Ethnicity may influence signs of suicide risk

Research suggests possible cultural differences in expressing mental distress and symptoms, which could mean that traditional signals currently used by clinicians to assess suicide risk may not be indicative of the actual risk in certain populations.

**Overview:** Prevention of suicide is an international health priority but the most effective approaches to prevention may differ between different patient groups. Many people who die by suicide have a psychiatric disorder at the time of death, most commonly mood disorders, or alcohol or drug misuse.

In England, a person dies every 2 hours as a result of suicide. People in treatment with mental health providers represent the group at greatest risk, for which there will be one suicide in 1000 patients every year (While et al. 2012).

Suicide by burning is a rare method of choice, accounting for less than 2% of all suicides in England and the Americas. However, there are reports of high rates in some immigrant populations, particularly those of South Asian origin. If you would like to read more about this topic see: Bhui et al. 2007, Rockett et al. 2010, Husain et al. 2011, Cooper et al. 2010, Borrill et al. 2010, and Baldwin et al. 2009.

**Current advice:** There is no single approach to suicide prevention. It needs co-ordination and contributions from several areas including public services and organisations, academic researchers, voluntary groups, the private sector and individuals.

NICE has guidance on the long-term management of self harm, which recommends that health professionals prescribing drugs for associated mental health conditions for people who self-harm should take into account the toxicity of the prescribed drugs in overdose. When considering antidepressants, selective serotonin reuptake inhibitors (SSRIs) may be preferred because they are less toxic than other classes of antidepressants.

NICE also recommends that risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm, or to determine who should and should not be offered treatment, or who should be discharged.

**New evidence:** Two recent studies have examined the influence of ethnicity on suicide with regard to both suicide risk indicators and method of suicide.

Bhui et al. 2011, investigated the influence of ethnicity on suicide and related risk indicators, including psychiatric symptoms, among patients committing suicide while admitted to psychiatric hospitals. They analysed national suicide data on the 4 largest ethnic groups in England and Wales: black Caribbean, black African, South Asian (Indian, Pakistani, and Bangladeshi), and a white British comparison group between 1996 and 2001 (Bhui et al. 2011).

Results showed that classical suicide risk indicators such as suicidal ideas, depressive symptoms, emotional distress, and hopelessness were significantly more common among white British inpatients than other ethnic groups, suggesting possible cultural differences in expressing mental distress and symptoms.
Male inpatients from black African backgrounds had a higher risk of completed suicide as an inpatient than white British males. However, suicides among inpatients were less common among black Caribbean and South Asian women compared with white British women.

A second study looked specifically at suicide by burning in England and Wales, in the general population and in people of South Asian origin (Tuck et al. 2011).

A cross-sectional secondary analysis was undertaken of all deaths recorded as suicide by the Office for National Statistics for England and Wales between 1993 and 2003. There were 55,140 identified suicides, of which 1455 were individuals of South Asian origin. The ratio of male to female suicides was 3:1.

Suicide by burning accounted for 1.77% (978 cases). However, in the South Asian population this rose to 8.45%, and the results showed a significant association between being born outside the UK and increased likelihood of suicide by burning.

There were no significant associations between religion and suicide by burning, and there was no increase or decrease in suicides by burning during this time period.

The researchers suggest that health and social care staff encountering burns in the South Asian population might ensure a suicide risk assessment, and carry out an assessment and treatment for psychiatric problems if present.

**Commentary:** "Suicides are among the most 'preventable' causes of death -- if the signs are picked up and a suitable intervention applied. The government has announced a refreshed national suicide prevention strategy, building on that announced in 2002 (Department of Health 2002). It recognises that a substantial flaw in current practice is lack of evidence about how diversity in the population affects patterns of suicide and the necessary responses. Consequently the Department of Health policy research programme has called for research proposals to address this evidence gap. These two papers provide a useful start to the process, by highlighting the differences in patterns found in certain ethnic groups.

"The greatest danger, probably, is that of 'clinician bias' -- of not recognising so-called 'red flag' signals, or of treating the absence of 'traditional' signs as evidence of absence of risk -- when in fact for different groups, different red flags might exist. Only by a more open awareness of the values and stresses affecting members of diverse communities can such personal tragedies be averted -- and the costs involved either in treatment of 'unsuccessful' attempts or care of those affected by deaths as well as the personal losses and waste of human life. The lesson of these two papers taken together is that all involved in providing healthcare must be alert to the possibility that people may think and act differently, and self-harm or suicide may not be predicted by the behaviours one has relied on in the past with others." – Mark R D Johnson, Professor of Diversity in Health and Social Care, Mary Seacole Research Centre/De Montfort University.

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