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Short Report

Immigration and recommended care after a suicide attempt in Europe: equity or bias?

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This report describes the investigation of care recommendations in the medical system across European countries to immigrants who attempted suicide. Data from seven European countries with 8865 local and 2921 immigrant person-cases were derived from the WHO/EURO Multicentre Study on Suicidal Behaviour and ensuing MONSUE (Monitoring Suicidal Behaviour in Europe) project. The relationship between immigrant status and type of aftercare recommended was analysed with binary logistic regression, adjusting for gender, age, method of attempt and the Centre collecting the data. Clear disparities were identified in the care recommendation practices toward immigrants, compared with hosts, over and above differing policies by the European Centres.

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Introduction

Studies have shown that immigrants in Europe are at risk of suicidal behaviour.^{1–4} Yet, thus far there have not been any specific studies concerning care recommended for immigrants after attempted suicide in Europe.

Study Aims

The present study investigated the recommendations of care given by medical personnel at first contact after an attempted suicide across a number of European countries, comparing persons from immigrant and non-immigrant groups.

Methods

The data on suicide attempts were derived from the WHO/EURO Multicentre Study on Suicidal Behaviour, initiated in 1988 and described in detail elsewhere,⁵ and the ensuing MONSUE (Monitoring Suicidal Behaviour in Europe) project. The participating Centres collected information in a well-defined catchment area, from patients who had contact with the medical system following attempted suicide.

In the current study, data from eight Centres in seven European countries (Bern, Switzerland; Ghent, Belgium; Leiden, Netherlands; Oviedo, Spain; Stockholm, Sweden; Tallinn, Estonia; Umeå, Sweden;

and Wuerzburg, Germany) in which >30 immigrant suicide attempters were registered and information on given aftercare was available were analysed. The final analysis comprised 8865 local and 2921 immigrant person-cases.

The study analysed the association of immigration (and specifically the immigrants' region of origin) with recommended care, adjusting for relevant background factors described below.

The dependent variable in this study, the recommended aftercare, was classified into four categories: no recommended aftercare, non-psychiatric aftercare, psychiatric or psychotherapeutic outpatient aftercare and/or counselling services and psychiatric or psychotherapeutic inpatient aftercare.

Owing to differences in strategies of care recommendation after suicide attempts, the Centres were divided in three classes based on a tentative principle component analysis: Leiden and Oviedo, where the use of inpatient care was rare but outpatient care more frequent than elsewhere, Tallinn, where non-psychiatric care was almost never recommended, and the other Centres which, while showing some differences, were similar enough to be treated as belonging basically to the same type.

The immigrant groups were divided by general region of origin into three major categories: West European (and other Western) immigrants ($n=543$), East European immigrants ($n=1702$) and non-European immigrants ($n=695$). These were compared with the (European) host group ($n=8865$).

Table 1 Determinants for recommended care after a suicide attempt: immigrant groups by region vs. hosts^a

Variable	No care OR (CI 95%)	Non-psychiatric care OR (CI 95%)	Outpatient care OR (CI 95%)	Inpatient care OR (CI 95%)
Immigrant group ^b				
East European	1.57*** (1.28–1.92)	0.78 (0.51–1.20)	0.86 (0.74–1.01)	0.94 (0.82–1.07)
West European	0.67* (0.46–0.97)	0.80 (0.58–1.11)	1.26* (1.03–1.54)	0.99 (0.82–1.19)
Non-European	1.32* (1.04–1.69)	1.33* (1.03–1.70)	1.08 (0.90–1.29)	0.73*** (0.62–0.87)
Sex: Women (vs. Men)	0.82** (0.72–0.93)	0.99 (0.85–1.14)	1.22** (1.03–1.23)	0.98 (0.90–1.06)
Age	0.99*** (0.98–0.99)	0.99 (0.99–1.00)	0.99** (0.98–0.99)	1.01 (1.00–1.01)
Method: 'Hard' (vs. 'Soft')	0.69*** (0.60–0.81)	0.74** (0.67–0.88)	1.01 (0.91–1.12)	1.22*** (1.11–1.33)
Centre ^c				
Tallinn	1.11 (0.92–1.33)	0.31*** (0.16–0.61)	1.07 (0.95–1.22)	1.38*** (1.23–1.54)
Oviedo & Leiden	2.54*** (2.19–3.02)	0.51*** (0.39–0.66)	5.41*** (4.75–6.17)	0.12*** (0.10–1.15)
–2 Log likelihood	7289.419	5660.812	12625.034	14872.733
Nagelkerke R ²	0.032	0.100	0.091	0.121

a: Variables included in models: Immigrant group, gender, age, method of suicide attempt, the Centre in which the suicide attempt was registered.

b: Hosts as ref. group.

c: All other Centres as ref. group * $P < 0.05$; ** $P < 0.01$; *** $P < 0.001$.

The relationship between immigrant status and the type of aftercare recommended was analysed with binary logistic regression analyses, one for each of the recommended-care categories, along with controls for gender, age, the type of the method of the attempt ('soft' or 'hard') and the Centre at which the data were collected according to a division presented above. The effects were described as odds ratios (OR) along with 95% confidence intervals (CI) to these.

Results

Immigrants from East Europe and from outside Europe were found to have significantly higher odds for not being recommended any care than people from the host country. On the other hand, West European immigrants were significantly less likely than the hosts not to be recommended any further care (see table 1).

Location had a substantial effect: patients from Oviedo and Leiden stood out with clearly higher odds for not being recommended any care after an attempt because of the fact that more than one-third of all the patients in the last-mentioned Centre were left without recommendation for further care.

Focusing on non-psychiatric care, Non-European immigrants were found to be 33% more likely to be recommended non-psychiatric care after a suicide attempt. For the other immigrant groups, the odds were similar to the hosts'. The strongest effects among the control variables were of those of the location.

West European immigrants seemed to have significantly higher odds of being recommended outpatient care, when compared with hosts (see table 1). Again, location was important, with Oviedo and Leiden standing out with much higher odds of recommending this type of care, compared with other Centres. Interestingly, the type of method used did not have an effect on the recommendation of outpatient care.

Adjusting for all variables, significantly lower odds for inpatient care existed only for non-European immigrants, while no difference was found in the odds of East or West European immigrants.

Overall, the predictive power of the care location was substantial, while that of the other variables was not very large, although often significant. Sex, age and the method of the attempted suicide had mostly significant crude effects on the type of recommended care (not shown), but interestingly did not influence immigrants' probability of being recommended different types of care.

Discussion

Our results point to the possibility that immigrant status does influence the recommendation of care after a suicide

attempt, in addition to the existing disparities between the European Centres.

The results correspond to Cooper *et al.*'s⁶ study comparing self-harm, provision of services and risk of repetition of Whites and South Asians in the UK. They found that South Asians were more likely to be discharged from emergency department without referral to other services, or be referred to their GP; they were also less likely than Whites to be referred to specialist medical, surgical, or psychiatric services. In that study, clinical staff tended to rate both South Asian men and women as being at lower medical risk and lower risk of future self-harm compared with Whites.⁶

It is possible that some migrant groups communicate their distress in a manner different from their host culture, e.g. through more concrete expression about their body, emotions, social and life situation.⁷ Also, the contextual circumstances that put immigrants at increased risk for suicidal behavior may be different from non-immigrants. Thus, the staff may misunderstand the symptoms of immigrants or interpret them as less serious owing to cultural distance and/or communication problems related to language barriers, and may discharge them without a suitable referral. To this add the attitudes of immigrants themselves, who may refuse referral to aftercare services owing to fear of stigma, lack of information or previous negative experience with health services.⁸ Another possible explanation could be the lack of aftercare services with necessary linguistic and cultural adaptation⁸ that might be forcing the staff to discharge immigrants after a suicide attempt without adequate referral.

As opposed to other, culturally more different groups, West European immigrants were more often recommended outpatient care, even as compared with hosts. It is possible that this population, coming from more affluent countries with a more similar cultural background, is economically more privileged and better acquainted with the treatment of mental health problems,⁹ and is also better insured compared with immigrants originating from other regions.

Summing up, there is evidence that the quality of health and psychosocial care for migrants may be affected by access barriers, such as the administrative structures or financing of health care, linguistic or communicative skills, demands or lack of demands of the migrants, the cultural distance or similarity to the host country culture and the expectations of health-care providers.⁸ The results of this study are generally in line with such assumptions, focussing on the recommendation of care by medical staff in the emergency situation after an attempted suicide, which has seldom been investigated.

Clear guidelines for care after suicide attempt in hospital emergency settings now exist in Europe, such as have recently

been published by the European Psychiatric Association¹⁰ and can be applied in the care of all suicidal patients. The need for clear care recommendation is even more acute in care of immigrants, as their initial contact with the medical system immediately after their suicide attempt may constitute the best opportunity to receive a proper referral to psychiatric and psychosocial help in their suicidal crisis. Yet, such referral also demands clear referral guidelines for culturally competent after-care services, and well-trained staff with intercultural competence.

Limitations

Some variables of possible importance could not be analysed owing to non-availability and thus limit the generalizability of the conclusions. There were no data available on neither the length of stay in the country or the legal status of immigrants. Certainly, the diversity of health care policies in the European countries is also influenced by the legal status of immigrants. Also, owing to the local nature of the study, the catchment areas cannot be considered to be representative of the countries involved, and the immigrants living within them may not be representative of the immigrants to those countries. However, because this study has been made using the largest European data material at hand and the current examples of practices from the different European sites indicate clear disparities in recommendation of care for immigrants and locals, future investigation of these results is clearly needed.

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Conflicts of interest: None declared.

Key points

- Immigrant status influences the recommendation of care after a suicide attempt, over and above the existing disparities between different European localities.
- Eastern European and non-European immigrants, probably perceived as more culturally different, are more often

discharged without further recommendation of care after a suicide attempt when compared with non-immigrants in Europe.

- There is need for clear and culturally adapted care recommendations after a suicide attempt for immigrants in Europe, as their initial contact with the medical system immediately after their suicide attempt may provide the best opportunity to receive a proper referral to psychiatric and psychosocial help in their suicidal crisis.

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