

SUICIDE IN OLDER BLACK AND MINORITY ETHNIC PEOPLE: A CAUSE FOR CONCERN

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The reference to ethnicity in the 2012 National Suicide Prevention Strategy for England (1) is mainly with regard to promoting mental health in Black and Minority Ethnic (BME) groups. However, there is little detailed information about any specific strategy to reduce suicide rates in BME groups. The Suicide Prevention Strategy and Action Plan for Northern Ireland has only one brief reference relative to BME groups: “to ensure appropriate support services reach out to all marginalised and disadvantaged groups” (2). There is no reference to BME groups in either the Scottish or the Welsh National Suicide Action Plans (3, 4). This lack of reference to BME groups in the United Kingdom (UK) suicide prevention strategies may have been due to paucity of epidemiological data on suicide in BME groups at the time the action plans were developed. Only six studies have examined suicides in older people from Black and Minority Ethnic (BME groups) in the United Kingdom (UK) (5-10). They have examined age-associated trends (5,6,10) and trends over time (7), compared suicide rates with those born in England and Wales (5,6,7,9,10) and also compared with those in the country of origin (9), and the methods of suicide (9).

Demographic trends

The proportion of elderly people (those aged 65 years and over) in BME groups in England and Wales has progressively increased over the last four decades and reached 8.2% in the 2001 population census (11,12). The total number of elderly people from all BME groups combined in the 2001 population census was 531, 909. This is likely to be even higher in the 2011 census, when the findings become available.

Suicide rates and methods of suicide

Traditionally, suicide rates were reported to increase with ageing (13). However, in the UK, suicide rates in elderly men and women have fallen in the last decade, so that the highest rates are now in the 15-44 year age group for men and 45-74 year age group for women (14). A recent cross-national study reported that there was a significant increase in suicide rates with ageing in males and females in 25 and 27 of the 62 studies' countries respectively (15). Previously, suicide rates were

reported not to increase with ageing among those originating from the Indian sub-continent in England and Wales and that suicide rates were low among older people in this group (5); this study had examined data on suicides over three decades old. It also reported low suicide rates in Muslims in keeping with the literature (16). More recently, suicide rates were reported to increase with ageing in an amalgamated group of Asian females in London (6). Moreover, in a recent study covering the years between 2001 and 2005, suicide rates increased with ageing among male migrants in England and Wales from the Indian sub-continent and female migrants from Africa and China (10). Suicide rates increased among older women originating from the Indian sub-continent between 1993 and 2003 (7).

There were wide variations in the standardised mortality ratios (SMRs) when suicide rates in older people from different BME groups in England and Wales were compared to those born in England and Wales (10). Overall, SMRs for suicide were generally higher in older males born in Western and Eastern Europe, Australasia and the Caribbean, and in older females born in the Caribbean, Africa and China (10). Suicide rates were higher in males aged 75+ years from most migrant groups compared to those born in England and Wales (9).

A study examining the methods of suicide used by older people from all BME groups combined in England and Wales observed that: hanging, poisoning by drugs, and drowning were the most frequent methods of suicide in older people from BME groups (8). However, methods of suicide used by older people from BME groups were generally similar to those used by 'indigenous'¹ older people (9).

Depression

The two most common mental disorders in old age are dementia and depression. The prevalence of depression in a population-based study in Bradford of older people from the Indian sub-continent was 20% (17). The prevalence of depression in a population-based study in Liverpool of older people from black African, black Caribbean, Chinese and Asian groups was 19%, 16%, 13% and 15% respectively (18). The prevalence of depression in a population-based study in Islington of older people born in the UK, Ireland, Cyprus, and Africa and the Caribbean was 18%, 16.5%, 28% and 14% respectively (19). Although the prevalence of depression was

¹ The term 'indigenous' refers to the majority White British population, as it relates to ethnic group categories for data collected in the UK. However, it is recognised that this group is itself diverse and any term used risks being controversial.

not measured, depression scores were not significantly different between Gujarati and 'indigenous' older people in Leicester (20). The prevalence of depression in convenience samples of older Bengalis and Somalis in east London was higher than in older white British individuals (21-23), but lower in a convenience sample of older Gujaratis compared with white British individuals in north London (22-24). The observed prevalence of depression among BME older people is variable, but, in general, is similar to or higher than that among 'indigenous' older people (25). A recent study estimated the absolute number of cases of depression among BME older people to be between 33,559 and 52,980 (26). Given that up to 90% of elderly suicide victims are reported to have depression (13), depression is likely to also be an important risk factor for suicide in older people from BME groups.

Conclusions and ways forward

There is evidence in the UK that: suicide rates are higher in older people from some BME groups than in 'indigenous' older people, and may increase with age. The evidence from the admittedly sparse literature suggests that suicide in older BME individuals is likely to become an important public health concern, not least because of demographic population changes and the observation that depression is common in older people from several BME groups. There is, therefore, a need to develop action plans to reduce suicides in older people from different BME groups and incorporate them into the suicide prevention strategies of all UK jurisdictions. Action plans should address the need for further epidemiological research to inform the evolution of prevention strategies, and the identification of high risk BME groups and individuals within these groups, in order to enable appropriate management. The suicide strategy should emphasize that BME groups are heterogeneous and that public health, mental health, primary care and social care professionals should be made aware of this heterogeneity and the cultural and religious differences across different BME groups. The presentation and clinical features of depression vary in different BME groups and are different from older 'indigenous' people (20, 27). The identification and treatment of depression in older people from BME groups at higher risk of suicide should be a priority. Training of primary care, mental health and social care staff in the varying presentations and clinical features of depression in older people from different BME groups will facilitate this. Models for such training to enable culturally sensitive and appropriate identification and treatment of depression have been developed (28,29). This should be coupled with careful consideration of factors related to migration, degree of assimilation and acculturation, fluency in English, religion and culture. These factors may be important in the development of depression among first generation migrants. Little is known about suicide in

second generation BME older people as they are only now beginning to reach old age.

REFERENCES

1. Department of Health. Preventing Suicide in England. A Cross Government Outcomes Strategy to Save Lives. London, (www.dh.gov.uk/government/uploads/system/uploads/attachment_data/file/156153/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf.pdf). 2012
2. Department of Health, Social Services and Public Safety. Protect Life. A Shared Vision. The Northern Ireland Suicide Prevention Strategy and Action Plan 2006-2011. (www.dhsspsni.gov.uk/phnisuicidepreventionstrategy_action_plan_3.pdf). 2006.
3. Scottish Executive. Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland. (www.chooselife.net/home/Home.asp). 2002.
4. Welsh Assembly Government. A National Action Plan to Reduce Suicide and Self-harm in Wales 2008-2013. (www.new.wales.gov.uk/consultations/healthsocialcare/talktome/?lang=en) 2008.
5. Raleigh VS, Bulusu L, Balarajan R. Suicides among immigrants from the Indian subcontinent. British Journal of Psychiatry. 1990; 156: 46-50.
6. Neeleman J, Mak V, Wessely S. Suicide by age, ethnic group, coroner's verdict and country of birth. A three-year survey in inner London. British Journal of Psychiatry. 1997; 181: 463-467.
7. McKenzie K, Bhui K, Nanchahal K, Blizard B. Suicide rates in people of South Asian origin in England and Wales: 1993-2003. British Journal of Psychiatry. 2008; 193: 406-409.
8. Dennis MS, Shah AK, Lindsay J. Methods of elderly suicides in England and Wales by country of birth groupings. International Journal of Geriatric Psychiatry. 2009; 24: 1311-1313.
9. Shah AK, Dennis M, Lindsay J. Comparison of elderly suicide rates amongst migrants in England and Wales with their country of origin. International Journal of Geriatric Psychiatry. 2009; 24: 292-299.
10. Shah AK, Dennis M, Lindsay J. Suicides by country of birth groupings in England and Wales: Age-associated trends and standardised mortality ratios. Social Psychiatry and Psychiatric Epidemiology. In Press.
11. Shah AK, Oommen G, Wuntakal B. Cultural aspects of dementia. Psychiatry. 2005; 4: 103-106
12. Shah AK. Demographic changes among ethnic minority elders in England and Wales. Implications for development and delivery of old age psychiatry services. International Journal of Migration, Health and Social Care. 2007; 3: 22-32.
13. Shah AK, De T. Suicide and the elderly. International Journal of Psychiatry in Clinical Practice. 1998; 2: 3-17.
14. National Statistics Online. Suicides: UK Suicides Increase in 2008. (www.statistics.gov.uk/CCI/nugget.asp?ID=1092&Pos=6&ColRank=2&Rank=1000). Accessed 19/03/2010. 2010.
15. Shah AK. The relationship between suicide rate and age: an analysis of multinational data from the World Health Organisation. International Psychogeriatrics. 2007; 19: 1141-1152.
16. Shah AK, Chandia M. The relationship between suicide and Islam: a cross-national study. Journal of Injury and Violence Research. (<http://jivresearch.org/jivr/index.php/jivr/article/view/60>). 2010.

17. Bhatnagar K S, Frank J. Psychiatric disorders in elderly from the Indian subcontinent living in Bradford. *International Journal of Geriatric Psychiatry*. 1997; 12; 907-912.
18. McCracken CFM, Boneham MA, Copeland JRM. *et al.* Prevalence of dementia and depression among elderly people in black and ethnic groups. *British Journal of Psychiatry*. 1997; 171; 269-273.
19. Livingston G, Leavey G, Kitchen G, et al. Mental health of migrant elders - the Islington study. *British Journal of Psychiatry*. 2001; 179: 361-366.
20. Lindsay J, Jagger C, Hibbert MJ, Peet SM, Moledina F. Knowledge, uptake and availability of health and social services among Asian Gujarati and white elders. *Ethnicity & Health*. 1997; 2; 59-69.
21. Silveira E, Ebrahim S. Mental Health and health status of elderly Bengalis and Somalis in London. *Age & Ageing*. 1995; 24; 474-480.
22. Silveria E, Ebrahim S. Social determinants of psychiatric morbidity and well-being in immigrant elders and whites in east London. *International Journal of Geriatric Psychiatry*. 1998; 13; 801-812.
23. Silveria E, Ebrahim S. A comparison of mental health among minority ethnic elders and whites in east and north London. *Age & Ageing*. 1998; 27; 375-383.
24. Ebrahim S, Patel N, Coats M, Greig C, Gilley J, Bangham C, Stacey S. Prevalence and severity of morbidity among Gujarati Asian elders: a controlled comparison. *Family Practice*. 1991; 8; 57-62.
25. Shah AK. Psychiatry of Old Age and ethnic minority older people. *Reviews in Clinical Gerontology*. 2009; 19: 119-134.
26. Shah A. Estimating the absolute number of cases of dementia and depression in the black and minority ethnic elderly population in the UK. *International Journal of Migration and Health and Social Care*. 2008; 4: 4-15.
27. Shah AK. Can the recognition of clinical features of mental illness at clinical presentation in ethnic elders be improved? *International Journal of Geriatric Psychiatry*. 2007; 22: 277-282.
28. Shah AK. Elders and Carers Guide . PRIAE-ISCRl Managing Better Mental Health Care for Black and Minority Ethnic Elders. *Elders and Carers Guide* . Preston, UCLAN. 2010; 15-30.
29. Shah AK. Guide to Mental Health Assessment. -ISCRl Managing Better Mental Health Care for Black and Minority Ethnic Elders. *Elders and Carers Guide* . Preston, UCLAN. 2010; 31-52.