Summers, 2018). Furthermore, it prevents these agencies from responding effectively and ensuring access to appropriate mental health services for racialised groups (Barnett et al, 2019). Similarly, there is a lack of systematic data on suicide by ethnicity. Although, personnel conducting inquests into suicide do not record ethnicity because they are not required to. Without this data to shed light on the true extent of the problem, it is difficult to ensure that responding agencies are implementing appropriate suicide prevention interventions targeted at racialised groups (Choo et al, 2017; NICE, 2012).

To date, extensive research on suicide and mental health in minority groups has not been conducted in Scotland. Research has focused mainly on exploring the mental health experiences and suicide in minority groups like the LGBT+ community and individuals with learning disabilities. It seems that there has been a lack of urgency to explore the mental health experiences and suicide of racialised minority groups in Scotland.

Although, grey literature from NGOs targeted at supporting racialised groups in Scotland, have been instrumental in creating awareness of the disparities in mental health services for racialised groups, there is a need for research to prioritise exploring the mental health experiences of racialised groups extensively. This could help to ensure that mental health interventions targeted at racialised groups are designed based on evidence-based research rather than generalised statistics.

Pathway to Mental Health Support

The pathways to suicide support appear to be unclear or poorly communicated to racialised groups, as far as general mental health support is concerned. The pathway for mental health support for racialised groups appears problematic. Evidence suggests that mental ill health in some racialised individuals are often ignored in primary care facilities. Furthermore, there is evidence that racialised individuals are afforded mental health care pathways that unnecessarily result in contact with the police (The Synergi Collaborative Centre, 2018). Research suggests that racialised groups are less likely to receive primary care management for mental health symptoms and more likely receive care through the criminal justice system. When patients are taken to the police due to a “perceived risk” of harm to themselves or others, an individual could have a longstanding personality disorder and have diagnoses that are influenced by racialised stereotypes (The Synergi Collaborative Centre, 2018). This pathway may have resulted in a high prevalence of involuntary detentions in racialised groups and worsening mental health conditions for affected individuals. Furthermore, these adverse experiences have negatively impacted mental health help-seeking behaviour in racialised groups (The Synergi Collaborative Centre, 2018; BBC, 2019; Barnett et al, 2019).

Generally, the first contact with mental health support services for racialised groups is through organisations that have community-based activities. For example, SAMH who engage with racialised communities in East Glasgow through their Community Strides project. That project seeks to support individuals from racialised communities to be included in their communities and receive adequate support for their mental health and physical health through the power of physical activity. REACH conducts

various projects that focus on engaging with racialised groups in communities around Scotland, to provide mental health support, community physical and mental outdoor activities, and holistic support for other aspects of an individual's lives. Similarly, Saheliya conducts an array of activities and provides mental health support to racialised groups. BEMIS provides multilingual and ethnic and religiously sensitive support for racialised groups in Scotland. Health In Mind provides various mental health support options for individuals in need, like peer support, guided self-help, counselling and many more.

After contact with these organisations, individuals are then referred to the NHS or other support facilities when further psychiatric care is required. As it pertains to suicide support, the aforementioned organisations have generalised information on suicide. This information focuses on creating awareness on the growing burden of suicide, educating individuals on how to best support individuals who may be showing suicidal behaviour, and providing a help directory and contact details of agencies individuals can seek support from. With SAMH providing the most extensive suicide help directory. However, there appears to be no specialised suicide support suicide targeted at racialised groups.

Conclusion

To ensure the successful delivery of the Scottish Government national suicide prevention plan: Every Life Matters. Action 7 of the plan focuses on identifying and facilitating preventable actions targeted at "at risk" groups in Scotland. This works was done in response to the gaps in knowledge on the experiences of suicide ideation and completion in racialised groups. One of the key "at risk" group the action plan aims to engage. This work emphasises that exploring the experiences of suicide ideation and attempts in racialised groups is incomplete without exploring the full diversity of the mental health experiences of racialised groups in Scotland. Furthermore, it finds that effective suicide prevention in racialised groups cannot be addressed in isolation, but rather in conjunction with addressing the prevailing systemic issues that perpetuate unequal access to mental health services for racialised communities, and recognition that experiencing racism itself is a kay factor. Moreover, this work emphasizes the need for mental health agencies and related practitioners to acknowledge that mental health help-seeking behaviour in racialised groups, is significantly influenced by the ethnic variations of service users and the interaction between services users and services providers. Therefore, ensuring cultural competence and sensitivity of staff, and an ethnically diverse mental health workforce could dramatically improve the appropriateness of mental health services.

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7.2 Appendix 2 – Rapid reviews proposal

Scottish Government's National Suicide Prevention Leadership Group
Academic Advisory Group
Proposals of Rapid Reviews to be delivered to Action 7's request

Rapid Review 1: Interventions to mitigate suicide risk among Scottish and UK veterans

1 Research question

What is the evidence on effective interventions to mitigate suicide risk among Scottish and UK veterans published in the past 10 years?

2 Methods

2.1 Search concepts

2.1.1 Concept #1: Suicidal behaviour/self-harm

suicide OR suicides OR "suicide attempt" OR "attempted suicide" OR parasuicide OR self-harm OR "self harm" OR "self injury" OR self-injury OR "self-injurious behavior" OR "self-injurious behaviour" OR "self injurious behavior" OR "self injurious behaviour"

2.1.2 Concept #2: Veterans.

veteran* OR military OR servicemen OR serviceman OR servicewomen OR servicewoman OR servicemember* OR navy OR naval OR army OR air force OR airforce OR soldier* OR marines OR marine corp OR "marine corps" OR corpsmen OR corpsman OR airmen OR airman OR "flight crew" OR sailor* OR submariner* OR reserves OR infantry* OR deployment* OR postdeployment* OR post deployment* OR war OR warfare OR warfighter* OR combat OR "armed conflict*" OR "active duty" OR armed OR defense OR security OR coastguard OR "Department* of Defense"

2.1.3 Concept #3: Intervention.

prevention OR preventative OR intervention OR treatment OR program OR programme OR control OR strategy OR management OR counseling OR counselling OR therapy OR psychotherapy OR "means safety" OR "means restriction" OR "safety planning" OR "safety plan" OR "crisis management"

2.1.4 Concept #4: Review.

"systematic review" OR meta-analysis OR "literature review" OR "review of literature" OR "scoping review" OR meta-synthesis OR "rapid review"

2.1.5 Concept #5: United Kingdom.

"united kingdom" OR uk OR britain OR british OR scotland OR scottish OR england OR english OR wales OR welsh OR "northern Ireland"

2.1.6 Concept #6: Scotland.

scotland OR scottish OR scots OR scot

2.2 Search strategies

Given the short timeframe for delivering this rapid review, we will adopt a set of search limits that will allow us to identify and retrieve the most relevant information in the shortest period.

2.2.1 Strategy 1 (Scotland only) = #1 AND #2 AND #3 AND #4 AND #6

- Limits 1: 2010-current; Search by titles.
- Limits 2: 2010-current; Search by title and abstracts.

2.2.2 Strategy 2 (UK) = #1 AND #2 AND #3 AND #4 AND #5

- Limits 1: 2010-current; Search by titles.
- Limits 2: 2010-current; Search by title and abstracts.

2.2.3 Strategy 3 (Any country) = #1 AND #2 AND #3 AND #4

- Limits 1: 2010-current; Search by titles.
- Limits 2: 2010-current; Search by title and abstracts.

2.2.4 Strategy 4 (No reviews, UK) = #1 AND #2 AND #3 AND #5

- Limits 1: 2010-current; Search by titles.
- Limits 2: 2010-current; Search by title and abstracts.

2.3 Databases

The employment of strategies will be hierarchical (from 1 to 4), depending on the amount of relevant evidence identified by each search. For example: Limits 2 of Strategy 1 will be only employed if Limits 1 of Strategy 1 does not convey the amount of relevant information necessary to respond the research question, and so on.2.3 Databases:

The following databases were searched: MEDLINE, EMBASE, PsycInfo, PsycArticles, CINAHL, and Web of Science (including Web of Science Core Collection, BIOSIS Citation Index, BIOSIS Previews, CABI: CAB Abstracts, Current Contents Connect, Data Citation Index, Derwent Innovations Index, KCI-Korean Journal Database, Russian Science Citation Index, SciELO Citation Index, Zoological Record).

Rapid Review 2: Risk and protective factors associated with suicidal thoughts and behaviours among Black, Asian, and Minority Ethnic (BAME) groups in Scotland and the UK

1 Research question

What is the evidence on specific risk and protective factors associated with suicidal thoughts and behaviours among Black, Asian, and Minority Ethnic (BAME) groups in Scotland and the UK published in the past 10 years?

2 Methods

2.1 Search concepts

2.1.1 Concept #1: Suicidal behaviour/self-harm.

suicide OR suicides OR “suicide attempt” OR “attempted suicide” OR parasuicide OR self-harm OR “self harm” OR “self injury” OR self-injury OR “self-injurious behavior” OR “self-injurious behaviour” OR “self injurious behavior” OR “self injurious behaviour”

2.1.2 Concept #2: BAME[1].

ethnicity OR ethnic OR black OR african OR "people of colour" OR "persons of colour" OR caribbean OR asian OR jewish OR indian OR begali OR pakistani OR arabs OR mixed-race OR "mixed heritage" OR multi-cultural OR cross cultural OR trans cultural OR transcultural OR muslin OR bame OR bme OR aame OR gypsy OR traveller OR roma

2.1.3 Concept #3: Review.

"systematic review" OR meta-analysis OR "literature review" OR "review of literature" OR "scoping review" OR meta-synthesis OR "rapid review"

2.1.4 Concept #4: United Kingdom

"united kingdom" OR uk OR britain OR british OR scotland OR scottish OR england OR english OR wales OR welsh OR "northern Ireland"

2.1.5 Concept #5: Scotland.

scotland OR scottish OR scots OR scot

2.2 Search strategies

Given the short timeframe for delivering this rapid review, we will adopt a set of search limits that will allow us to identify and retrieve the most relevant information in the shortest period.

2.2.1 Strategy 1 (Scotland only) = #1 AND #2 AND #3 AND #5

- Limits 1: 2010-current; Search by titles.
- Limits 2: 2010-current; Search by title and abstracts.

2.2.2 Strategy 2 (UK) = #1 AND #2 AND #3 AND #4

- Limits 1: 2010-current; Search by titles.
- Limits 2: 2010-current; Search by title and abstracts.

2.2.3 Strategy 3 (Any country) = #1 AND #2 AND #3

- Limits 1: 2010-current; Search by titles.
- Limits 2: 2010-current; Search by title and abstracts.

2.2.4 Strategy 4 (No reviews, UK) = #1 AND #2 AND #4

- Limits 1: 2010-current; Search by titles.
- Limits 2: 2010-current; Search by title and abstracts.

The employment of strategies will be hierarchical (from 1 to 4), depending on the amount of relevant evidence identified by each search. For example: Limits 2 of Strategy 1 will be only employed if Limits 1 of

[1] Most of the terms were extracted from Aspinall, P. J. (2020). Ethnic/racial terminology as a form of representation: a critical review of the lexicon of collective and specific terms in use in Britain. Genealogy, 4(3), 87.

Strategy 1 does not convey the amount of relevant information necessary to respond the research question, and so on.

2.3 Databases

The following databases were searched: MEDLINE, EMBASE, PsycInfo, PsycArticles, CINAHL, and Web of Science (including Web of Science Core Collection, BIOSIS Citation Index, BIOSIS Previews, CABI: CAB Abstracts, Current Contents Connect, Data Citation Index, Derwent Innovations Index, KCI-Korean Journal Database, Russian Science Citation Index, SciELO Citation Index, Zoological Record).

7.3 Appendix 3 – Participant information sheet individual interviews

Every Life Matters – National Suicide Prevention Action Plan

Action 7 – At Risk Groups: Participant Information

This information sheet will tell you more about this work and what you can expect by participating. The sheet also includes instructions for joining the online focus group and support information.

About the focus group
Thank you very much for agreeing to take part in the focus group. Your participation will help us develop a greater understanding of suicide risk and ultimately inform the design of actions to support groups at increased risk of suicide in Scotland.

This work is part of the Scottish Government's National Suicide Prevention Action Plan – Every Life Matters. The plan was published in 2018 and has an ambitious goal of reducing the rate of suicide by 20% by 2022. This focus group is part of Action 7 of the Every Life Matters plan. Action 7 aims to identify and facilitate preventative actions targeted at risk groups of suicide.

An initial phase of activities to support Action 7 was completed between December 2019 – October 2020. However, analysis of the engagement identified a number of gaps which found little involvement of people from minority ethnic communities, including migrant and refugee communities. Therefore, this second phase of activities has been developed to ensure the perspectives of minority ethnic communities are included in the analysis of suicide risk groups.

SAMH is responsible for the delivery of Action 7.

The Training Research Education and Engagement Management (TREEM) Consultancy has been commission by SAMH to carry out the second phase of the research with ethnic minority communities. Therefore, the Focus Group will be facilitated by TREEM Consultancy.

TREEM is a collective of community engaged scholars, and activists with a combined more than 30 years' experience of working with communities and individual people racialised in our policy and service provisions processes to support their perspective to become evidenced and incorporated into decision making.

If you have any questions or concerns, please get in touch with Ima (i.jackson@gcu.ac.uk) or Judy (judy.wasige@gcu.ac.uk / 07909878111).

What's involved?

- You will be asked to participate in an online group discussion with other people with experience of suicide. By experience of suicide we mean experience of thoughts of suicide; past suicide attempts; supporting someone with thoughts of suicide; and/or bereavement by suicide.
- Groups will be facilitated by someone who has had suicide prevention training.
- The following topics will be discussed:
- Your experience of suicide
- Your experience of interventions/services that helped when you experienced suicide
- Your experience of interventions/services that did not help when you experienced suicide
- Things that you believe would help people experiencing thoughts of suicide
- The discussion will last up to 2 hours and will be held through the online video platform Zoom.

What will happen to the information provided?

- All the information given to us will be strictly confidential. This means that answers given during the group discussion are private between individuals, us and the other people who attend the group discussion.
- Everyone who attends the group discussion will be asked to keep the conversations private.
- We will not ask anyone to disclose personal information that could be used to identify them.
- The only exception to this is if anyone divulges information during the discussion that indicates there is an immediate risk of serious harm. In that case we have a duty of care to pass this information on to appropriate authorities.
- All focus groups will be recorded; this will be transcribed to help with our analysis.
- Once the information has been written up, we will delete the recording.
- Only the project team will have access to the recording and the written transcript.
- We may use direct quotations from the group discussions in our final report, in which case these will be anonymised so that you cannot be identified.
- All information collected during this work will be stored and processed in strict accordance with data protection regulations. We will retain the recordings until the project is completed, but no longer than 12 months.

Focus group log in details

Due to the ongoing COVID-19 pandemic all focus groups will be held online on the video conferencing software Zoom. All meetings will be password protected.

- You will be emailed the log in details for the Zoom meeting. This will include a link to the Zoom meeting and a confirmation of the meeting time.
- To join the focus group: Click the link in the email at the time the meeting is due to start. This will automatically take you to the Zoom webpage (or app if you have this installed)
- The focus group facilitator will then accept you into the Zoom meeting
- You can join the Zoom meeting from a computer, tablet or smart phone

If you are having technical difficulties please call Judy Wasige on 07909878111

General tips

We recognise that talking about suicide and personal experiences can be challenging and potentially upsetting. Below are some tips to consider in advance and during the session.

- Prior to the session ensure you have a private space to take part in the focus group. This will ensure your confidentiality and that of the other participants.
- Prior to the session test your computer/tablet audio and video to ensure it is working ahead of the session.
- During the session please only share what you are comfortable with. There is no obligation to answer any questions you are not comfortable with.
- You can take a break from the focus group at any time. If you are leaving your screen for whatever reason please ensure you message the facilitator to let them know. At the start of the session the facilitator will explain how to do this through Zoom's message system.
- Consider setting some time aside after the session to relax or do something you enjoy. This could be a favourite TV programme, a chat with a friend or bubble bath.
- If you find the session upsetting or distressing please access the support services included in this information sheet below.

Support and Safeguarding

We hope taking part in the focus groups is a positive experience for you, but we are aware that it could be upsetting. If you need support please contact the national services below:

Breathing Space:

- Breathing Space is a free, confidential, phone service for anyone in Scotland over the age of 16 experiencing low mood, depression or anxiety.
- Opening hours:
- Weekdays: Monday to Thursday 6pm to 2am
- Weekends: Friday 6pm to Monday 6am
- Telephone: 0800 83 85 87
- Breathing Space is a free confidential service for people in Scotland. Open up when you're feeling down - phone 0800 83 85 87

Samaritans:

- Samaritans volunteers listen in confidence to anyone in any type of emotional distress, without judging or telling people what to do.
- Open 24hrs a day everyday
- Telephone: 116 123
- Email jo@samaritans.org. (response within 24 hours)
- https://www.samaritans.org/scotland/samaritans-in-scotland/

SAMH Information service:

- The SAMH Information Service provides information and support on mental health. Whether you're seeking support, are looking for more information for you or someone you love, or just want to have a chat about mental health, we're here.
- Open 9am-6pm, Monday to Friday (except Bank Holidays).
- Calls charged at local rates, charges from mobile telephones vary considerably.
- Telephone: 0344 800 0550
- https://www.samh.org.uk/informationservice

Shout

- Shout is volunteer-run and is the UK's first 24/7 crisis text service, free on all major mobile networks, for anyone in crisis anytime, anywhere.
- Open 24hrs a day
- Text: 85258
- Free, 24/7 mental health text support in the UK | Shout 85258 (giveusashout.org)

7.4 Appendix 4 – Project plan

Research time table

Milestone	December	January	February	March	April	May
Core team recruited	X					
Literature review		X				
Participants recruited		X	X			
Organisations recruited			X			
One-one interviews			X	X		
Transcribing			X	X		
Focus groups				X		
Thematic analysis					X	
Report writing					X	
Submit report/revisions					X	X

Interviews / Focus groups

Date	One-one interviews	Transcripts	Date	Focus groups	Transcripts
18/02	Practice interview	N/A	13/03 11:00	Young people	
19/02 10.00	Participant 1	Ready	23/03 11:00	General / adults	
19/02 12:00	Participant 2	Ready	16/03 11:00	Organisations	
23/02 11:00	Participant 3	Ready			
24/02 10:00	Participant 4				
26/02 11:00	Participant 5				
01/03 11:00	Participant 6				

Potential organisations – organisation invite emails sent on 19/02/2021

	Organisation
1	African Caribbean Society Scotland
2	African Caribbean Women's Organisation
3	Baba Yangu Foundation
4	Jones&us
5	Multi-Cultural Family Base
6	ILFA Project Sotland
7	Reach
8	Saheliya
9	Shakti
10	Waverley Care
11	Violence Reduction Unity – One Community Project
12	Mental Health Foundation

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