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.[4] 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.[5]

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.

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McKenzie *et al*'s findings[1] 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.[2] 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[2] 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.[3] A recent study found a 2.8-fold higher suicide rate among South Asian women aged 25–39 in contact with mental health services.[4] 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.[5] 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.[1] The findings of a decreased rate of suicide in South Asian men has not been challenged. It is reassuring that the experimental

methods of SANGRA do not produce unexpected findings for this group.

The comparison with our study of the National Confidential Inquiry should be made cautiously, as that study included suicides among people in contact with services rather than from all deaths reported by the ONS.[2] We would also suggest self-harm rates are not a proxy for comparative suicide rates.

Dr Aspinall makes important comments about ethnicity classification. There are no data that investigate self-assigned *v.* ascribed ethnic identity and variations of this relationship across geographical areas of the UK, over time, or the patterns of transmission of ethnic identity through the generations. There are often unpleasant trade-offs when using descriptors of ethnicity and culture from survey research.[3] Ethnicity is not a measure of cultural identity.[3] Perhaps nested within self-reported ethnic categories we need more complex models of identity that take account of acculturation, social stratification and their interaction.[4] This may help more precisely to disentangle specific influences on health. Unfortunately, the concepts and methods to do this are still being developed.

The information on the denominators so far is useful but incomplete to forge a new study design or recommend specific changes in routine data sets; for example, we would need a breakdown of self-reported ethnicity in the 'Asian Other' and 'White and Asian' categories by gender and age. Adding more ethnic categories which are imprecisely measured, or for which the difference between self-rated and ascribed may vary over time and place, may lead to more random misclassification; therefore, more ethnic categories may not always be helpful or explain any more precisely which specific ethnic identity groups are at greater or lesser risk.

The finding of high rates of suicide in young South Asian women in the UK are based mainly on papers sampling groups born in Southern Asia – using the same methodology would miss the 50% of South Asians currently in the UK.[1] Of the two studies that used different methodologies, one used names to ascertain South Asian suicides but the methodology was not validated or described so that it could be replicated, and the other studied parts of London, although we know that there are significant differences in South Asian suicide rates by geographical location.[5]

The main purpose of the study was to improve the accuracy of the estimate of suicide rates in all South Asian people living in the UK, irrespective of place of birth. We know that over 50% of the South Asian population was born in the UK and future studies need a way of accurately including them in rate calculations. We believe that ethnicity assigned on death certificates is likely to be the most useful way forward. We concur with the view that there is a need to assess trends over time.

We agree that there are caveats because of the SANGRA program. However, we do not think that the program would have worked less well in the 1999–2003 cohorts than the 1993–98, that it would work so differentially for men and women, or that artefact can explain the findings in both the older and the younger female population.

We would welcome attempts to replicate these findings using different methodologies and show the raw data to facilitate this and the calculation of other statistics such as confidence intervals (Table 1). However, in the meantime, this is the first contemporary attempt to ascertain the suicide rates for the whole of the UK South Asian population. The findings for older women should be viewed with concern and the drop in younger women should be replicated and followed over time. Policy has to be based on the best evidence available rather than the best evidence that is sought and might one day become available.

Table 1 SANGRA South Asian Suicides 1993–2003

Age range, by gender	1993–1998	1999–2003
Male		
15–24	136	72
25–34	145	158
35–44	121	109
45–54	54	72
55–64	46	39
65–74	18	18
>74	14	10
Total	534	478
Female		
15–24	60	29
25–34	75	55
35–44	54	29
45–54	28	25
55–64	12	15
65–74	13	14
>74	6	11
Total	248	178

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Risperidone for adolescent schizophrenia

We would like to make a few comments on the study by Haas *et al*[1] which compares the efficacy and safety of two dosing regimes of risperidone. First, we would like to raise concerns with regard to the design of the study. Both groups were receiving a flexible dose of risperidone in the first 4 weeks. The dose was to remain stable only during the last 4 weeks – a very short duration. Patients started showing substantial response in the first week onwards. It is not possible to rule out the placebo effect and difficult to determine the dose-related response. Surely this design cannot establish the optimal effective dose as the dose was changing very often especially in the first 4 weeks.

Second, patients in the control group were not allowed the assured effective treatment. The control group received risperidone tenfold less than the intervention group. This dose was as good as a placebo. This raises serious doubts as to whether the lower dose was also effective or whether it was a placebo effect. This is clearly evident as a substantial improvement compared with baseline was noted in both groups within 7 days. It also raises ethical issues as the authors decided to continue a presumably ineffective dose (0.15–0.6 mg/day) in the control group for 8 weeks.[2] Patients in this group had a higher discontinuation rate owing to lack of efficacy. It was unethical to continue with such

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