

identities affect our ability to make an individual life and have relevance in the context of suicide risk.

The investigators exclude 'Other Asian' (the free-text 'Any other Asian background' under the 'Asian or Asian British' label, numbering around 240 000 in the 2001 census) from the denominator 'because the majority of this group are of Middle Eastern or Sri Lankan origin'. Although around one in four were born in Sri Lanka and one in six in the Middle East, 37% had a region of birth in South Asia and 31% in the UK.<sup>4</sup> Given that the focus is on ethnicity rather than country of birth, the ONS Longitudinal Study data are, again, informative: of members with a 1991 and 2001 ethnic group, 42% of 1285 'Other Asian' persons identified as Indian, Pakistani or Bangladeshi in 1991. In this study, none from the 'Other Asian' group are counted in the denominator.

Finally, the investigators point out that SANGRA was validated against real data. However, the key data-set were London and Midlands hospital in-patient admission data from the mid- to late-90s, a period during which the quality of ethnic coding was very poor, the team itself admitting that further studies are needed to confirm whether SANGRA is able to produce valid results across Britain.<sup>5</sup>

Beyond the parsimonious way in which the statistical data is presented (with no measure of the precision of the rate estimates), the collective effect of potential problems with numerator/denominator compatibility and concerns about SANGRA's performance is a factor which needs to be considered in making a judgement whether to accept these findings as the accurate contemporary evidence needed to shape specific prevention strategies.

- 1 McKenzie K, Bhui K, Nanchahal K, Blizard B. Suicide rates in people of South Asian origin in England and Wales: 1993–2003. *Br J Psychiatry* 2008; **193**: 406–9.
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- 5 Nanchahal K, Mangtani P, Alston M, dos Santos Silva I. Development and validation of a computerised South Asian Names and Recognition Algorithm (SANGRA) for use in British health-related studies. *J Public Health Med* 2001; **23**: 278–85.

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McKenzie *et al*'s findings<sup>1</sup> of low suicide rates among South Asian men in both 1993–98 and 1999–2003, and of high suicide rates among young South Asian women in 1993–98, are consistent with previously reported findings.<sup>2</sup> The difference from previous findings lies in the absence of an excess in young South Asian women in the recent period, 1999–2003, and an excess instead in older women.

In the absence of observed numbers of deaths and confidence intervals for the rates, it is not possible to interpret the statistical significance of the findings in Tables 1 and 2 of their article (i.e. which ethnic differences by age, gender and over time are statistically significant). Likewise, although the results were 'essentially unchanged' following the sensitivity analysis, it is unclear which differences remained statistically significant after the 11% inflationary adjustment for potential underidentification of South Asian suicides arising from the use of SANGRA.

High rates of suicide and attempted suicide among young South Asian women have been a consistent and enduring finding in national and international research over decades (see Raleigh<sup>2</sup> for references). Research specifically commissioned to examine this issue reported high rates of attempted suicide among young South Asian women in London, including those who were UK-born.<sup>3</sup> A recent study found a 2.8-fold higher suicide rate among South Asian women aged 25–39 in contact with mental health services.<sup>4</sup> Given the evidence overall, any decline in suicide rates in this group over the past decade would therefore be welcome. However, as this finding is counter to the evidence to date, it should be kept under review to ensure it is a real trend and not an artefact, given the caveats associated with analyses based on software-assigned ethnicity, many of which are acknowledged in the paper.

The constraints to inclusion of ethnicity at death registration were established by ONS in its review of death certification some years ago. Given the growing need for epidemiological monitoring of mortality rates and trends by ethnicity and cause of death, ONS, the Department of Health and the Information Centre should consider alternative approaches for making these data available, for example through data linkage, as undertaken in Scotland and recently by ONS for deriving infant mortality rates by ethnic group.<sup>5</sup> This would provide sound, comprehensive epidemiological data with self-assigned ethnicity coding of numerators and population denominators on a consistent and comparable basis, thereby avoiding the potential mismatch between numerators and denominators in the use of name-recognition software. It would also obviate the need for researchers to have access to names, which is frequently not possible for data protection reasons.

In the interim, given the growing use of such proxies for epidemiological purposes, there is a strong case for these national agencies to undertake a systematic review of the available name-recognition software programs, to establish their robustness for epidemiological analyses using national data-sets and across the spectrum of morbidity and mortality. This would also be in keeping with the statutory responsibility of these national agencies for ensuring the availability of comprehensive national data to support equality monitoring.

- 1 McKenzie K, Bhui K, Nanchahal K, Blizard B. Suicide rates in people of South Asian origin in England and Wales: 1993–2003. *Br J Psychiatry* 2008; **193**: 406–9.
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**Authors' reply:** Our paper is the first to report findings at variance with previous studies and we welcome the opportunity to discuss the findings and subject them to scientific scrutiny.<sup>1</sup> The findings of a decreased rate of suicide in South Asian men has not been challenged. It is reassuring that the experimental