Profiling mental health needs: what about your Irish patients?

In January 2005 the Department of Health published its most recent guidance on how health services should deliver 'race equality' in mental health.[1] This follows wider concerns about institutional racism in many statutory services, but in particular, responds to the inquiry relating to the death of David Bennett in a medium secure psychiatric unit after being restrained by staff. David Bennett was a 38-year-old African–Caribbean man, and fits well the stereotype many people have, if our university health students are at all representative, of the ethnicity of the people at greatest risk of serious mental health problems. They are often surprised to learn that in terms of both physical and mental health, Irish people have a record as poor as, or worse than, many of the main minority ethnic groups living in England and that this disadvantage persists into second and third generations.[2] Irish people are also very regular visitors to their GP, are over-represented among people with the less severe forms of mental health problems,[3] and are included in the January report.

Raised rates of suicide among Irish people in England have also been reported now for many years,[4,5] and research cited in the National Institute for Mental Health in England (NIMHE) report *Inside Outside*[6] suggests that rates may have been underestimated, seeming now to be higher than those in all other minority ethnic groups, particularly among 20–29-year olds.

The Irish have hitherto been overlooked because they are a white population, and race relations in the UK and the experience of minority ethnic communities has most commonly been considered in relation to skin colour. This has been reflected in our data collection systems, with 'Irish' added as a separate ethnicity category in the national census only in 2001. They are also less visible because of their relatively even distribution across the country, as compared with the large Bangladeshi community in Tower Hamlets (33% of the population), or the Indian population in Leicester (25%). The needs of Irish people were also omitted entirely from the compilation of research on London's Mental Health,[7] even in sections relating to ethnic minorities. Yet Irish people are the fourth largest minority ethnic immigrant group in London.

That the Irish should be considered as a separate minority ethnic group can be argued because of their raised rate of mental health problems and suicide,[2,4] but also because they have shared the experiences of racial harassment and discrimination in England more commonly associated with dark-skinned minorities. Older Irish people who arrived in the UK before such overt discrimination was made illegal may remember the 'no blacks or Irish' notices on the doors of boarding houses, and may have feared hostility toward them when the IRA was most active.

Irish immigration peaked in the 1950s and early 1960s and again in the 1980s, and the first group, who are now nearing retirement age, were often starting out in their working life in manual labour trades with little or no employment protection. Many will now be facing an impoverished old age. Government statistics on population trends show that nearly one in four Irish people in the UK are 65 years or over, compared to 16% of the rest of the population, and their need for health and social care is likely to grow in the near future. In the 2001 census from which these figures derive, nearly 15% of the Irish responders reported their health as 'not good', compared to under 10% of the general population.

The Health Survey for England[8] interviewed more than 8000 adults and children of Indian, Pakistani, Bangladeshi, Chinese, Irish and black Caribbean ethnicity. The report showed raised rates of ischaemic heart disease and smoking among Irish men and Irish women compared to the general population, and a raised rate of diabetes, obesity, and high alcohol consumption in Irish men. Irish men reported a raised rate of longstanding illness, disability or infirmity that limited their activities to some extent. Irish women were particularly likely to consult their GP for stress-related problems.

While high rates of inpatient mental health treatment have been found among Irish people living in England and Wales since 1989,[9] this was not always reflected in community data. The recent Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) study,[3] however, now seems to confirm this high prevalence, at least in terms of common mental disorders. Building on the Health Survey data, including standardised assessments, and in-depth interviews, this detailed and extensive study showed that Irish men and Pakistani women had the highest rates of common mental health disorders, while Caribbean men did indeed have higher rates of psychotic illness.

The *Inside Outside* report on mental health provision for ethnic minorities argues that we now need to move from documenting inequalities to responding to them, commenting on two issues in relation to Irish people.[6] One relates to some lack of help through failures to explore and treat mental health problems associated with alcohol problems, another to the tendency for some people with alcohol-related problems to bypass general practice and attend A&E departments. Homeless men and travellers are often not registered with GPs. The need for 'culturally competent' provision is emphasised.[6]

This concept of culturally competent provision seems to originate from the US, a country whose population is growing in diversity at such a rate that predictions by the US Bureau of the Census in 1996 are that the proportion of the population described as 'white' will decline from 73% in 1996 to 53% by 2050.[10,11] In response, the US government issued national standards for Culturally and Linguistically Appropriate Services (CLAS) in December 2000,[12] and the 14 standards include

guidelines on 'culturally competent care' and organisational support, and mandates on language access. Access to certain government monies will depend on the inclusion of the mandated areas in contracts, and the expectation is that the guidelines will increasingly also feature in contracts. The report defines the principles of cultural competence as 'attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations'.[12] That is, for effective assessment and treatment, practitioners need good understanding of the variance in normative acceptable behaviours, beliefs, and values.

On this score it might reasonably be argued that Irish people in the UK have behaviours, beliefs and values that are very similar to the main indigenous population, so the health service response may not need to be very different. Yet NIMHE highlights particular concerns about suicide and attempted suicide rates,[6] and Cohen and Goode argue that the rationale for cultural competence is to 'eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds' and to 'improve the quality of services and outcomes'.[10]

Efforts in Liverpool to provide a culturally competent service have included an Irish government-funded outreach project for older Irish people with poor health and living in unsuitable accommodation, to improve service access, and an experimental ethnicity profiling project by one health centre.[13] Others, for example, the MIND factsheet[14] on the mental health of Irish people, suggest that GPs should establish greater links with religious and community support groups in their own area, such as the counselling service in Islington for Irish women. Bhui and colleagues[15] debate the case for and against specialist services for minority ethnic groups with mental health problems and acknowledge the value offered by the voluntary independent providers in enabling people to feel understood, to engage with services, to improve assessments and to improve patient satisfaction. But they note the disadvantages of such services, which are often insecurely funded, marginalised, and

lacking power. They argue for a more integrated approach so that the funding and accountability of such services is part of the mainstream, and for stronger partnerships that will also enable the mainstream providers to become more knowledgeable about diverse populations.

With the commitment expressed by the government to address inequalities in health experiences and outcomes, it will not be long before general practice is required to demonstrate how it is responding. General practices will need to improve their practice profiling in relation to ethnicity, and could add an Irish code to their information systems if they have not yet done so. One early NHSE funded project in the West Midlands attempted to do this in 1998.[16] It addressed existing software barriers and trained staff to improve their routine data collection arrangements. Those who kept it up were able to record information on 70% of their practice population within 6–9 months. It was clear, however, that there needed to be national involvement in the revising of the coding system and in setting out requirements to software suppliers.

The indications are that the time to respond has arrived in the shape of the latest 'action plan' from the Department of Health.[1] Although the main focus is on more appropriate and responsive mental health services, the other two of the three action areas are as relevant to general practice as to secondary care. These are to improve information, particularly ethnic monitoring, and to enhance community engagement, including the recruitment of 500 new community development workers by primary care trusts. Let us hope that the needs of Irish people will feature clearly in the plan.

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