Irish mental health in England: the evidence

Researching Irish mental health in England: the wider context

The Black and Minority Ethnic (BME) Agenda in Britain has tended to exclude Irish people. However, the basis for this exclusion is increasingly being regarded as tenuous, and questioned by academics, practitioners, policymakers and public bodies (Commission for Racial Equality 1995; Aspinall 1997; Hickman and Walter 1997; Ouseley 1997; Aspinall 1998; Bracken, Greenslade et al. 1998; Department of Health 1998; Department of Health 2000a; Runnymede Trust 2000; Bracken and O'Sullivan 2001). This is due in part to an increasing body of evidence relating to Irish mental and physical health disadvantage as well as evidence of related experiences of discrimination and socio-economic disadvantage among Irish people living in Britain (Hickman and Walter 1997).

The reasons for previous Irish official invisibility are complex and located in wider political debates (Hickman and Walter 1997; Bracken and O'Sullivan 2001; Mac An Ghaill 2001), but what is clear is that the experience of Irish people is more similar to that of other ethnic minority populations and divergent from the majority 'White' population (Hickman and Walter 1997).

The failure to provide a satisfactory framework for locating the experience of the Irish in Britain has had a marked impact on how research on the Irish has been conducted, analysed and interpreted, as well as creating a situation where Irish people have been excluded during most of the 1990s from major studies of health/mental health and/or ethnicity (Modood, Berthoud et al. 1997; Nazroo 1997a; Nazroo 1997b; Bracken and O'Sullivan 2001). Where research has been done, findings on have further tended to be descriptive rather than explanatory, and thus present difficulties with translation into policy formulation.

The differential research treatment of the Irish compared with other BME groups has had an obvious knock-on effect on the sources of data drawn upon here. From the data which are available, it is clear that Irish people, even though they are predominantly white-skinned, are disadvantaged in relation to mental health experience, a disadvantage which is likely to be linked to wider experiences of employment, housing, patterns of migration, poor health, discrimination and hostility. Being white-skinned is therefore no safeguard against discrimination and disadvantage. Additionally, the failure to monitor Irish people as an ethnic group has resulted in more data being available on the Irish-born migrant group, rather than subsequent generations of Irish people in Britain, which is not parallelled among other groups for whom ethnic minority status, rather than place of birth, is the usual categorising variable. Where data are available on the wider Irish ethnic group, these will be presented as necessary. It needs therefore to be emphasised that just because Irish people have not been researched as fully as other BME groups, that this can not be interpreted as representing either a

lack of need or equality with the White majority, but merely reflects questionable political and research priorities, which have conflated a racialised black/white dichotomy with minority/majority ethnicity. On the basis of the research evidence and the experience of the Irish community groups dealing with mental health issues referenced below (IMHS), what is clear is that the situation of the Irish queries the black/white dichotomy which characterises much BME mental health research in Britain, that Irish experience of disadvantage at many levels must inevitably be linked to the particular experience of and patterns of service use of Irish people within mental health services, and that crucially, any understanding of Irish mental health needs to start from an understanding of the *experience of being Irish in England* (Kelleher and Hillier 1996).

Recent positive trends have been the defining of the Irish as a separate ethnic group in the 2001 Census and consequent recommendations by public bodies to include an Irish category in ethnic monitoring systems (Commission for Racial Equality 1995; Department of Health 2000a). Progress has also been made by inclusion of Irish first (Irish-born) and second generation (children of Irish-born) people in Department of Health-funded general health (Erens, Primatesta et al. 2001) and psychiatric morbidity surveys concerned with ethnicity (O'Connor and Nazroo 2002; Sproston and Nazroo 2002). Irish representation on the External Reference Group and reference to Irish people within the policy report Inside/Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England (NIMHE 2003) show further Department of Health commitment to addressing 'invisible' ethnic minority needs.

The formal research on Irish mental health is characterised by a) a quantitative descriptive bias, b) a failure to locate mental health experience in a context of minority ethnic status, c) a lack of data on people of Irish origin born in England, d) a muddling of data on Irish people with the white British or 'white minority' group, d) general exclusions based on skin colour.

The problems with the impact of a black/white approach to ethnicity within research has been mirrored in the activities, policies and initiatives of voluntary groups (see King's Fund, Sainsbury Centre for Mental Health, SANE, Mentality, Mental Health Foundation, etc) and the statutory sector concerned with mental health, where Irish people, despite having an apparently poor record of mental health, get overlooked and implicitly treated as not having specific needs.

In this wider context of Irish mental health needs generally being overlooked, the research evidence, experience and knowledge of mental health issues derived from Irish community groups in the voluntary sector are an important supplementary source of data. The Irish sector has much experience of dealing with and providing services and support for Irish users of mental health services and more generally, vulnerable Irish people with needs unmet outside of the Irish sector.

Although most studies of ethnicity and mental health during the 1990s excluded consideration of Irish people as an ethnic minority, one major study of community mental health which focused on 'visible' minorities did conclude that, 'the white minority group (56% of whom were Irish) seemed to have the highest rates of mental illness. Their rates for anxiety, depression, suicidal thoughts and psychosis were not only higher than the rates for the white British group, but were also higher than the rates for the other minority groups.....one implication is that factors associated with ethnic minority status might increase risk of mental illness *regardless of skin colour*' (Nazroo 1997a:85-6). Despite this conclusion, the author did not go on to discuss any implications for future research or policy with regard to Irish people or other white minorities. However, the most recent DoH-funded ethnic psychiatric morbidity study did include Irish first and second generation people (O'Connor and Nazroo 2002; Sproston and Nazroo 2002).

Key areas of concern

- Suicide and attempted suicide

There are significantly high rates of suicide among Irish people of both sexes, with particularly high rates among young women. Rates have persisted for decades and increased over time. Latest figures reveal a 53% excess (higher than all other BME groups and the population of England/Wales) for all Irish people. Among young (20-29 years) people a 75% excess was found for males and nearly a three-fold excess for young women (Raleigh and Balarajan 1992; Balarajan 1995; Leavey 1999). There is also Irish community concern about perceived high suicide rates among Irish men in prison, particularly Irish Traveller men (IMHS). There is evidence that these Irish rates may be *under*-estimated (Neeleman, Mak et al. 1997).

Early British studies in Birmingham focused on attempted suicide among those born in Ireland and found over-representation among suicide attempters with statistically significant rates for young Irish women (Burke 1976; Merrill and Owens 1988). A more recent local analysis of acute psychiatric admissions in Haringey found a link among Irish people between a history of attempted suicide and admission for depression (Walls 1996). Recent studies of female suicide attempts, self-harm and ethnicity have excluded the Irish(Bhugra, Baldwin et al. 1999; Bhugra, Desai et al. 1999), even when Irish women clearly make up a large proportion (11%) of comparison 'white' attempters (Bhugra, Baldwin et al. 1999). This inevitably leads to erroneous conclusions being drawn about other ethnic minorities in comparison with 'whites'.

- Depression/anxiety

Excessively high rates for depression have been found for Irish people admitted to psychiatric hospital and within community samples, particularly Irish women, and at both national and local levels (Clare 1974; Bebbington, Hurry et al. 1981; Cochrane and Bal 1989; Walls 1996). Of particular concern to Irish community groups and Irish counsellors are the particular psychological problems of some Irish women around depression, and unaddressed problems of depression and

anxiety among Traveller women (IMHS). In 1981, Irish women in England had admission rates of depression of 410 (per 100000), compared with a rate of 166 among English women (Cochrane and Bal 1989). A local study in Haringey in 1995 found that Irish women's hospital admission rate for depression was 22 (per 10000) compared with 6 for English women and 7 for Black women (Walls 1996).

- Alcohol misuse

The research evidence presents a complex picture of Irish use, non-use and misuse of alcohol. The issue of alcohol misuse is raised here due to the perceived importance among the Irish community of the links between alcohol misuse and mental health issues (IMHS), the significant over-representation of Irish people in psychiatric admissions for alcohol disorders (Cochrane and Bal 1989; Walls 1996), the Irish over-use of community-based alcohol agencies (Walls 1996; Luce, Heather et al. 2000), and the perceived offense and possibility of misdiagnosis of Irish people suffering mental distress due to a stereotype of Irish people which equates cultural identity with alcohol problems (IMHS). There is evidence of high Irish alcohol-related mortality (Greenslade L, Pearson et al. 1995; Harrison, Sutton et al. 1997) and over-use of alcohol among the Irish first and second generation in a recent survey on health (Erens, Primatesta et al. 2001). There is also evidence that particular populations of Irish people may have alcohol problems linked to wider disadvantages of isolation, poverty, being single men, having particular employment histories, being homeless and marginalised, being in poor general health, etc (Harrison and Carr-Hill 1992; Harrison, Carr-Hill et al. 1993).

Irish service experience

- Primary care level

a) Consultation

Irish-born people have higher rates of consulting GPs for mental health problems despite having lower overall consulting rates (McCormick and Rosenbaum 1990). Recently evidence from Health Survey for England shows that Irish people (both first and second generation), and particularly young men, have higher than average rates of consulting GPs for psychological problems (Erens, Primatesta et al. 2001).

Evidence from community groups suggests that despite this general picture, there are some groups of Irish people (particularly older homeless men, people with alcohol problems, Travellers) who do not access primary care for reasons of stereotyping, hostility, mental health problems not being addressed, lack of confidence, lack of knowledge of what services are available and who need support with accessing adequate services (IMHS).

There is evidence that vulnerable and often stigmatized groups such as Travellers, people who are homeless or have alcohol problems, are being denied being allowed to register with GPs, thus disallowed through prejudice and/or fear of longterm cost considerations, access to any form of basic health care. There are

also problems connected with the mobile lifestyle of some Travellers that they do not get referred on or are unable to effectively access community-based services.

There are many examples from the Irish community of a lack of understanding and competence in primary care consultations and of witnessed accounts of health staff behaving offensively to Irish clients. An approach to care which is sensitive to Irish people is therefore a primary concern within the Irish sector. However at a general level, Irish organisations are not involved pro-actively with primary care trusts and have a history of being overlooked in health initiatives targeted at ethnic minority groups.

b) Recognition

There is a general population problem of feeling that GPs are unable to help with psychological problems (Shaw, Creed et al. 1999), so it is difficult to assess the extent to which Irish people may have additional problems with GP recognition of mental health issues. It still seems that some groups of Irish people prefer to access emergency services for general and mental health problems and this may indicate problems with GP recognition and Irish patient dissatisfaction with GP services (IMHS), or be related to specific health problems (Gater 2002). Overall, Irish community groups express concern about the lack of apparent skills around mental health in general, and Irish mental health in particular, at primary care level.

A recurring concern expressed has been the extent to which GPs fail to deal with mental health issues underlying presenting alcohol problems among Irish people. There are two issues here, a) failure to treat depression, anxiety etc., as relevant to alcohol problems, b) offensive stereotyping of Irish people. It seems currently unclear whether Irish people suffer disproportionately from general service problems around 'dual diagnosis' or whether Irish people are being inaccurately and disproportionately labelled as having drink problems. One small, though dated study of attenders of an alcohol advisory agency in Camden found no evidence to suggest that there was stereotyping of Irish people by referral sources, including GPs (Kennedy and Brooker 1986).

There is the perception that some Irish may find it difficult to disclose issues relating to mental health to some non-Irish mental health professionals, thus professionals may be unaware of how to treat particular Irish individuals. Some Irish mental health workers believe that some Irish women may have difficulties communicating distress:

'I believe Irish women access services at the point of crisis or near breakdown. Asking for help seems to be a last resort. The majority seem to have long histories which include trauma, neglect and deprivation. They belong to the most marginalised within out community, being both economically and educationally disadvantaged. Often they present to GPs etc, but for reasons, personal/cultural, find it hard to communicate their distress in a way that gets recognised'
Irish women's counsellor (IMHS)

c) Treatment

Treatment is inevitably linked to recognition, and it may be discerned from the high numbers of Irish people accessing alcohol services in England and Wales, at both local and national levels [(Kennedy and Brooker 1986; Walls 1996; Luce, Heather et al. 2000), that many Irish with mental health problems, receive treatment primarily for alcohol issues. As much of these treatments occur outside of the statutory mental health sector and are likely to involve both medical (detox) and non-medical (counselling) treatments, it is arguable that Irish (and others) with drink problems, *because of alcohol issues,* are more likely to get access to needed talking therapies, even if this is outside of the statutory mental health sector. It is possible that this access may a) point to an Irish cultural dimension which favours admitting to alcohol rather than explicitly mental health issues, b) indicate possible preference among Irish people for dealing with mental health issues outside of the statutory sector and a preference for accessing voluntary sector support, c) highlight greater expertise within both the wider voluntary sector and the Irish voluntary sector in particular for dealing with mental health/alcohol related issues.

There is a community perception of widespread major tranquilliser abuse among Traveller populations, which is perceived to be an easy way to quickly dispatch Travellers who may benefit from alternative help and support (IMHS). Concern was expressed about the lack of alternatives to medication or wider range of treatments for common mental disorders, a reflection of general issues raised in the National Service Framework for Mental Health (Department of Health 2000b). At the community level, there is evidence to suggest that Irish counselling initiatives are invaluable in dealing with distress among Irish people although they have not been formally evaluated. The apparent demand for these services would suggest that provision both culturally sensitive and non-medical alternatives are important factors influencing uptake. More broadly, Irish community workers and users, in common with the wider population face enormous difficulties in negotiating mental health systems, due to delays and complexities of services (IMHS).

- Access to specialist services

Due to the failure to specifically address Irish issues, there is little data available which can clarify how Irish people access specialist statutory mental health services. Again, the evidence points rather to a preference (which may or may not be an Irish preference), for general voluntary sector mental health services (MIND), alongside specifically Irish community services providing varying degrees of expertise in dealing with mental health issues. Some small-scale work illustrates this pattern of community-based usage of services, with low numbers of Irish clients found among statutory services, but this needs to be read with caution, as problems surrounding Irish ethnic monitoring and the Irish often being perceived as part of the white majority and therefore ‘invisible’, may be masking the true picture (Walls 1996). A Birmingham study did find an Irish excess using specialist mental health and addiction services, which when

controlled for age and gender, remained significant for Irish men aged 16-44 (Commander, Odell et al. 1999).

What is clear is that a failure to acknowledge and to provide for the specific needs of Irish people in home treatment services, crisis interventions and community mental health services, may be connected to patterns of high rates of hospital admissions and significant rates of suicides and therefore a key to their reduction.

There is Irish community-level concern that previous negative experiences of psychiatric services, lack of knowledge of their rights, lack of confidence and low self-esteem, desire not to be any trouble, anti-Irish and other discrimination (on grounds of being Travellers, being homeless, having alcohol problems), ignorance of what services are available, the inflexibility of providers, all militate against some Irish people, effectively using specialist psychiatric services (IMHS).

- Secondary care experience

Most of the research record available on how Irish people access mental health services is on their rates of psychiatric hospital admissions (Cochrane and Bal 1989). Unfortunately these data are now dated, and there have been no major national published analyses of admission by either place of birth or ethnicity status since 1981. Nonetheless, the persistent pattern found here of significant excessive admissions for Irish people from 1971-1981 failed to lead to much interest of Irish health within ethnicity debates (Bracken and O'Sullivan 2001), while some of the same data on the admission rates and prevalences of diagnoses derived from the same studies on other BME populations were integral to policy debates and health targets during the 1990s (Balarajan and Raleigh 1993). Since then, smaller studies have produced conflicting results on Irish patterns of admissions to psychiatric care. One London study found that the pattern of Irish people having highest overall admission rates compared with Black and White British populations, with particularly high rates for depression, alcohol-related disorders and second to the Black population in rates for schizophrenia/other psychoses. This replicated the earlier national pattern found. Another study in Birmingham did not find an Irish hospital admission excess (Commander, Odell et al. 1999).

A study in Manchester and Salford examined whether there was an Irish (3 generations) over-use of A and E departments based partly on the reasoning that Irish people might not be accessing primary care as readily as the English and therefore would be more likely to get more severely ill and present as emergencies. This study was not solely concerned with mental health issues. Although there were some methodological issues about who may have been excluded from the study, the findings in this case revealed *neither* than Irish people were over-represented at A and E, *nor* that Irish people were less likely to be registered with GPs, but it was found that Irish people were much more likely to present at A and E with mental disorders and to be heavy drinkers. Heavy drinking was connected with older age in men, single marital status and overall

poorer health, and although such men presented to A and E, the finding that they also had frequent contact with their GPs, suggests that some people with particular health issues clearly opt for hospital services (Gater 2002), for reasons currently unclear.

- Compulsory psychiatric admissions

Data on sectioning of Irish under the Mental Health Act is harder to find due to ethnic monitoring issues. However, there is a strong conviction among those working in Irish mental health that Irish men and women are particularly over-represented among those receiving ECT, being compulsorily detained, in secure units, etc. (Farrell 1996; Butler 1999).

The profile of Irish mental health in England raises many questions which further research may address. However, it is clear from academic research and from Irish community experience that the mental health experience of the Irish has been of concern for a considerable time, even if this has not been given much consideration outside of the Irish community (Bracken and O'Sullivan 2001). Some of the reasons for the past failure to address Irish mental health needs have been outlined, and progress towards the Irish being recognised as an ethnic minority group with specific needs is being made. An important omission however is research which is Irish user-driven, which clearly identifies how people who use services feel and where and how improvements might be made.

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