

# The 2006 Irish in Brent Health Profile Report

A report of research undertaken for  
Brent Irish Advisory Service and  
Brent Health Action Zone  
by Dr Patricia Walls



**Brent Irish Advisory Service**



## **Foreword by Jackie Collins, Brent Health Action Zone Manager**

The Brent Health Action Zone is delighted to support the production of this report into the needs of the Irish community in Brent. As the home to the largest Irish community in England it is important for this Borough to recognise the needs of the Irish community, both first, second and future generations.

It remains an astonishing fact that the Irish are the only community of immigrants, who experience worse health after arrival in this country. It is also striking, that a child of Irish parents will fare less well than their English counterparts in the factors that determine good health over their lifetime.

Health inequalities occur when barriers exist to people accessing health services, or, when people's health is impacted negatively by environmental and socio-economic factors. Some barriers are social constructs, for example, discrimination and lack of cultural or religious understanding act as barriers which are 'social' in nature. Other barriers are more practical, for example someone who cannot attend an appointment because the venue is not accessible in a wheelchair. The other side of inequalities are the things that cannot be changed by processes of inclusion in a social model. They are far more intrinsic inequalities. People who live in poor housing; in areas of high crime, high pollution; who are living on low incomes, or benefits; those with poor educational achievement and therefore poor employment prospects - people who in each realm of life have less chance of a healthy life and for whom life expectancy is dramatically reduced. These 'broader determinants of health' take multi-level interventions by all sectors working in partnership to make a difference.

This report has explored the experience of the Irish community in relation to these factors. Through this report, BIAS have been able to highlight the issues, now it is for the public sector service providers, in partnership with the Irish community, to respond and tackle the inequalities that so clearly exist.

Jackie Collins

Brent Health Action Zone Manager

## **Foreword by Karen McHugh, Director of Brent Irish Advisory Service**

BIAS is a community development and welfare agency providing advice, information and specialist support services to Irish people in need in Brent and London. Set up in 1978, we are a registered Charity and Company limited by Guarantee. Our objectives are, 'to relieve the poverty and promote the welfare of Irish people in London'.

The health and the social care needs of sections of the Irish community continue to be of great concern to all involved in BIAS. Everyday we witness increasingly poor health, homelessness, isolation, and discrimination, with no evident signs of health improvement over time, among first, second and third generation Irish people.

The Irish community is not a homogenous group and BIAS works to ensure its services are accessible to all sections of our community. Our current service provision aims to reflect its diversity but we are continuously assessing gaps in our service provision and working to develop services to meet those needs. We are the only Irish voluntary organisation in a borough which hosts the largest population of Irish people outside Ireland, and one of the Brent's largest migrant ethnic groups.

Our Advice Services include a Generalist Advice Service, a Housing Advice Service and a Disability Advice Service. Our Specialist Support Services include a Children and Families Social Work Service, an Outreach Project targeting 40-65 year olds, community care services targeting older people which include a Day Care Project and a Luncheon club, a Criminal Justice Project which facilitates Irish groups in specified London prisons and a Travellers Youth Project. Our services are provided in a range of venues as well as from our base at Willesden Green Library Centre.

We welcome this Research Report and hope that relevant local and national statutory bodies will not let it sit on a shelf but will work in partnership with BIAS and other organisations to ensure its recommendations are carried out. We also hope that it will contribute greatly to tackling Irish health inequality in Brent and in England.

Karen McHugh  
Director of BIAS

## **Author's comment**

This report does not claim to be a definitive account of Irish health issues either in Brent or in England. There are inevitably gaps in the literature due to some areas of Irish health receiving much greater research attention than others, and due to problems with datasets and ethnic monitoring of the Irish, as well as some researchers' biases about which minority groups are deemed worthy of study. Additionally, the time constraints involved in any research project have meant that as well as the reasons outlined above, that some health issues have received greater attention than others. Nonetheless, efforts were made to cover as comprehensively as possible, and in as much detail as possible, the health and related social circumstances of greatest concern to the Irish in England, and more specifically in Brent.

Karen McHugh, Director of BIAS, provided enormous expertise, guidance, support and enthusiasm for this project throughout its duration. Jackie Collins, Manager of Brent Health Action Zone provided needed support and advice. This report substantially benefited from the research skills of Caroline Moran (on housing accommodation research in Brent) and in particular Richie Butler (on a number of important areas relating to Irish health), who were both attached to Brent Irish Advisory Service (BIAS). Other members of the BIAS steering group provided important insights. Many unnamed individuals provided information and are due thanks for their co-operation. Organisations involved are listed in Appendix 1.

I am responsible for any errors in the text and would be willing to receive any comments on this report from any interested parties at WallsAMP@aol.com. What follows is disturbing evidence on the health of the Irish in Brent and in England. Within the constraints of the project, it has not been possible to make more explicit the links between the ways in which being Irish in England affects health. However, it is should be made clear that as with all other ethnic minorities and the majority population, the health of the Irish is affected by both cultural and structural factors and their interaction.

Patricia Walls (Dr), Research Consultant

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## Summary of key findings on Irish health

Significantly high rates of all-cause mortality among first, second and third generation Irish

The health of the Irish in England is worse than the Irish in Ireland, as well as worse than White English people

There has been no improvement in Irish mortality rates in the last couple of decades

Exceptionally high deaths mortality rates for suicides, cancers, accidents and respiratory disease, raised rates for coronary heart disease and stroke

Significant incidence and mortality for many cancers affecting both first and second generation Irish, particularly lung cancer

Exceptionally high prevalence of permanent sickness/disability, limiting long-term illness, perception of health being 'not good' and highest percentage of special needs households in London

High mental health admissions, attempted suicides, average use of community mental health services and high rates of GP consulting for psychological problems

Highest rates of heavy smoking and disproportionate use of drug and alcohol treatment services, given wider population figures

Irish Travellers' health status is comparatively even poorer, although less comprehensive data on Travellers were available. Morbidity data show excessively poor health status both physically and psychologically

High levels of housing disadvantage, including stark homelessness profile

High levels of Irish socio-economic disadvantage measured by a range of indices

## Turning findings into action to improve health

General recommendations are outlined below which focus primarily on greater inclusion of an Irish dimension in the planning and delivery of services, within the equality agenda, the promotion of wider community and health service understanding of the Irish community and its health needs, and building the capacity of the Irish sector to more effectively address the health of its members.

Specific health interventions, targets and actions which might be achieved locally to benefit the health of the Irish population in Brent, would have to be locally consulted upon, planned and supported. The Conference to be held on Friday 27<sup>th</sup> January 2006, jointly hosted by Brent HAZ and BIAS, will be one mechanism used to devise a community strategic response to this report. Given the breadth of the research evidence detailed in this report, it is only possible here to provide a brief summary of some of the key areas of health concern, which appropriate actions should be focused upon, in order to improve Irish health with the support of the local Irish community.

Actions should be focused upon the following key areas of health concern in Brent:

1. Relative disadvantages, in particular housing/homelessness problems
2. Suicides among the general Irish population; poor mental health
3. Cancers among the first and second generations
4. High rates of permanent sickness/disability and limiting long-term illness in Brent
5. High prevalence of addiction problems: alcohol, nicotine and other drugs in Brent
6. Irish Traveller health
7. The health of Irish elders

## General Recommendations

1. The inclusion of an Irish category in all monitoring of health and social care commissioned services and partner agencies
2. To ensure that local primary care and other health/social care staff are trained in the health vulnerabilities of the local Irish population
3. Conduct a mapping exercise of staff to assess/ensure Irish staff representation reflecting size of the local Irish community
4. To support Irish community health capacity building, possibly by providing a link worker
5. To ensure Irish representation on key local strategic planning and development bodies
6. To facilitate more effective engagement of local Irish councillors in local health matters
7. To acknowledge the local Irish population in key documents affecting race, ethnicity and health
8. To include a more comprehensive and specific Irish dimension/focus in strategic documents such as Brent Council's Race Equality Scheme and Brent PCT Business Plans
9. To facilitate more effective joint working and networking in relation to the provision of health services to especially marginalised Irish groups, e.g., Travellers, housebound elders
10. To resource BIAS to take on a more active role involving more health responsibilities.

11. To produce a pamphlet which summarises the key findings and recommendations of this report, for inclusion in induction packs of all front line primary care and other health/social care staff

12. To promote/provide cultural awareness training for all relevant organisations and agencies

13. To encourage and fund regular information/promotion/motivation initiatives, targeting isolated or disadvantaged Irish groups and individuals, in order to increase access to services

14. For the benefit of Irish Councillors and Irish representatives on boards and committees, to produce a bullet point statistical summary of the report's most dramatic conclusions

15. To develop a BIAS website which helps to raise awareness of the general health issues affecting the Irish community and which promotes healthy lifestyles among the Irish community itself

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## **Introduction and Background to The 2006 Irish in Brent Health Profile Report**

In 1997 Brent and Harrow Health Authority in conjunction with Equal Access and Brent Irish Advisory Service produced an Irish Health Profile: An Investigation into the Health Needs of the Irish Communities in Brent and Harrow. The 1997 report reviewed the evidence on the population characteristics of the Irish, the available health evidence and produced a number of recommendations for health care providers and the health authority. This report aims to provide an update on the 1997 evidence, and a current re-assessment of particular areas of concern regarding the health of Irish people living in Brent. This includes making a number of workable recommendations aimed at recognising and leading to improvement in the overall health of the Irish community in Brent, and calling for the development of more specific actions based upon the research findings, geared to Irish subgroups as well as health issues of particular concern.

This research project was commissioned by Brent Irish Advisory Service (BIAS) and funded by Brent Health Action Zone.

### **Why a health profile of the Irish in Brent?**

There are a number of reasons for profiling the health of the Irish in Brent:

1. The Irish are one of the largest ethnic and migrant groups in Brent
2. The health of the Irish population in England across a range of indices is exceptionally and persistently poor relative to the White majority and many other ethnic minority communities
3. In May 2005 the North West London Strategic Health Authority (SHA) published its Race Equality Scheme (RES) 2005-2008. The Scheme is the response of the SHA as a listed public body to its responsibilities under the Race Relations (Amendment) Act 2000. The Scheme outlines the importance of tackling health inequalities and improving both the health care and the

overall health of the population. The SHA's objectives include: 'to promote race equality and diversity in the NWL health services; to tackle health inequality and social exclusion among BME communities; ...to manage the performance of PCTs and Trusts in improving the health of the black and minority community' (North West London Strategic Health Authority 2005:1). Reducing the health inequality experienced by one of Brent's longest standing ethnic minority communities should therefore be a key objective for the SHA and Brent PCT.

4. Targeting Irish health would help Brent PCT to meet its targets on a number of key areas for health improvement.

## **Methods**

This research was carried out with close co-operation between the researcher and members of the Brent Irish Advisory Service (BIAS) steering group which actively participated in discussions about the health of the Irish locally and considered avenues to explore in accessing local data, given the members' knowledge of the area and the diverse, often health-related needs of their Irish client group.

The academic literature on Irish health is reviewed. Previously unpublished data on general hospital admissions, mental health admissions, access to local services, etc., are analysed in terms of Irish ethnicity. The 2001 Census is utilised as the best recent source of data on the demography of the Irish population in Brent and providing the most comprehensive source of information about the social and economic circumstances of the Irish in Brent, including information on a number of health-related indices. Local groups providing specific services were contacted for data, including homelessness projects, Travellers' projects, alcohol projects, drug projects, housing providers, etc. Various Brent Council departments were contacted for data on Irish usage of different services provided. Academics and practitioners working in the area of public health were contacted for advice on accessing data. A list of contributing organisations is listed at Appendix 1.

## **Constraints and Contexts of Researching the Irish**

Previous research conducted for the Department of Health (Walls 2004a) noted that the Black and Minority Ethnic (BME) agenda in Britain has tended to exclude Irish people. This exclusion is enacted mainly in practice by including the Irish in an overarching White 'ethnic' category with the majority ethnic group. The basis for this exclusion is increasingly being regarded as tenuous, and questioned by academics, practitioners, policymakers and public bodies (CRE 1995, Aspinall 1997, Hickman and Walter 1997, Aspinall 1998, Bracken, et al. 1998, Department of Health 2000a, Runnymede Trust 2000, Bracken and O'Sullivan 2001). Querying why the Irish are often excluded as a BME community has been based partly on 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 Ghail 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' British population (Hickman and Walter 1997). The health research on the Irish in England discussed later is a key area where the experience of the Irish diverges from the White British majority across a range of health indices.

The previous 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, et al. 1997, Nazroo 1997a, 1997b, Bracken and O'Sullivan 2001). Where research has been done, findings have 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 which may be drawn upon. From the data which are available, it is clear that Irish people, even though they are predominantly white-skinned, are disadvantaged in relation to

health, a disadvantage which is likely to be linked to wider experiences of employment, housing, migration, discrimination and hostility (Walls 2004a).

Even prior to the Census, public bodies were encouraged to adopt categories for ethnic monitoring similar to those used in the 2001 Census (CRE 1995, Department of Health 2000a), which include having a separate 'White Irish' category. Although there continue to be general problems in the extent to which ethnic monitoring is conducted which vary across regions and providers, as well as a continued practice of collapsing the Irish group into an overarching 'White' category in some analyses, the collection of data on the Irish ethnic group presents a greater possibility of health data being made available for future analyses.

Some progress has 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 et al. 2001) and psychiatric morbidity surveys concerned with ethnicity (O'Connor and Nazroo 2002, Sproston and Nazroo 2002), and reference to research on the Irish within the policy report *Inside/Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England* (NIMHE 2003) shows further Department of Health commitment to addressing 'invisible' ethnic minority needs. Recent studies of ethnic health disparities in England (Aspinall and Jacobson 2004, Fitzpatrick, et al. 2005), the recent Mental Health Census (Healthcare Commission 2005), and studies of suicide (De Ponte 2005), have included the Irish, and brought further attention to the importance of separately analysing the Irish from the White majority.

This research on the health profile of the Irish in Brent is set within these historical and practical constraints. Even when evidence has emerged of significant Irish health disadvantage across myriad indices of health (as the later review will clarify), there has been little attempt on the part of policymakers and practitioners to seriously consider how Irish health inequalities might be addressed and reduced in local contexts. As was noted recently in the *British Medical Journal*, 'Unless responsible authorities address cancer in the Irish community it is difficult to imagine how they will achieve their own targets especially in areas of high Irish population..... Apart from the moral and legal imperative, there is a sound business case for tackling

cancers among the Irish in Britain urgently' (Tilki 2005). Although the author was referring to cancer, this argument could be applied equally well to a range of health problems among the Irish. As Brent is the London borough with the highest proportion of Irish in England, positive efforts to reduce Irish health inequalities in Brent present a key means for health providers to fulfil their obligations regarding reducing health inequalities, their legal obligations regarding racial equality, and would go some way to improving overall population health and meeting targets on health.

## **A brief history of Irish immigration to and social circumstances in England**

### **Irish emigration patterns and profile of emigrants**

Ireland has historically been a country of emigration. Ireland's population size dropped continuously from 8.2 million people in 1841 to 4.2 million people in 1961. In the nineteenth century the majority of Irish migrants went to the United States, but since the 1920s, the destination for the largest number of Irish emigrants has been Britain (Walter et al. 2002). Between the 1950s and the 1980s, Walter et al. state that about 80% all Irish emigrants came to Britain. During the 1950s over 500 000 Irish people settled in Britain. Many of these people remained in Britain and account for the relatively disproportionate older age of the Irish population in Britain today.

A second major wave of emigration to Britain occurred during the 1980s. In 1989 68% emigration from the Irish Republic was to the UK, totalling over 48 000 persons coming to the UK during this year (Walter et al. 2002). This wave of emigrants differed from the previous one in that it was more likely to contain more middle-class and highly educated young emigrants, although it has also been noted that there continued to be significant proportions of those with poor education and poor skills (Hazelkorn 1990, Walter et al. 2002). Although emigration from Ireland to the UK has dramatically decreased in recent years, recent research shows that between April 2004 and April 2005 approximately 4 100 persons emigrated from the Republic of Ireland to the UK, of an overall total of 16 600 persons or 25% those who emigrated from Ireland during this time (Central Statistics Office 2005). This research on recent

vulnerable Irish emigrants revealed particular concerns about the vulnerability of Irish males, including vulnerability to ill health, prior to and following migration to England (Walls 2005).

Since the post-war period, the majority of Irish emigrants have settled in the South East of England and especially in the Greater London area. Analyses of data on the Irish second generation show that there is a preponderance of those in their 30s and 40s who are the children of those who migrated in the 1950s (Hickman et al. 2001).

Irish migration patterns differ from other Black and Minority Ethnic groups in that Irish people predominantly migrate as young single adults, rather than as part of a marital family unit. Walter et al. (2002) record that consistently the majority of Irish emigrants have been aged 15-24 years. This feature of Irish emigration may be importantly related to the development and experience of health problems among the Irish, as crucial support structures, often provided by families, may be unavailable when needed, to many Irish migrants in the UK.

The profile of Irish emigrants is marked by a gender imbalance: more women emigrated during the 1951-1991 period than men (Walter et al. 2002). In 1991, Census data showed that an exceptionally high number of Irish-born men and women in Britain were divorced, relatively low numbers were married, there were high numbers of widows reflecting an older age profile compared with other BME groups and the White population, and particularly high proportions of single men from the Irish Republic (Owen 1995). The 2001 Census shows that for England as a whole, 30% Irish households compared with 37% White British households contain married couples and 7% Irish households contain cohabiting couples compared with 9% White British households. 38% Irish people live in one person households compared with 30% White British single person households. These patterns suggest some greater degree of isolation among Irish people and possible problems in gaining social support, which may be implicated in health profiles and service use patterns described later.

## Employment

Seeking employment has been the major factor in Irish emigration to the UK reflecting poor employment prospects in Ireland and the demand for labour in the British economy. Analysing Censuses from 1951-1991 Walter et al. (2002) show that in 1991 as in 1951, construction and labouring were the most common forms of occupation for Irish men (33.9% in 1951 and 25.2% in 1991; 14.0% all men in the total workforce in 1951 and 10.9% in 1991 worked in construction/labouring). At the time of the 2001 Census 20% Irish men in England and Wales worked in construction (Howes 2004).

Irish women were distinguished between those who worked in professional jobs such as nursing, and low-skilled manual jobs (22.2% Irish women worked in professions in 1951 compared with 21.4% in 1991; 40.3% Irish women worked in personal services such as domestic and catering work in 1951 and 34.6% in 1991). In the 2001 Census, the greatest occupational differences between Irish and White British women was the greater proportion of Irish women working in health and social work (Howes 2004). High rates of upward social mobility are experienced by the second-generation Irish, particularly those with two Irish parents (Hickman et al. 2001), and particularly low rates of social mobility among those born in Ireland (Research Development and Statistics Directorate 2001). The reasons for the low rates of mobility among the Irish-born in Britain are unclear, but it is likely, that as with other groups, some level of discrimination impedes the social mobility of people born in Ireland.

The 1991 Census found that Irish-born people were over-represented compared with White people and other minority groups among those with higher level qualifications within 18-29 and 30-44 age groups and among those of pensionable age, but not among those aged between 45 years and pensionable age (Owen 1995). Both Irish-born and Irish second-generation people in Britain are more likely to stay at school after compulsory schooling and more likely to have degrees (Hickman et al. 2001).

## Housing, homelessness and amenities

In 1991 Irish-born people were less likely to own their own homes in Britain (55.4%, compared with 66.6% White people and 59.5% other Minority Ethnic groups). They were more likely to be renting from the public sector (26.3%, compared with 21.4% White people and 21.8% other Minority Ethnic groups) (Owen 1995). Among the second generation, owner-occupation is similar to the rest of the population (Hickman et al. 2001).

The 2001 Census shows that among Londoners, the Irish are less likely than all groups to own their own homes (52% compared with 57% all groups), a smaller proportion than the Irish-born a decade earlier, and the Irish are more likely to be in socially rented housing (33%) compared with all groups (26%) (Howes 2004).

Irish-born people are over-represented among disadvantaged homeless populations including rough sleepers, hostel dwellers and street-drinkers (McCann 1995, Cope 2001, Crane and Warnes 2001). In 1996, 47% of all those in London's emergency accommodation were 'Black and Irish' (Dodd 1996). In London in 1999/2000 11% of rough sleepers had been born in Ireland, compared with 1% who were Black Caribbean and 1% Asian. Irish people formed 11% of hostel residents in 2000, and Irish men particularly had been resident in hostels for exceptionally long periods of time. Irish people overall were much less likely to have been resettled into permanent accommodation than other ethnic groups. Despite their high numbers among rough sleeper populations, Irish people were significantly under-represented in numbers resettled into tenancies created by the Rough Sleepers Initiative (Crane and Warnes 2001).

Most recent data for London shows that Irish-born people continue to be over-represented among London's new street homeless contacts (Data from CHAIN, Combined Homelessness and Information Network shows 6% of new street contacts are Irish). A recent report identifying the housing and support needs of Irish people in north and west London boroughs showed that the Irish population has a 'high proportion of: one person households; pensioner single households and retired people; tenants of social housing and a low proportion of home owners; households with

people with special needs; people who are permanently sick or disabled; people sleeping rough, especially older rough sleepers; older hostel residents; hostel residents with alcohol problems; long term hostel residents; resettled homeless people with alcohol and mental health problems; users of day centres for homeless people, including those who have been rehoused but who continue to use the centres' (Randall and Brown 2005:4). The authors also found that higher levels of housing and support needs were concentrated among middle aged and older Irish people in London from an earlier generation of migrants.

More generally, in terms of amenities, the 2001 Census data show that Irish people in England are 2.6 times more likely to live in 'shared' dwellings than White British people, and in these shared dwellings the Irish compared with the White British are more likely not to have central heating (37% versus 28%). In unshared housing ('unshared' is when all the rooms of the dwelling are behind a door that only the household can use), Irish people are almost twice as likely (11%) as White British people (6%) to experience overcrowding. In London, despite having the highest proportion of one person households of any ethnic group, 16% Irish households experience overcrowding compared with 11% White British households. Irish Londoners are more likely (48%) than all groups (37%) in London not to have a car (Howes 2004).

## **Religion**

85% Irish people in England and Wales are Christian and 6% have no religion. The Census for England and Wales did not break down the Christian category, but other surveys indicate that the vast majority of the Irish in England are Roman Catholic. The proportion of Irish defined as Christian is similar in London (84%) and raised among the Irish-born in Brent (89%) (statistics.gov.uk).

## **Irish Travellers**

Irish Travellers represent a significant proportion of the Travelling community in the UK. It is estimated that there are 15 000 Irish Travellers in Britain, and there is a large community of Irish Travellers in Brent. Travellers are a distinct ethnic group who suffer particular extremes of social and health disadvantage and extremes of social

exclusion and racism. Throughout this report, available evidence on Irish Travellers' health and circumstances is included.

### **Other vulnerable groups**

Within the Irish community there are particular groups of Irish people who are particularly vulnerable in relation to health. These groups include Irish prisoners, young people in care, Irish migrant victims of childhood institutional abuse in Ireland and gay and lesbian Irish people. Again, where detail on these groups is available, it is included within this report.

### **Irish prisoners**

Howes' (2004) analysis of 2001 Census data has shown that the ratio of Irish people to White British people in prison service establishments in England and Wales is 2.4 (2.5 for Irish males and 2.3 for Irish females). In London the prison ratio of the Irish compared with the White British is 1.5 (1.6 for Irish males and 1.1 for Irish females). A recent Home Office (2003) report which focuses on the prison population in 2002 includes the Irish under the White category for ethnicity purposes, but also reveals that 30% all European foreign nationals in prison in England and Wales are from the Republic of Ireland (those from Northern Ireland were obviously not recorded as foreign nationals). 663 prisoners on 30 June 2002 were from the Republic of Ireland, which is second largest number of foreign nationals after those from Jamaica (2583). The rate per 100 000 population for the Irish is 140, and for Irish Republic-born men the rate is 294 per 100 000. This compares with a rate of 132 for UK nationals, 41 for Indian nationals and 1770 for Jamaican nationals. The rate for Irish women is 18, which is higher than the rate for UK-born women (14). (These figures are based on population totals from 2001 Census table S150 Sex and country of birth by religion and not age standardised).

This report submerged the Irish into the White category, but since 2003 the prison service has been using 2001 Census codes which monitor the Irish separately, although analyses have yet to be published in the new form. However, Irish Travellers will not be recorded separately. This is of concern, given the widespread community concern about the disproportionate numbers of Irish Travellers in prison. The CRE

reports the difficulties of Irish Travellers in prison and in high suicide rates noted later. The Commission for Racial Equality (CRE 2004) notes that in 1993 research showed that 38% admissions of all young White people, from London regional courts to Feltham Young Offenders Institution were young Travellers.

### **Children in Care**

With regard to young Irish people in care, as with many areas of anti-discriminatory discourse in Britain, social work practice has tended to exclude an Irish dimension and led to the situation where there is little regard for the cultural needs of Irish children in need of fostering and adoption (Garrett 1998, 2000), despite the Department of Health's (1991) recognition of Irish children's distinct culture. Since the 2001 Census recording of Irish ethnicity is performed by social service departments. The Dept. for Education and Skills (2004) records that in February 2003 in England 1 500 Irish children were in need, including looked after children (560) and children supported in families or independently (960), which was higher than would be expected given overall population figures.

### **Childhood victims of institutional abuse in Ireland**

There are a substantial number of Irish migrants who as children were victims of multiple abuses in children's homes in Ireland. An Irish government tribunal has investigated these abuses and many of the victims now living in England have given evidence to the tribunal. The childhoods of these people were clearly damaged and these experiences are likely to be implicated in some of the health issues in adulthood explored later, including abuse of drugs and alcohol and high rates of mental health problems.

### **Gay and lesbian Irish people**

As well as hostilities faced by the general homosexual population in England, Irish people who are gay or lesbian may face additional hostilities on the basis of their ethnic identity. Young gay and lesbian Irish, even recently (Walls 2005), appear particularly vulnerable to encountering difficulties living in England, which may be

exacerbated by some who felt they had to leave Ireland because of others' hostile responses to their sexual orientation.

### **Anti-Irish discrimination and hostility**

There continues to be a general societal blind spot about acknowledging the existence and impact of anti-Irish racism. A study on the Irish-born experience of discrimination in England was commissioned by the Commission for Racial Equality during the 1990s. Two of the most common sources of harassment for Irish people are their neighbours and the police, and the authors postulated that the latter 'may be part of a pervasive set of anti-Irish attitudes in the British police force' (Hickman and Walter 1997:127). Attacks on Irish people are rarely acknowledged as racially motivated among statutory agencies (Hickman and Walter 1997).

Travellers, including Irish Travellers are particularly excluded, marginalised and discriminated against in Britain (Kenrick and Clark 2000, Power 2004) and the focus of many racially motivated attacks. One of the most serious occurred in 2003 when a fifteen year old Traveller boy, Johnny Delaney, was kicked to death by two youths in Cheshire. The judge ruled that this crime was not racially motivated even though the Chief Inspector of Cheshire police recorded the crime as racially motivated. One of the defendants was reported as stamping on Johnny's head with both feet and said he deserved it because 'he was only a... Gypsy' (The Guardian 28 November 2003). The high prevalence of anxiety among Travellers described later has been linked to experience of, and fear of racist attack, as well as violent eviction from unauthorised sites (Parry et al. 2004:70).

Anti-Irish abuse has been recently reported in London's prisons. Both Irish and Traveller communities are recognised as racial minorities and some have won legal redress for experiences of discrimination under 1976 Race Relations Act (Walter 2000).

Much has been written about the failure to recognise not only that Irish people in England often do not share common experiences with the White British majority, but that they have experienced and continue to experience anti-Irish discrimination. The

British policy focus on ‘visible’ minorities has tended to imply that being white-skinned is a protection against any form of prejudice, hostility and discrimination. This common political stance is contradicted by a wide literature which shows that part of the experience of being Irish in England has been to experience social exclusion in areas of employment, housing and in wider social life, as well as in relation to the Criminal Justice System (Walls 2004b). There is evidence that Irish men in prison, including Irish Travellers, have faced racist abuse which may be factor in a disproportionate number of suicides among Irish prisoners (Irish World 25 May 2001, Catholic Communications Office 2004). Concerns about prisoners’ health are addressed later.

### **Explaining Irish ill health**

A failure to grasp that Irish people may experience hostility and discrimination in England, because they are Irish, overlooks one explanation of the relative social disadvantage of Irish people, and thus their health. Discrimination has been shown to affect not socio-economic status and thus health, but discrimination outside of employment may also affect health via psychosocial pathways (Krieger et al. 1993, Krieger 1999) as well as having direct health effects (Krieger 1990, Benzeval et al. 1992, Krieger et al. 1993), and also be implicated in poor health through an experience of relative deprivation (Wilkinson 1996). Researchers outlining patterns of Irish health in particular have tended to side-step the possibility of anti-Irish discrimination, and have tended instead to locate possible explanations for Irish ill health in unproven assumptions about Irish culture, a focus on health behaviours out of the contexts in which they are located, or in theories of the selection of (usually) unhealthy Irish migrants for emigration.

The research on Irish health, and its interpretation, reflects the wider problematic of the place of the Irish within debates on ethnicity in Britain, and this forms an obstacle to understanding of the health of the Irish. However, the most promising routes towards understanding the health of Irish people in Britain have been proposed by medical sociologists, who argue that considering all the possible explanatory frameworks, ‘**the experience of the Irish in England** is central to understanding’ their poor health (Kelleher and Hillier 1996:116) as is, ‘the possibility of **sustained**

**disadvantage in a specialised minority environment** in Britain' (Williams 1992:97). These assessments together point to the importance of the experience of ethnic minority identity and the specificity of the experiences of the Irish as central to addressing their health.

Explanations of Irish ill health have taken various forms and have generally, although not always, been in relation to Irish migrants. For example, Adelstein et al. (1986) propose negative selection as a precursor to Irish mortality in Britain, while others attribute mortality to health behaviours (Balarajan and Yuen 1986), although among some there is recognition of the link between stress of some sort and engagement in health damaging behaviours (Adelstein et al. 1986). In addition to negative selection (Marmot et al. 1984), a dual process of both negative and positive selection of Irish migrants has been suggested as possibly explaining mental health (Williams 1992). Others have stressed the importance of cultural and family patterns in mental health in Ireland as well as Britain (Cochrane and Bal 1987), and religion, culture and identity sustenance problems have been linked to mental and physical health (Kelleher and Hillier 1996), or accounted for by the effects of the experience of colonisation on the Irish psyche (Greenslade 1992).

Regarding the second generation, the possible explanatory potential of cultural and lifestyle factors (Harding and Balarajan 1996) has been noted. Hickman and Walter (1997) in their CRE study linked Irish social and health disadvantage with experiences of discrimination, and Tilki (2003) has argued that anti-Irish discrimination is a key factor in Irish migrants' health.

What is notable is that the Irish present a conundrum for theorists and others, which is partly linked to how and whether they are perceived as an ethnic group. What is interesting is that even when some theorists deny their ethnic status, the Irish are inadvertently described as different from the British, often as though this (usually negative) difference is something which is essentially 'Irish'. This seems to be part of a wider practice of pathologising the culture of minorities (Sheldon and Parker 1992, Ahmad 1993) It has been implied that not only does being Irish bring inevitable disadvantages (Peach 1996), but dissociating Irish disadvantage from the possibility of discrimination (Caulfield and Bhat 1981), is reminiscent of nineteenth century

accounts of the Irish being blamed for their misfortunes, including disease and poverty (Williams 1992). More usefully, drawing on the clear health deficits among first and second generation Irish people, Raftery et al. (1990) have argued that regarding 'race' and ethnicity as synonymous is untenable with regard to health, and Nazroo, in a community study of mental health, noted, that among Britain's major ethnic groups, 'factors associated with ethnic minority status might **increase risk** of mental illness **regardless of skin colour**' (Nazroo 1997a:85-86).

However, even as the Irish population is generally overlooked in terms of the provision of health policy solutions and practice, there is a growing awareness that Travellers, many of whom are Irish Travellers, are a particularly socially excluded and disadvantaged group with serious health concerns, married with an increasing research interest in the health of Travellers in Britain.

The failure not only of academic theorists, but perhaps most importantly, of health providers, to understand the experiences of Irish people in England, as well as Irish Travellers, means that measures to improve Irish population health are not being introduced, and health staff may remain culturally insensitive as well as ignorant of the health needs of the Irish.

### **Making sense of the evidence on Irish health**

Health is broadly and inevitably an effect of both structural and cultural processes. There are a number of explanations given generally for ethnic health inequalities, summarised by Smaje (1995) as artefact explanations, material explanations, cultural explanations, social selection, the effects of migration, the effects of racism and genetic explanations. Williams (1992) and Kelleher and Hillier (1996) have systematically assessed these explanations in relation to the Irish. Kelleher and Hillier (1996) argue for the importance of material factors as contributory, as well as for the importance of the influence of culture and exploring the issue of Irish identity in England, while Williams (1992) argues that examining the disadvantaged minority environment of the Irish is the place to look for explanation. There seems little dispute about culture being dynamic and shaped within a new environment, and itself affected by wider structural aspects of disadvantage and experience of discrimination. This is

important to bear in mind in understanding and making proposals on how Irish health inequality may be tackled.

## **General profile of the Irish community in Brent**

Seven per cent of Brent residents, or 18 313 people living in Brent at the time of the 2001 Census identified as Irish. This population represents the highest proportion of Irish people in any London borough. 48% the Irish are male (8812 Irish males, 9501 Irish females, derived from 2001 Census, Standard Table T13, Theme Table on Ethnicity).

There is also a substantial Irish Traveller community living in Brent. Ninety nine per cent of the Travelling community in Brent is Irish: some of these Irish Travellers live on an official Travellers' site which is home to over 200 Travellers. Brent also plays host to an unknown number of 'settled' Travellers. Accurate local and national figures for Irish Travellers are difficult to find. Power (2004) cites recent research (O'Dwyer 1997:9) which estimates there are about 15 000 nomadic Irish Travellers in Britain, but this figure does not include 'housed' Travellers.

Brent has only one official Traveller site which is situated in Neasden, Lynton Close, NW10. The Local Authority Education Department provides a Traveller Education Service to school aged children in the borough, their main concern being that the education of Travellers is in keeping with the principles of the Education Reform Act 1988 and the Authorities curriculum statement. There is also a Health Visitor for Travellers who works on the Lynton Close Traveller site. Based at a local Health Clinic her main role involves working with women and under 5s in providing a range of health services in the area of pre and post natal care, immunisation, health checks, family planning and well women services.

## **Age structure**

The Irish population in Brent is older than all other ethnic populations. The age structure of the Irish has implications for their health needs. Fewer of the Irish are young (16.9% Irish; 26.6% White British; 37.7% Asian; and 40.2% Black population

are aged 24 and under, see Table 1 below). 45.9% Irish population of Brent is aged over 50 years. This compares with 33.8% White British population of Brent, 20.7% Asian population and 19.5% Black population who are aged 50 years and over. 12% pensioners in Brent are Irish and 13% those aged over 55 in Brent are Irish.

**Table 1: Age profile of selected ethnic groups in Brent**

	<i>Ethnic Group</i>			
	Irish	White British	Asian*	Black**
<i>Age group</i>				
<i>in years</i>				
0-15	8.9%	15.0%	22.0%	27.3%
16-24	8.0%	11.6%	15.7%	12.9%
25-49	37.3%	39.7%	41.7%	40.4%
50-59	18.4%	10.7%	9.5%	6.8%
60-64	8.3%	4.3%	3.9%	4.4%
65-74	12.3%	8.6%	5.2%	6.4%
75 and over	6.9%	10.2%	2.1%	1.9%

Source: 2001 Census, Standard Table T13, Theme Table on Ethnicity

Asian\* includes Indian, Pakistani, Bangladeshi and Other Asian; Black\*\* includes Black Caribbean, Black African and Other Black here and throughout this report.

### **Place of birth: migrants and subsequent generations**

The majority of those classified as ‘White Irish’ at the time of the 2001 Census were born in Ireland: 69% Irish in Brent were born in the Republic of Ireland and 4% were born in Northern Ireland. A quarter of Brent Irish (26%) was born in England. However, what the Census figures fail to reveal is the realistic size of those who are second generation or third generation Irish (that is, those whose parents and grandparents were born in Ireland). Howes (2004) cites a recent Greater London Authority (GLA) survey which revealed that 11% Londoners have Irish parents and 19% have Irish grandparents. This implies that many of those who might have identified as Irish in the Census because of Irish parentage/grandparentage did not do so.

It is important to bear in mind that regardless of the reasons why many did not identify as Irish, research evidence during the last decade has revealed that the health disadvantage of the first or migrant Irish has clearly persisted into subsequent generations. These studies analysed mortality and morbidity of second and third generations (Harding and Balarajan 1996, Harding 1998, Harding and Balarajan 2001) as part of the ONS Longitudinal Study, following up those with Irish-born parents and their children, identified originally from a question on parents' place in birth in the 1971 Census.

### Proportion of Irish by ward of residence

The Irish population of Brent is spread throughout the borough, with highest concentrations of Irish people in Dollis Hill, Mapesbury, Dudden Hill, Kilburn and Willesden Green, and lowest concentrations in the wards of Kenton, Alperton and Wembley Central. It is notable that the Irish population in Brent is more densely concentrated in the less affluent (eastern and southern) wards of the Borough.

**Table 2: Percentage of Irish people by ward of residence in Brent**

13.2% Dollis Hill	10.6% Mapesbury	9.3% Dudden Hill
9.1% Kilburn	9.1% Willesden Green	8.8% Welsh Harp
8.5% Fryent	7.8% Kensal Green	7.1% Harlesden
6.7% Brondesbury Park	6.2% Queen's Park	6.2% Northwick Park
6.0% Stonebridge	5.7% Tokyngton	5.7% Queensbury
4.9% Sudbury	4.8% Barnhill	4.3% Preston
4.2% Kenton	4.1% Alperton	3.1% Wembley Central

Source: London Borough of Brent website - [www.brent.gov.uk](http://www.brent.gov.uk)

### Housing of the Irish in Brent

Irish people (59.3%) in Brent are as likely to be living in their own homes (either owned outright or mortgaged) as White British (60.0%) people. However, they are more likely to live in housing which is rented from the council or other socially rented

dwellings than the White British (23% versus 18.3%), and less likely than White British people to live in privately rented dwellings. Given the much older age structure of the Irish population, these data imply a level of housing disadvantage among the older Irish. Unfortunately, no data are available to confirm this, as housing tenure was not disaggregated by age in the released Census data. There are highest and lowest levels of home ownership among Asian and Black populations respectively.

While similar proportions of Irish and White British people in Brent live in communal establishments, a lesser proportion of non-staff Irish in communal establishments are found in medical and care establishments (46.0%) compared with non-staff White British (50.8%) people. Irish people therefore are disproportionately found in hostels and other establishments not providing a care element, than White British people. A greater proportion of Irish males than White British males are in medical and care establishments (48.6% those in communal establishments compared with 42.6%), and a greater proportion of White British females than Irish females in medical and care establishments (57.2% compared with 44.1% respectively of all those in communal establishments, derived from 2001 Census Standard Table S125, Sex and type of communal establishment by residence type and ethnic group).

**Table 3: Tenure by selected ethnic group in Brent**

	<i>Ethnic Group</i>			
	Irish	White British	Asian	Black
<i>Tenure</i>				
Owned	59.3%	60.0%	73.3%	35.1%
Rented from council	9.5%	8.9%	4.3%	19.0%
Other social rented	13.5%	9.4%	5.5%	29.3%
Private rented	14.2%	17.8%	14.0%	11.0%
Communal establishments	1.1%	1.2%	0.4%	0.6%

Source: 2001 Census, Standard Table T13, Theme Table on Ethnicity

## Brent Local Housing Information: housing associations, hostels, homelessness and rough sleepers

A range of local housing providers (hostels, housing associations) was surveyed as part of this research. The following table summarises the numbers and proportions of Irish clients residing in different establishments.

**Table 4: Numbers and percentages of Irish clients in housing of different providers in Brent**

	(Number) Percentage of Irish clients
<i>Housing organisation</i>	
Abbeyfield Society	(2)
Cyron Housing Co-operative	(5) 9.4%
Brent Housing Partnership	(758) 8.2%
Network Housing Group/Stadium HA	(90) 13%
Willow Housing	(155)
Irish Centre Housing	(22)
Coss ECHG	(11) 7.4%
Paddington Churches (PCHA)	16%*
Innisfree Housing Association	(79)
St Mungo's Hostel	(20) 18.5%
St. Christopher's	(0)
De Paul Trust hostels	(4) 3.7%
English Churches Hostel	(6) 6.7%

\* PCHA were unable to provide precise information on the number of Irish tenants. This figure relates to information gained from a status survey of tenants conducted between October and December 2003. The survey had an overall response rate of 43.8%, and a 40% response rate in Brent. The figure of 16% represents the proportion of respondents to this survey in Brent who identified as Irish.

In 2001, Irish men were 3.3 times more likely to be hostel dwellers in Brent compared with White British men. Rates for men from other selected ethnic groups compared

with White British men were much lower (Indian 0, Pakistani 1.0, Bangladeshi 0, Black Caribbean 1.3 – see Table 5- derived from 2001 Census data). The percentage above of proportions of Irish staying at St. Mungo’s hostel (18.5%) suggests that Irish people continue to be over-represented in local temporary housing. 80% St. Mungo’s Irish clients are aged 50 years and over and 90% are male. The average stay of these clients in this hostel is 1191 days, with the shortest stay of 32 days and the longest of 3675 days (over ten years). The figures for London generally reveal an even higher proportion of Irish people living in hostel accommodation. Overall in London, Irish people are four times more likely than White British people to be living in hostel accommodation, and this is raised for Irish men (5.1 times more likely than White British men - see Table 6 below).

**Table 5: People living in hostels by selected ethnic group in Brent, 2001**

	Numbers in hostels			Ratio of group % to White British		
	People	Males	Females	People	Males	Females
All groups	130	102	28	1.8	1.4	-
Irish	16	16	0	3.2	3.3	-
White British	21	21	0	1.0	1.0	
Indian	0	0	0	-	-	
Pakistani	6	3	3	2.1	1.0	
Bangladeshi	0	0	0	-	-	
Black Caribbean	9	9	0	1.2	1.3	

Source: 2001 Census Standard Table S125 Sex and type of communal establishment by resident type and ethnic group and includes youth hostels, hostels for the homeless and people sleeping rough and excludes housing associations

**Table 6: People living in hostels by selected ethnic group in London, 2001**

	Numbers in hostels			Ratio of group % to White British		
	People	Males	Females	People	Males	Females
All groups	10 024	5 720	4 304	2.1	1.8	2.6
Irish	591	474	117	4.0	5.1	2.2
White British	2 855	1 879	976	1.0	1.0	1.0
Indian	256	146	110	0.9	0.8	1.1
Pakistani	122	71	51	1.3	1.1	1.7
Bangladeshi	105	45	60	1.0	0.7	1.7
Black Caribbean	475	239	236	2.1	1.8	2.8

Source: 2001 Census Standard Table S125 Sex and type of communal establishment by resident type and ethnic group and includes youth hostels, hostels for the homeless and people sleeping rough and excludes housing associations

### Homelessness and rough sleeping

A recent survey of London's homeless day centres revealed that 15% (323/2191) clients were Irish (ALG 2004). In Brent, one third of the clients of Cricklewood Homeless Concern are Irish people and 87% these Irish clients are male. The highest proportions of Irish clients are in the 45-64 year old age group (50% of the total), with a large proportion (38%) also in the 25-44 year old age group. Brent Council reports about 100 homeless applications per year from Irish people. A homelessness review carried out by Brent Council in April 2003 reported figures on the ethnicity of clients approaching voluntary and charitable organisations during the year 2001/2. The total number of people who engaged charitable and voluntary services over the year 2001/2002 was 2,667 and the ethnicity of approaches to voluntary organisations was 527 Black or Asian, 525 White and 596 Irish. Given wider population figures, this

suggests that Irish people are disproportionately seeking help and support in relation to homelessness and housing. As mentioned earlier, the Irish comprised 6% all new CHAIN street contacts throughout London from 1/4/05-9/9/05. 8/122 (6.6%) of all Irish bedded down street contacts in all inner and outer London boroughs recorded by CHAIN were recorded in Brent.

### **Household composition**

Irish people and White British people in Brent in 2001 were much more likely than other main ethnic populations to live in one person households as Table 7 below shows. London-wide data show that 58.1% frail elderly households contain just one person, so a large proportion of elderly frail Irish as well as others are likely to be living alone. Special needs households are twice as likely in London as a whole to contain only elderly people, which suggests high levels of isolation among those with special needs (which includes frail elderly, physical disability, learning disability, mental health problem, severe sensory disability, other) (Fordham Research 2005).

Asian households were most likely to comprise married couples and Black households most likely to be lone parent households. Irish households were less likely to comprise co-habiting couples compared with White British households and Irish households were more likely than White British households to be lone parent households. The prevalence of one person households among the Irish and White British is a likely effect of their older age structure compared with other groups. However similar proportions of Irish (21.9%), White British (21.5%) and Black people (22.3%) live in one person, non-pensioner households, whereas this is much less common among Asian households (7.4%).

Irish couple households were almost twice as likely to contain non-dependent children (16.1%) as White British households (8.8%). Irish households (10.0%) were also slightly more likely than White British households (8.3%) to have two or more dependent children.

**Table 7: Household composition by selected ethnic group in Brent, 2001**

	<i>Ethnic Group</i>			
	Irish	White British	Asian	Black
<i>Type of household</i>				
One person household	36.4%	40.0%	10.4%	20.8%
Married Couple	27.9%	20.8%	52.2%	19.3%
Co-habiting couple	6.0%	8.9%	1.9%	5.2%
Lone parent household	12.0%	8.8%	7.4%	27.1%
Total number of households	9519	34771	20352	20718

Source: 2001 Census

### Special Needs Households

Relevant to overall health is the proportion of households with members with special needs. A recent GLA report by Fordham Research (2005) analysed data from over 40 000 London households and defined 13.1% these households as special needs households. Special needs as noted above includes those defined as frail elderly, those with physical disabilities, learning disabilities, mental health problems, severe sensory disabilities and other special needs. Analysing by ethnicity revealed that London-wide, Irish households have the greatest proportion of households with special needs (17.9% White Irish compared with 14.1% White British; 14.5% Black Caribbean and 13.3% all households). The authors say this is due to the larger proportion of older people among the Irish (Fordham Research 2005).

### Car ownership

Car ownership is often taken as a proxy for socio-economic disadvantage. The following table shows the proportions of different ethnic groups in households not owning cars in different types of housing provision. Black households (45.7%) overall were the most likely not to own cars or vans, followed by Irish households (43.5%). Asian households were highly likely to own vans or cars. However, disaggregating car ownership by housing type revealed that among those in the most disadvantaged

housing (council, other socially rented, rented from private landlords/agencies), Irish households were much less likely than all other groups to have cars or vans. 71.9% Irish council tenants had no cars, 71.4% Irish households in other social housing (housing associations, etc) had no cars/vans, and 60.8% Irish households renting from private landlords/agencies had no cars or vans.

**Table 8: No cars/vans by household type and selected ethnic group of household reference person (HRP)**

	<i>Ethnic Group of HRP</i>			
	Irish	White British	Asian	Black
All households	43.5%	38.9%	20.3%	45.7%
Council rented	71.9%	70.2%	47.1%	60.1%
Other social rented	71.4%	64.8%	41.0%	54.2%
Rented from private landlord or agency	60.8%	52.7%	47.0%	55.8%

Source: 2001 Census Standard Table T111, Tenure and number of cars or vans by ethnic group of household reference person

### Central heating and overcrowding

Irish people in Brent were 1.5 times more likely to be living in households described as ‘shared’ (‘unshared’ is when all the rooms of the dwelling are behind a door that only the household can use) compared with White British people. Among the vast majority who live in unshared dwellings, those living in Irish households were as likely as those living in White British households to have central heating (Irish households 92.2%; White British households 92.5%). However, those in unshared Irish households were more likely than those in White British households to face overcrowding: among those with central heating, 19.2% those in Irish unshared dwellings faced overcrowding compared with 15.1% White British households, and in unshared dwellings with no central heating, 27.4% people living in Irish households

were overcrowded compared with 17.4% those living in similar White British households. Irish people were nearly five times more likely than White British people to be living in, 'caravan or other mobile or temporary structure' which probably represents the high proportion of Irish Travellers living in Brent. (Derived from Census 2001 Standard Table S123, Shared/unshared dwelling and central heating and occupancy rating by ethnic group).

### **National Statistics Socio-economic Classification (NS-SeC) and Irish ethnicity**

Social class has a proven gradient in relation to health. Table 9 below shows the percentages of Irish people in Brent compared with White British people in the different categories of classification. What is most striking is the relative lack of Irish people, both male and female Irish in managerial and professional jobs, compared with White British people. While 41.3% White British men in Brent are thus employed, this falls to 22.5% for Irish men. Similarly, White British women are more likely to be found in these better jobs (36.7%) relative to Irish women (25.6%). Irish men and women were much more likely to be in semi-routine or routine occupations than White British people, and more likely to never have worked or to be long-term unemployed.

Compared with all men in Brent, Irish men were less likely to be in managerial and professional jobs (22.5% Irish males, 31.3% all Brent males), intermediate occupations (3.9% Irish males, 5.7% all Brent males), and less likely never to have worked and be long-term unemployed (4.8% Irish males, 5.5% all Brent males): they were more likely than all Brent males to work as small employers and own account workers, reflecting high numbers in construction (18.8% Irish males, 10.6% all Brent males were small employers/own account workers), to work in lower supervisory and technical jobs (8.3% Irish males, 7.1% all Brent males), and in semi-routine and routine occupations (18.6% Irish males, 17.0% all Brent males).

Compared with all women in Brent in 2001, Irish women were less likely to be in managerial and professional jobs, intermediate, and small employers/own account workers, and were 1.7 times less likely than other women never to have worked or to

be long-term unemployed. They were however 1.2 times (or 20%) more likely to be in routine and semi-routine occupations than all other women in Brent.

**Table 9: National Standard Socio-economic Classification: comparison of Irish and White British people by sex in Brent, 2001**

	Irish		White British	
	Males	Females	Males	Females
<i>NS-SeC</i>				
Managerial and professional occupations	22.5%	25.6%	41.3%	36.7%
Intermediate occupations	3.9%	13.1%	5.8%	13.9%
Small employers and own account workers	18.8%	2.6%	10.5%	4.1%
Lower supervisory and technical occupations	8.3%	3.2%	6.8%	2.8%
Routine and semi-routine occupations	18.6%	19.5%	13.1%	12.0%
Never worked and long-term unemployed	4.8%	5.8%	3.0%	3.7%

Source: 2001 Census Standard Table S112, Sex and NS-SeC by ethnic group

## Employment

As Table 10 shows economic activity among Irish people aged 16-74 years (61.9%) is less than that among White British people (70.1%) in Brent. Lesser rates of economic activity among the Irish in Brent are likely to be attributable to the older age of the Irish population. Among the economically active, unemployment rates are similar among the Irish and the White British (5.9% Irish unemployed of economically active, 5.5% White British unemployed of economically active).

Among those who are economically inactive, similar proportions of Irish and White British people are looking after their homes/families. However, much higher

proportions of Irish than White British people are economically inactive due to permanent sickness/disability (21.8% Irish economically inactive are permanently sick/disabled compared with 16.0% White British people who are economically inactive due to sickness/disability). There are, however, marked gender differences discussed later. Overall among those aged 16-74 years, 8.3% Irish people are permanently sick/disabled, compared with 4.8% White British people who are permanently sick/disabled.

**Table 10: Economic activity of Irish and White British aged 16-74 years in Brent, 2001**

	Irish	White British
Economically active	61.9%	70.1%
Economically inactive	38.1%	29.9%
- % economically inactive looking after home/family	16.5%	16.4%
- % economically inactive permanently sick/disabled	21.8%	16.0%

Source: 2001 Census Standard Table T13, Theme Table on Ethnicity

### Occupation and industry

The high rates of permanent sickness and disability among Irish people noted above, are likely to be linked to the high proportions of Irish men who have worked in the construction industry. Howes (2004) notes that 20% Irish people in Brent work in construction, which compares with 12% Irish people across London working in construction and 22% Irish men in London compared with 6% White British men in London working in construction.

In Brent in 2001, 35.9% Irish men who were working in the week before the Census were working in the construction industry. This compares with 9.1% local White British men, 8.7% Asian men and 6.3% Black men living in Brent who were working

in construction during the same time period (2001 Census Standard Table S110, Sex and industry by ethnic group). These figures obviously exclude the high numbers of Irish men (35.1%) noted later aged over 25 years who are permanently sick and disabled, probably as a result of prior working in the construction industry. Howes (2004) states that in a Sample Census in the 1960s, 70% all foreign-born construction workers in London and in Great Britain as a whole were born in Ireland. This pattern of employment has persisted and is a key contributor to ill health among Irish men.

The majority of Irish women in Brent work in health, social work and education (35.6% compared with 28.4% White British women working in similar occupations) (2001 Census Standard Table S110, Sex and industry by ethnic group).

### **Educational disadvantage**

Educational disadvantage is associated with socio-economic and health disadvantages. The Irish population of Brent is highly educationally disadvantaged compared with the White British population. 33.6% Brent's White British population aged 16-74 years have higher level qualifications compared with 18.2% Irish population in Brent. 48.4% Irish population aged 16-74 years have no qualifications compared with 27.8% White British people in Brent who have no qualifications in this age group.

Local data were not obtained for eligibility for Free School Meals (FSM), which is used as a proxy measure of poverty disadvantage and social exclusion. Nationally, Irish Travellers (Travellers of Irish Heritage) are the group with the highest proportion of children eligible for FSM. More than 80% Irish Traveller primary school children in London are eligible for FSM and 70% Irish Traveller secondary school children are eligible (Fitzpatrick et al. 2005). This compares with less than 20% White British primary and secondary school children. These national data are likely to be replicated at local level among Brent's Irish Traveller population.

Generally educational attainment is worst among those who are eligible for FSM, and this is particularly marked among White British, White Irish and White Other groups. Nationally the highest achieving groups among those not eligible for FSM are

Chinese, White Irish, White and Asian, Asian Other and Indian groups (Fitzpatrick et al. 2005). This pattern suggests a diversity within the Irish population with the worst off children achieving worse than average, and the best off better than average nationally.

### Permanent sickness/disability rates among the Irish

**Table 11: % Permanently sick/disabled by ethnic group and gender, persons aged 25 – 74 years in Brent, 2001**

	All persons	Males	Females
All persons	5.6%	6.0%	5.2%
Irish	9.0%	11.5%	6.6%
White British	5.5%	6.0%	4.9%
Indian	5.7%	5.3%	6.2%
Pakistani	6.9%	7.1%	6.6%
Bangladeshi	6.5%	7.3%	5.3%
Black Caribbean	6.1%	6.6%	5.6%
Black African	4.7%	4.9%	4.5%

Source: 2001 Census Standard Table S108, Sex and age and economic activity by ethnic group

Howes (2004) notes that in the borough of Brent, 8% Irish population aged 16-74 years are permanently sick/disabled. This rises to 9% for all Irish aged 25-74 years who are permanently sick/disabled. The Irish (both men and women) have the highest sickness/disability rates of all major ethnic groups in Brent (see Table 11 above). Comparative analysis reveals that while 5.6% all Brent residents aged 25-74 years are permanently sick/disabled, the Irish rate of 9% is 1.6 times the average and 1.6 times the rate for White British people in Brent of similar age. However, there are marked gender differences: 11.5% Irish men suffer from permanent sickness/disability, compared with an average of 6.0% among all men. Among men, **being Irish nearly doubles the risk of experience of permanent sickness/disability**. Irish and Pakistani women have the highest rates of permanent sickness/disability at 6.6% each.

Data noted earlier has drawn attention to the high rates of permanent sickness among Irish people in Brent who are permanently inactive. Analysing data further for gender and permanent sickness/disability among those aged 25 and over, reveals important patterns of health disadvantage, gender and economic inactivity among the Irish below.

**Table 12: % Permanent sickness by ethnic group and gender, among economically inactive persons aged 25-74 years in Brent, 2001**

	All persons	Males	Females
All persons	17.2%	24.7%	12.9%
Irish	23.3%	35.1%	15.0%
White British	18.7%	26.3%	13.6%
Indian	18.7%	25.8%	15.3%
Pakistani	15.8%	30.5%	10.1%
Bangladeshi	14.1%	27.3%	8.2%
Black Caribbean	17.0%	20.1%	15.1%
Black African	13.3%	20.1%	10.3%

Source: 2001 Census Standard Table S108, Sex and age and economic activity by ethnic group

17.2% all those who are economically inactive in Brent are permanently sick/disabled, and men are almost twice as likely to be economically inactive because of permanent sickness/disability, than women. 24.7% all men in Brent who are economically inactive are permanently sick/disabled, compared with 12.9% Brent females aged 25 and over who are economically inactive due to permanent sickness/disability. However, as Table 12 above shows, 35.1% Irish men who are economically inactive are permanently sick/disabled. This compares with 24.7% all other men over 25 years. Lowest rates of economic inactivity among men due to permanent sickness are found among Black Caribbean (20.1%) and Black African (20.1%) men. 12.9% all women who are economically inactive because of permanent sickness, and this is higher than average among Irish women (15.0%), Indian women

(15.3%), Caribbean women (15.1%) and slightly raised among White British (13.6%) women.

### Limiting long-term illness

**Table 13: Limiting long-term illness among Irish and White British by age group and sex in Brent, 2001**

<i>Age group</i>	Irish		White British		
		Males	Females	Males	Females
All age groups	21.6%			18.6%	
0-15 years	3.4%	3.0%	3.9%	3.9%	4.4%
16-49 years	11.0%	11.8%	10.2%	8.8%	9.1%
50-64 years	29.7%	33.9%	25.6%	27.6%	28.0%
65+ years	43.6%	44.0%	43.4%	49.8%	52.5%

Source: 2001 Census Standard Tables S107, Sex and age and limiting long-term illness and general health by and T13, Theme Table on Ethnicity

Limiting long-term illness in the Census is defined as ‘any long-term illness, health problem or disability which limits your daily activities or the work you can do’. As Table 13 reveals, Irish people in Brent have higher overall rates of limiting long-term illness than White British people (21.6% compared with 18.6%). 11.0% Irish aged 16-49 years have limiting long-term illness compared with 8.8% White British people of similar age. In this age group Irish males have 1.3 times more limiting long-term illness. Among those below pensionable age, Irish males have excessively high rates of limiting long-term illness. A third (33.9%) Irish males aged 50-64 years suffer limiting long-term illness. In the oldest age group (65 years and over), White British people have higher rates of limiting long-term illness, with a particularly high proportion of White British women in this age group suffering limiting long-term illness (52.5%).

## General Health

The 2001 Census recorded whether people assessed their health as either ‘good’, ‘fairly good’ or ‘not good’ over the previous twelve months. The following table summarises the responses for All people, White British people and Irish people living in Brent in different age groups and by gender of those stating they were not in good health.

**Table 14: Comparison of % Irish and % White British and All people reporting their health as ‘Not Good’ by age and gender in Brent, 2001**

	All		Irish		White British				
	M	F	M	F	M	F			
16-49 years	5.2%	4.6%	5.8%	7.3%	7.8%	6.8%	5.2%	4.9%	5.5%
50-64 years	18.1%	17.6	18.7	20.1%	23.1	17.2	15.7%	16.0	15.4
65 years+	26.2	23.5	28.4	23.2	23.5	23.0	23.7	21.3	25.3

Source: 2001 Census

Table 14 shows that in the 16-49 year old age group, Irish people, particularly Irish men reported their health as ‘not good’. 7.8% Irish men in this under 50 years old age group reported their health as not good compared with 4.6% all men and 4.9% White British men. Irish men were thus 1.7 times more likely than all other men in Brent to say their health was not good. Similarly, Irish women were more likely than average to report their health as not good.

Among those aged 50-64 years, Irish men once more reported their health as not good more than other men. 23.1% Irish men in this age group said their health was not good compared with 16.0% White British men and 17.6% all men in Brent in this age group. 17.2% Irish women aged 50-64 years reported their health as not good, which was higher than White British women (15.4%) but less than all women (18.7%) in Brent in this age group. In the oldest age group (65+), Irish and White British were less likely than the population in general to report ‘not good’ health.

## The health evidence base on the Irish, nationally and locally

### All cause mortality

Over the last two decades studies have consistently shown higher mortality among the Irish-born living in Britain (Marmot et al. 1984, Balarajan 1995, Balarajan and Bulusu 1990, Raftery et al. 1990, Harding and Maxwell 1997, Wild and McKeigue 1997, Harding and Rosato 1999). In England and Wales, the second and third generation Irish have also been found to have significantly raised mortality rates compared with the rest of the population (Raftery et al. 1990, Harding and Balarajan 1996, 2001).

Wild and McKeigue (1997) found that the standardised mortality ratio (SMR) for Irish-born men aged 20-69 years during 1989-1992 was 139, and for Irish-born women it was 120. This compares with ratios of 106 and 100 among South Asian men and women respectively. Ratios for those born in the Caribbean were 77 for men and 91 for Caribbean women during this time. Irish men and women living in England and Wales have higher SMRs than comparable groups living in Ireland, suggesting that Irish experiences in Britain are relevant to significantly raised rates of mortality in Britain.

Most recent data (Harding and Maxwell 1997) from the 1990s (covering deaths from 1991-1993) show that there is a 35% excess in overall mortality among Irish-born men aged 20-64 years (SMR 135), with an excess of 73% in classes IV/V (SMR 173). This compares with SMRs of 107 for all men born in the Indian subcontinent and 158 for those in social classes IV/V.

Analysing deaths among younger men shows that Irish men had the highest mortality ratios in the 20-44 age group: a SMR of 145. This compares with SMRs of similarly aged men from the Caribbean (SMR 113) and the Indian subcontinent (SMR 99). Irish men aged 20-44 years in manual jobs have a SMR nearly twice as high as those in non-manual jobs (171 compared with 88) and this is particularly elevated in social classes IV/V (SMR 208 for Irish men aged 20-44 years). SMRs for Caribbean-born men and men born in the Indian subcontinent in social classes IV/V aged 20-44 years are 143 and 93 respectively. Among men aged 45-64 years, Irish men again have the

highest all cause mortality (SMR 133), which again is particularly elevated among manual workers (SMR 169).

Overall, while social class explains much of excess male mortality in England and Wales, among Irish men, *in each social class*, mortality is higher than all men in England and Wales in the same social class. Contrasting SMRs from the early 1970s with the early 1990s reveals that Irish men's mortality overall has worsened by 11% (comparing SMRs of 122 and 135). Irish men's mortality has worsened by 36% among those in manual social class III (comparison of SMR of 122 in 70-72 with SMR of 166 in 1991-1993), and by 22% among those in social classes IV/V (comparison of SMR of 142 in 1970-1972 with SMR of 173 in 1991-1993). Irish-born manual workers' mortality has worsened by 26% over this period of more than twenty years (Wild and McKeigue 1997). All cause standard mortality ratio for Irish women was 115 from 1991-1993 (Maxwell and Harding 1998).

Among the second generation Irish in England and Wales, at working ages the mortality ratio for Irish men was 126, and 129 for women, and significantly higher than all men and all women (Harding and Balarajan 1996). At ages 15-44 years, relative disadvantages were even greater for men (SMR 145) and for women (SMR 164). Harding and Balarajan write that, 'mortality (among the Irish) was raised for most major causes of death. At working ages, mortality of the second generation Irish in every social class and in the categories of car access and housing tenure was higher than that of all men and all women in the corresponding categories. Adjusting for social class did not explain the excess mortality' (Harding and Balarajan 1996:1389).

Marital status has been found to be a factor in excess Irish mortality. Maxwell and Harding (1998) found that Irish men who are not married have twice the all cause mortality rate of Irish men who are married (2.06) and there is a slight excess in the same direction for Irish women (1.28). Mortality was nearly three times higher among Irish men aged 20-44 years who were not married, and the highest differential in terms of marital status in this age group. Among older men (aged 45-64 years), the differential is still high, at nearly twice the rate of all cause mortality among not married compared with married men.

Most recent work from death registration data for 1999-2003 shows that again, people born in Ireland have significantly highest all cause mortality rates (Fitzpatrick et al. 2005).

There has been no improvement in Irish-born mortality in Britain over the last two decades and comparisons have shown that over time, the Irish-born in Britain have elevated mortality compared not only to the British, but to the Irish living in Ireland (Marmot et al. 1984, Wild and McKeigue 1997), the latter suggesting the importance of environmental factors relevant to migration and/or ethnic status. And clearly, the consistently documented poor mortality profile of Irish migrants continues into subsequent generations of British-born people of Irish origin.

A study in Ireland found that life expectancy for Traveller women was 11.9 years less and for Traveller men 9.9 years less than women and men in the non-traveller population (Barry et al. 1987 cited in Parry et al. 2004).

### **Coronary Heart Disease (CHD) or Ischaemic heart disease mortality**

Coronary heart disease (CHD) happens when your arteries become narrowed by atherosclerosis. This causes a restriction in the supply of blood and oxygen to the heart, particularly when you exert yourself and the demands of the heart muscle increase.

Irish deaths (during 1988-1992) from CHD were 75.5 per 100000 compared with 59.3 per 100 000, the average for England and Wales – an excess of 27% among those aged under 65 years and an excess of 16% among Irish people aged 65-74 years (Balarajan 1995).

SMRs for ischaemic heart disease (Wild and McKeigue 1997) from 1989-1992 among those aged 20-69 years are 124 for Irish men, and 120 for Irish women. However, when broken down by age group, the SMR for males aged 20-44 years was higher among men (SMRs males 149, females 120). The SMR for Irish males aged 45-59 was 132 and was 141 for females. Among the oldest group (60-69 years) Irish males had a SMR of 118 and Irish females a SMR of 114. Deaths from 1991-1993

(Harding and Maxwell 1997) again show a significantly elevated SMR for Irish men aged 20-64 in all classes (SMR 121) for ischaemic heart disease, with higher rates among Irish men in manual classes (151). For Irish women, significantly higher rates of ischaemic heart disease (SMR 129) were found (Maxwell and Harding 1998).

Again mortality from ischaemic heart disease is higher for Irish immigrants in Britain than for residents in Ireland (Wild and McKeigue 1997). Marriage is also a factor relating to ischaemic heart disease among Irish men and women: ischaemic heart disease is significantly higher among not married (SMR 166) compared with married (SMR 99) Irish men. Not being married is also a high risk factor in mortality from ischaemic heart disease in Irish women (SMR 151 Irish not married women; SMR 117 Irish married women) (Maxwell and Harding 1998). Most recent work again shows higher than average rates of deaths among the Irish-born due to CHD (Fitzpatrick et al. 2005).

### **Cerebrovascular disease or Stroke mortality**

Cerebrovascular disease, or Stroke, refers to brain disorders caused when the blood supply to the brain is disrupted in some way. The commonest form of stroke is caused by a blockage of a blood vessel in the brain. Balarajan (1995) showed an excess of 34% in mortality by Stroke among Irish people aged under 65 years, which was replicated by findings of Wild and McKeigue (1997). The latter found that among deaths during 1989-1992 from cerebrovascular disease in the 20-69 years age group, the SMR for Irish males was 138, and 123 for Irish females, which were significant.

Harding and Maxwell (1997) analysing later deaths among those aged 20-64 years found that Irish men show a 30% excess (SMR 130), which was elevated among Irish men in this age group defined as belonging to manual classes (SMR 173). Irish women aged 20-64 years also had a significantly elevated ratio for Stroke (SMR 118).

Cerebrovascular disease was significantly elevated among unmarried Irish men (SMR 193) and married Irish men (SMR 103), and significantly elevated among married Irish women (SMR 120) compared with unmarried Irish women (SMR 112) (Maxwell and Harding 1998).

## Cancer mortality

‘Cancer mortality of first and second generation Irish living in England and Wales is higher than of all persons in England and Wales’ (Harding 1998:958). As well as having higher rates of all cancers than the rest of the population, there is particularly raised mortality for particular cancers. Data on cancer incidence and recent hospital admissions among the Irish for various cancers is noted later.

## Lung cancer

In one study (Balarajan 1995) Irish-born men and women were the only groups to have higher rates of lung cancer deaths than those overall in England and Wales – excesses of 44% and 45% respectively. Deaths during 1989-92 were analysed by Wild and McKeigue (1997). They found that among those aged 20-69 years, Irish males had a SMR for lung cancer mortality of 151, and Irish females a SMR of 147. Comparing these findings with earlier data showed that the increase of lung cancer deaths among Irish women increased over 20 years by 25%.

In exploring social class and cancer mortality, Harding and Maxwell (1997) found that Irish-born men had mortality from lung cancer 57% higher (SMR 157) than for all men. Deaths were greatly elevated among manual (SMR 215) compared with non-manual (SMR 103) workers, but even after adjusting for social class, excess mortality among Irish men due to lung cancer remained high at 45% above the mortality of all men in England and Wales. The ratio for Irish women for lung cancer mortality during the same time was 143.

While the rate of lung cancer mortality was significantly raised for all Irish men, this was much higher among unmarried Irish men (SMR 206) compared with married Irish men (SMR 133). The same pattern holds true for Irish women: the SMR for unmarried Irish women for lung cancer mortality is 161 and for married Irish women it is 132. While marriage appears to make a difference, significant rates of death by lung cancer in all categories of marital status suggest that it is **being Irish** which is the key issue here.

## Respiratory disease mortality

In the early 1980s, Irish-born people (both males and females) had highest standardised mortality rates from respiratory diseases and tuberculosis. The SMRs for men and women were 157 and 140 respectively. SMRs were 88 and 104 for those born in the Indian subcontinent, and 105 and 106 for those born in the African Commonwealth (Balarajan and Bulusu 1990). In England and Wales from 1991-1993, Irish men had the highest SMR (162) for death by respiratory disease compared with all men, sustained even when social class was adjusted for (SMR 143) (Harding and Maxwell 1997).

## Mortality by Suicide

During 1988-1992 national figures revealed a 53% excess (higher than all other BME groups and the population of England/Wales) for all Irish-born people (at this time the excess among the Indian population was 15%) (Balarajan 1995). During a slightly earlier period (1979-1983) SMRs for suicide among young Irish people (20-29 years) showed a significant 74% excess for young Irish males and nearly a three-fold excess for young Irish women (SMR 267) (Raleigh and Balarajan 1992).

Harding and Maxwell (1997) analysing deaths during 1991-93 found that Irish men had a suicide excess of 35% overall: among men in social classes IV/V, the SMR for suicide among Irish men (216) was more than double the rate for all men. Irish women during this time had significant suicide rates of 144 (44% excess). Indian subcontinent-born women, about whom much has been written, had a lesser, statistically insignificant rate of 115 (Maxwell and Harding 1998).

While suicide rates were significantly raised for Irish men overall (SMR 135) they were significantly higher among Irish men who were not married (185) compared with those who were married (81) which was significantly lower (Maxwell and Harding 1998). For Irish men, being unmarried appears to present a significant risk for suicide. Among Irish women, the SMR for suicide for the married was 98 and for the unmarried the SMR was 193.

Analysis of mortality by suicide among the Irish second generation (Harding and Balarajan 1996) has revealed SMRs of 145 for second generation Irish men and 125 for second generation Irish women during 1971-89 among those aged 15-64 years.

A three year study of suicide in 1991-1993 in inner London showed that Irish rates of suicide were 2.9 times the local rate. For Irish-born men crude rates were 2.2 times the rates for men born in England and Wales and the rates for Irish-born women were 2.9 times the rates for women born in England and Wales. Irish women clearly had higher rates than Indian women, and higher rates than women born in England and Wales (Neeleman et al. 1997). Neeleman et al. (1997) show that these excessive suicide rates among the Irish are likely to be **under**-estimated and suggest the selection of vulnerable Irish people for migration or the effects of relatively poor circumstances in England as possible factors contributing to suicide risk.

The most recent analysis of suicides (De Ponte 2005) again reveals significantly high suicide rates among Irish migrants. During 2001-2003, those born in Ireland comprised 6.6% all suicides in London (the Irish-born population of London is 2.7% overall population), and 2.3% all suicides in England during this time (the Irish-born population of England is 1.4% total population).

During 1999-2003 in England and Wales the SMR for Irish males for suicide and undetermined deaths was 139 and for Irish females the SMR was 140 (Indian males SMR 76 and Indian females SMR 104) (De Ponte 2005). The results of this analysis queries the policy focus on Indian and South Asian women and instead raises the question of why suicides among Irish men and women which have been significantly high for decades, have received no policy response. As is noted later, findings on suicide have been matched by high rates of parasuicide among Irish people, particularly among Irish women.

There is a great deal of concern within the Irish community about high suicide rates among Irish men in prison, particularly among Irish Traveller men. A report suggests that between 1992 and 2004 there were 23 Irish male suicides in prisons in England and Wales (Catholic Communications Office 2004). Seven Irish men committed suicide in Brixton prison between 1998 and 2002. Commentaries on these deaths

attribute them to poor overall conditions in prison, isolation and a culture of anti-Irish hostility (Irish World 25 May 2001, Catholic Communications Office 2004). The Commission for Racial Equality has reported its concern about the disproportionate rates of deaths in custody, particularly among Irish Travellers, reported also in The Heavens Report by the Home Office in 2003, and in a CRE formal investigation into the prison service in 2003 which reported that Irish Travellers had difficulties coping in prison and that a number had committed suicide (CRE 2004).

### **Suicides in Brent**

According to the recent Brent PCT Public Health Report (Brent PCT 2005), suicide was recorded as the cause of death in 5 deaths in Brent in 2003, with no reference to country of birth. Suicides are usually classified with deaths of undetermined intent/injury. In Brent during 2003, there were 22 reported deaths from suicide and undetermined injury. In 2004 in Brent there were 18 deaths from suicide and undetermined intent and eight of these were reported as suicide.

In the years 2002-2004 there were 62 deaths from suicide and injury of undetermined intent in Brent. There are only valid country of birth codes for 28 of these. Of these 28 there were 10 deaths of people born in Ireland (Source of information: London Health Observatory). These local figures suggest that Irish residents in Brent face similar increased risk for suicide as the Irish elsewhere in London and England, and targeting Irish migrants (and the second generation Irish, given high suicide mortality already noted) should be a key part of the development of Brent PCT's suicide strategy which aims to reduce Brent suicides further. Although the data mentioned above are somewhat incomplete, the finding that 36% those for whom valid data on country of birth was available were born in Ireland (in a borough where those born in Ireland represent 5.5% the population), is cause for concern and local action.

### **Mortality by Accidents**

Research has shown excess mortality among Irish migrants in all age groups due to accidents. Among those aged 15 years and under a 39% Irish excess was found, and excess mortality due to accidents among those aged 15-24 years, and 65 years and

over, of 37% and 36% respectively was noted (Balarajan 1995). Among men aged 20-64 during 1991-1993, Harding and Maxwell (1997) found that Irish-born men had the highest rates compared with all others of death by accidents and injuries (minus suicides): a SMR of 189 overall, rising to 280 among men in social classes IV/V. This compares with SMRs respectively of 80 and 121 for similarly aged men born in the Indian subcontinent and the Caribbean. Deaths by accidents and injuries are significantly higher among unmarried (SMR 266) than married (SMR 105) Irish men (Maxwell and Harding 1998).

Among Irish women, the SMR for death by accidents and injuries is also significantly high (SMR 160). Death by accident and injuries was significantly higher for unmarried (SMR 219) than married (SMR 108) Irish women (Maxwell and Harding 1998).

### **Infant Mortality and child deaths**

From 1982-1985 perinatal mortality (comprises stillbirths and deaths in the first week of life) by mothers' place of birth was 10.4 among infants of mothers born in the Republic of Ireland compared with 10.1 among infants of UK-born mothers (Balarajan and Raleigh 1990). Figures for 2002 show that the rates of perinatal deaths of infants is 7.8 for UK-born mothers and 8.8 for mothers born in the Republic of Ireland (ONS 2002). Although perinatal mortality has reduced over a couple of decades, the gap between these infant deaths among mothers born in the Republic of Ireland and mothers born in the UK has widened. Mothers born in the Republic of Ireland experienced higher rates of stillbirth than mothers born in the UK (6.2 compared with 5.3) (ONS 2002).

In a recent review of 20 research studies, Patel (undated) has noted the higher perinatal and neonatal mortality among Traveller infants, and higher than average rates of stillbirths. Parry et al. (2004) in a recent study of Travellers' health in England found high relative rates of miscarriages among Traveller women (29% versus 16% matched controls). Parry et al. also found that 17.6% Travellers had experienced the death of a child, compared with 0.9% in the comparator group.

## Other mortality

Parry et al. (2004) cite the Report of the Confidential Enquiries in Maternal Deaths in the UK 1997-1999, which states that Travellers have ‘possibly the highest maternal death rate among all ethnic groups’ (Parry et al. 2004:6). In five out of six of these deaths they observe that substandard care was implicated.

## General morbidity

Census (2001) data for London show that 14% Irish people feel that they are not in good health, 23% Irish people in London have limiting long-term illness, and 8% Irish people aged between 16-74 years are permanently sick or disabled. This compares with 9% White British people who feel they are not in good health, 17% with limiting long-term illness and 5% White British 16-74 year olds who are permanently sick/disabled, with marked differences in all age bands and among men and women. Overall, Irish people in London were less likely to report that their health was good compared with White British people (62% compared with 70%). These findings mirror morbidity data from the 1999 Health Survey for England, which sampled first and second generation Irish (Erens et al. 2001), and data from the 1991 Census on the Irish-born (Owen 1995).

The data on the Irish in relation to general morbidity in Brent have already been noted, showing high reported rates of ‘not good’ health among Irish men aged 16-49 years and aged 50-64 years. The Brent findings on limiting long-term illness mirror the findings of London generally and note the particular excess of limiting long-term illness among Irish men in Brent aged 50-64 years (33.9%), as well as those aged 16-49 years. While the Brent data show similarities with the London data on overall rates of permanent sickness, the Brent data also reveals important detail among different groups of Irish people: 11.5% Irish men in Brent aged 25-74 years are permanently sick/disabled compared with 6.0% White British men, and among Irish men aged 25-74 years who are economically inactive, 35.1% these men are permanently sick/disabled, compared with 26.3% White British men in Brent.

In her analysis of data on permanent sickness/disability among all ethnic groups, Howes (2004) shows that the White Irish have highest rates of permanent sickness compared with any other ethnic group, both in London, and in England and Wales. In London, this amounts to 1.7 times the rate for all groups.

Parry et al. (2004) also found that there was a 15% excess in poor health status of travellers over a comparator non-Traveller group, and an 11% difference in prevalence of greater long-term illness among Travellers than a matched comparator group. These researchers found that for most conditions, prevalence was significantly higher among Travellers. Parry et al. (2004) compared rates of limiting long-term illness among Travellers with general 2001 Census figures: Travellers were twice as likely to experience limiting illness than the general population (41.9% versus 18.2%). The prevalence of chronic bronchitis in the local Sheffield population was 8.5% compared with 41% in the Traveller population. Asthma like symptoms were prevalent in 25.6% the Sheffield population compared with 65% Traveller population, and symptoms of possible angina were prevalent in 12% of the Sheffield population and among 30% Travellers.

### **Cancer morbidity**

The highest cancer mortality of Irish first and second generation people, compared with all other groups in England and Wales has already been noted. As well as evidence from mortality data that the Irish people are at particular risk from cancers in England and Wales, there is also detailed evidence of cancer incidence among first and second generation Irish in England and Wales, including data on recent hospital admissions relating to cancers by ethnicity. These data make a strong case that addressing cancers among the Irish should be of key importance in any area of England with a large Irish population. The persistence of cancer morbidity and deaths into the second generation, as well as the emergence of higher rates of some cancers among the second generation is a particular cause for disquiet. Many of the cancers most common among the Irish are associated with lifestyle issues, and this gives some clue to what measures might be enacted to promote health and reduce cancers in this population.

Harding and Rosato (1999) conducted a detailed analysis of cancer incidence among first generation Scottish, Irish, West Indian and South Asian migrants living in England and Wales, using ONS Longitudinal Study data from 1971-1989. Among males from the Irish Republic, high standardised incidence ratios (SIRs) of oral and pharyngeal cancers (SIR 198), liver (SIR191), pancreatic (150) cancer, and leukaemia (SIR 168) were found. Among males aged 15-64 years, the incidence of prostate cancer (SIR 219) and leukaemia (SIR 252) was significantly higher than all men. Among males from Northern Ireland, high incidences of stomach cancer (SIR 200) cancer of pancreas (SIR 192) were found.

Among females from the Irish Republic, incidence of cancer of the oral cavity and pharynx combined (SIR 321) was significantly higher than all females, as was incidence of oesophageal (SIR 219), liver (SIR 373) and larynx (SIR 233) cancers. Significantly lower incidences of uterine cancer (SIR 44) and ovarian (SIR 36) cancers were noted. Among females from Northern Ireland, lung cancer incidence was high (SIR 193), accounting for 21% all cancers among these women.

Harding and Rosato (1999) concluded that many of these cancers (pharyngeal, laryngeal, oral, oesophageal and lung) are associated with alcohol consumption and smoking, while poor nutrition is also linked to oesophageal cancers among both men and women.

High incidence of cancers was also found among the second generation Irish (Harding 1998). Harding states that socio-economic status is an important factor: the incidence was significantly higher among local authority tenants than among those in owner-occupied housing. However, overall higher incidence was still evident even after adjusting for differences in socio-economic status between second generation Irish and all others. The five most common cancers accounted for 67% all cancers among Irish women (breast, lung, colorectal, ovary and cervix) and 74% among Irish men (lung, colorectal, prostate, stomach and bladder).

Among second generation Irish women, incidences of lung and cervical cancers were significantly higher in local authority tenants than those living in owner-occupied housing. For colorectal cancer, Harding (1998) noted that it was clear that socio-

economic status was a key determinant. Compared with other Longitudinal Study (LS) women, there was a significant incidence of lung cancer among both generations of Irish women.

For second generation Irish men, a significant differential was seen for men between local authority tenants and homeowners for lung cancer. Differences in socio-economic status however did not explain the higher incidence of these cancers compared with other LS men. Incidence of lung cancer was higher among those with two Irish-born parents.

Harding noted that at the time of writing, rates of smoking among first generation Irish were known to be high, but that the prevalence of smoking among the second generation was not known. Recent data from the Health Survey for England (which included first as well as second generation Irish) suggests high smoking rates among both generations of Irish men and women (health behaviours are discussed later). Attention should be given to the importance of smoking as a considerable risk factor for significantly elevated lung cancer incidence among the Irish.

Hospital admissions for cancers were analysed. Hospital episode admission statistics were available for 2002-3 broken down by ethnicity (Source: Admissions for selected primary diagnoses and causes of London residents by ethnicity, April 2002-March 2003, London Health Observatory). The data covered London, but detail was not available for Brent. The analysis below outlines standardised admission rates for the Irish and White British in London, and for the North West London Strategic Health Authority, which covers Brent and seven other London boroughs.

In London during 2002-3, the rate of hospital admission for all cancers was 1.3 times higher for Irish people than the rate for White British people, which means that during this year, Irish people had cancer admissions which were 30% greater than White British people in London. However, the rates varied in terms of particular type of cancer as Table 15 shows.

**Table 15: Hospital Admissions for Cancers, 2002-3 for London and North West London Strategic Health Authority (NWLSHA). Crude Standardised Ratios of Irish admissions to White British admissions for different cancers**

	London	NWLSHA
All Cancers	1.3	1.6
Lung Cancer	1.8	1.9
Cancer of head and neck	1.4	1.3
Oesophageal Cancer	2.1	2.6
Stomach cancer	1.8	3.0
Colon cancer	1.9	3.3
Rectal cancer	2.5	2.4
Pancreatic	0.8	0.7
Skin	1.0	0.8
Prostate	1.4	2.2
Bladder	1.0	1.6
Breast	1.1	1.1
Cervical	0.7	0.9
Ovarian	1.2	1.3
Uterine	0.7	-
Non-Hodgkins cancer	1.1	1.8
Leukaemia	0.7	1.2
Other cancers	1.0	1.1

Source: Admissions for selected primary diagnoses and causes of London residents by ethnicity, April 2002-March 2003, London Health Observatory

Comparison of Irish ratios with the White British ratio (1.0) shows that while there is a 30% relative Irish excess in all cancers for London, this raises to 60% among those living in the NWLSHA area where Brent is located. There are particularly high ratios of lung, oesophageal, stomach, colon, rectal, prostate and non-Hodgkins cancers and very few cancers where the Irish ratios in these data are less than the White British ratios. These data reveal a correspondence at local admission levels with wider

incidence patterns of particular cancers found by others (Harding 1998, Harding and Rosato 1999) noted above.

## **Mental health**

Concerns about the mental health of the Irish in Britain have been raised within the Irish community for decades, largely because of evidence of excessively high admissions of Irish people to psychiatric hospitals, alongside evidence on the ground within the Irish community sector of high prevalence of mental health problems among clients presenting for a range of services (Morgan 2003). Earlier evidence reviewed in the 1997 report drew attention to one of the last national studies of mental health admissions which showed that in 1981 Irish-born people exceeded all other groups in overall admission rates to psychiatric hospitals (rates per 100 000 population for the Republic of Ireland-born of 1080; N. Irish-born 797; Caribbean-born 548 and English-born 504) (Cochrane and Bal 1989). These national data also showed that Irish-born people had the highest admission rates for all diagnoses (depression, neuroses, personality disorders, alcohol abuse, other psychoses), except schizophrenia, which was highest for the Caribbean-born.

Previous reviews of Irish mental health have emphasised the excessively high rates of Irish admissions for depression and alcohol abuse (Walls 1996, Brent and Harrow Health Authority 1997, Walls 2004a). The pattern of significant excessive admissions of Irish people from 1971-1981 failed to lead to much interest in Irish mental 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. This may be accounted for by local differences in community care structures and responsibilities. One London study found a pattern of Irish people having highest overall admission rates compared with Black as well as White British populations, with particularly high rates for depression, alcohol-related disorders and second to the Black population in rates for schizophrenia/other

psychoses (Walls 1996). This replicated the earlier national pattern found. Another study in Birmingham did not find an overall Irish hospital admission excess but did find an Irish excess using specialist mental health and addiction services, when controlled for age and gender, which was significant for Irish men aged 16-44 (Commander, et al. 1999).

Excessively high rates of depression have been found among Irish people both admitted to psychiatric hospital and within community samples, particularly Irish-born women, and at both national and local levels (Clare 1974, Bebbington et al. 1981, Cochrane and Bal 1989, Walls 1996). Community surveys have found higher than average scores on GHQ12, a measure of psychological ill health, among the Irish first and second generations (Erens et al. 2001). In a recent community survey, which included Irish first and second generations, Irish informants, 'had consistently, and significantly, higher rates of depression and anxiety than all other groups, with the exception of Black Caribbean men and women' (Weich and McManus 2002 in Sproston and Nazroo 2002:25). Weich and McManus found, using the CIS-R as a measure of psychiatric morbidity, that 18.4% Irish men had a score of 12 or more, compared with 11.6% White men. Prevalence of psychosis among Irish men was associated with younger age, being single and never married, renting accommodation, being born in the UK or having migrated before the age of 11 and economic inactivity (Nazroo and King 2002 in Sproston and Nazroo 2002). This study is interesting because the vast majority of these Irish interviewees were born in the UK or migrated at an early age (82%) and thus gives useful information on psychological issues among the second generation.

There were some differences among the Irish in terms of migration status: those who were born in the UK or migrated as young children were less likely feel they had low levels of practical support (19%) compared with the migrant group (28%). Among the Irish, having low levels of confiding/emotional support was more common among those who were single and never been married, and those in manual work. These perceptions of levels of social support may be linked to different patterns found among Irish people suffering mental distress.

In spite of persistently high suicide rates for decades among the Irish in England, there appear to have been no recent studies which have considered suicide attempts

among the Irish. Early studies which did focus on attempted suicide among those born in Ireland found an over-representation of the Irish-born among suicide attempters with statistically significant rates for young Irish women (Burke 1976, Merrill and Owens 1988). Smaller studies have found a link among Irish-born people between a history of attempted suicide and hospital admissions for depression (Walls 1996). Recent studies of female suicide attempts, self-harm and ethnicity have excluded the Irish (Bhugra, et al. 1999a, Bhugra, et al. 1999b), even when Irish women clearly make up a large proportion (11%) of comparison 'white' attempters (Bhugra et al. 1999a).

### **Consulting behaviour and mental health**

Early analyses of consulting behaviour showed that Irish-born people had higher rates of consulting GPs for mental health problems despite having lower overall consulting rates (McCormick and Rosenbaum 1990). Recent evidence from the 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 et al. 2001). Standardised ratios for consulting a GP for psychological distress (regarding GP consultations in the past year about being anxious or depressed or about a mental, nervous or emotional problem) were significantly higher for Irish men (1.51), and significantly lower for Chinese men (0.59) and women (0.41) and Bangladeshi women (0.64). 22% Irish men consulted for these reasons compared with 14% men in the general population. Among those aged 16-34 years, 21% Irish males consulted for psychological problems on their own behalf compared with 11% men in the general population in this age group. Irish males also had the highest levels of consulting compared with all other men in the 35-54 age group (26% compared with 18% males in the general population). Irish women had the highest rates of consulting for these reasons in the 16-34 age group (23% compared with 18% females in the general population). In the oldest age group, Irish women and Chinese women had the lowest levels of consulting for psychological problems.

The evidence that young Irish men and women are highly liable to consult GPs about psychological problems seems important and is a key means to access additional

support services. It suggests that GPs in particular should develop cultural competency around dealing with Irish people, and in particular with Irish people who are distressed. The research evidence shows that both the Irish-born and the second generation do seek help with psychological problems.

There is a general population problem of feeling that GPs are unable to help with psychological problems (Shaw, 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. Irish community groups have expressed concern about the lack of apparent skills around mental health in general, and Irish mental health in particular, at primary care level (Walls 2004a).

Evidence from community groups suggests that despite this general picture of consulting GPs, 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 and a lack of knowledge of what services are available, who therefore need support with accessing adequate services (Walls 2004a).

The data on Irish mental health, although strong, has not attracted the same interest among researchers and policymakers as the record of mental health research among Britain's Black population. Nonetheless, in recent years, inclusion of the Irish in community surveys of mental health and in strategies to improve mental health services for people from BME communities (NIMHE 2003) show some signs that the profile of poor mental health of the Irish, measured by admissions, use of GP and other services, as well as persistent and statistically significant suicide rates, are beginning to become noted. The separate inclusion of Irish ethnicity in ethnic data monitoring has now led to a situation where the mental health profile of the Irish might be updated and examined in more detail.

## Mental Health Census

The most recent publication referring to mental health and ethnicity has been the report, *Count Me In: results of a national census of inpatients in mental health hospitals and facilities in England and Wales*, which was carried out on 31st March 2005 (Healthcare Commission 2005). It is the most recent source of national data on mental health admissions, giving a snapshot of all mental hospital inpatients on one night. This census covered all inpatients in mental hospitals and facilities in the NHS and the independent (private and voluntary) sector in England and Wales. 102 NHS Trusts and 148 providers of independent healthcare services were eligible for inclusion.

In this Census, two per cent of all inpatients, or 727 persons were Irish. The Irish comprise 1.2% the population as a whole in England and Wales. The profile of the Irish group of inpatients is markedly different from others: 61.8% Irish inpatients were aged 50 years and over compared with only 53.1% British inpatients aged 50+ years, 30.2% Indian inpatients aged 50+ and 25.4% Caribbean patients aged 50+. Irish inpatients were least likely to be under 24 years. This reflects overall differences in the age profile of different ethnic groups to some extent. However, given the Irish population age profile in England and Wales, where 52.1% Irish population is aged 50+, an excess of nearly 10% among Irish inpatients aged 50+ suggests a particular issue of concern about mental health among this age group of Irish people. In contrast, among Caribbeans, admissions in the 50+ group were similar to what one would expect given the Caribbean population profile (24.1% Caribbean population are 50+, and 25.4% Caribbean inpatients are aged 50+). In the youngest age group (0-17 years), although Irish numbers of inpatients are few, Irish children are more than twice as likely to be inpatients, given their general population profile, than Caribbean children.

Irish men are more likely to be inpatients than Irish women, both overall and in terms of their proportion in the wider Irish population: while 53.0% Irish inpatients are male, Irish males comprise 47.1% the Irish population.

The standardised rate (SR) of admission for Irish people is 146, which means that Irish people were significantly more likely than average to be admitted – 46% higher than would be expected. This was the case for both Irish males and Irish females. The standardised rate for males is 148 and for females it is 143. Rates for White British people are 90 for both sexes, 87 for males and 94 for females, and significantly below the national average. Thus, Irish people are more than one and a half times (1.6 times) more likely to be admitted than White British people. Irish males are 1.7 times more likely to be admitted than White British males, and Irish women 1.5 times more likely to be admitted than White British females. These figures suggest the importance of disaggregating the White category, as this clearly reveals a significant over-representation of Irish people and an under-representation of White British people compared with the national average.

Referral sources - Irish people were significantly less likely than average to be referred by their GPs. The overall rate for Irish people is 79, with little difference between males and females. White British people were the only group to be significantly more likely to be referred by their GPs (rate of 105). Irish people were more likely to be referred by the police (130 for all Irish people; 103 for Irish males and 178 for Irish females), although these rates do not reach statistical significance. White British people were the only group significantly less likely to be referred by the police (rate of 85). Irish people were more likely than average to be referred by the courts: the rate for all Irish being referred by the courts is 145, for males the rate is 148 and for females the rate is 126, although these rates did not reach statistical significance. Only the rate for White British people being referred by courts (89), was significantly lower than average. Irish females were more likely (SR 123) than either Irish males (SR 78) or White British females (SR 93) to be referred by social services, but these differences were not statistically significant. Only White British people were significantly less likely to be referred by social services, compared with the national average.

Detention under the Mental Health Act - 46% males and 29% females, or 38% inpatients overall, were detained under the Mental Health Act, or formally admitted. Irish people (SR 105), particularly Irish women (SR 108) were more likely than average to be detained under the Act, but this was not significant. White British

people (SR 93) were significantly less likely to be detained under the MHA. With regard to sectioning under different sections of the Act, Irish people (SR 104) were more likely to be detained under Section 2, particularly Irish women (SR 127), although rates were not significant, and Irish people (SR 113) were more likely to be detained under Section 37/41, particularly Irish men (SR 123), although again rates were not significant. Section 2 gives authority for a person to be detained in hospital for assessment. Section 37/41 is a Hospital Admission Order with an added restriction order imposed by the Home Secretary. Being admitted under this section means that a crime has been committed, and that the person is suffering from a condition which warrants detention in hospital, and allows the court to send a person to hospital for treatment when the outcome might otherwise have been prison. Section 41 allows a court to place restrictions on a person's discharge from hospital. White British men were the only group of men who were significantly less likely to be detained under sections 37/41.

Irish males were the only group to be **significantly more likely** to be detained under Sections 47, 48 and 49, having a standardised ratio of 168, and 68% more likely than White British males as well as all other men to be detained in this way (this statistically significant result was overlooked in the text. The authors feel it is now too late to amend the published text). Irish men comprise over 3% all those inpatients under these sections. These sections of the Act allow the Home Office to issue a direction to transfer a person detained in prison (both sentenced and unsentenced persons) to receive treatment in hospital. This finding raises additional concern about the mental well-being of Irish men in prison already alluded to in data on Irish suicides in prison, and the particular difficulties which Traveller men have in coping with prison life.

Being placed in seclusion - Although not statistically significant, Irish men were 1.7 times more likely than White British men to be placed in seclusion and Irish females 1.3 times more likely than White British females to be placed in seclusion. Overall Irish people were 1.5 times more likely to be in seclusion than White British people.

Use of restraint - Irish men were more than 20% more likely to be restrained than White British men, although this difference was not statistically significant.

## Irish mental health admissions during 2003-2004

The source for the following analyses is the Mental Health Minimum Data Set (MHMDS), Health and Social Care Information Centre covering 2003-2004. Examining rates for England, figures for admissions during 2003-4 correspond to the Mental Health Census which was a snapshot of one night. As Table 16 below shows, Irish people were 1.4 times more likely to be admitted to mental health hospitals during 2003-4 than White British people in England. This was higher for Irish men than Irish women. Irish men were admitted 1.5 times more than White British men (a 50% excess), and Irish women were admitted 1.3 times more than White British women. Other hospital admissions data for 2002-2003 shows the ratio of Irish episodes to White British episodes for mental health admissions as 1.5. The ratio of Irish episodes for schizophrenia was 1.4 (London Health Observatory data analysed).

**Table 16: Crude admission rates for England – selected ethnic groups 2003-2004**

	White British	Irish	Black Caribbean
All	225	312	590
Male	221	333	773
Female	230	294	435

Source: Mental Health Minimum Data Set (MHMDS), Health and Social Care Information Centre

Age standardising the rates reveals a number of issues. Among admissions, rates for Irish people are higher in all age groups, except for the age group aged 70 years and over. Rates for all Irish people are exceptionally high compared with White British people, particularly among those aged 40-69 years. Irish people in their forties were admitted 1.6 times more often than White British people in their 40s. Irish people in their fifties were admitted 1.4 times more often than White British people in their 50s, and Irish people in their 60s were admitted 1.6 times more often than White British people.

**Table 17: Age-standardised admission rates per 100 000 population in selected ethnic groups in England, 2003-2004**

	White British	Irish	Indian	Black Caribbean
Age group				
In years				
0-19	39	42	33	97
20-29	272	303	253	935
30-39	315	355	333	835
40-49	285	449	246	878
50-59	206	293	200	500
60-69	199	324	214	363

Source: Mental Health Minimum Data Set (MHMDS), Health and Social Care Information Centre

Among Irish men, rates are higher than White British men in all age groups, except those aged 70+. Irish men compared with White British men were admitted 1.4 times more often in their 20s, 1.1 times more often in their 30s, 1.9 times more often in their 40s, 1.6 times more often in their 50s and 1.4 times more often in their 60s.

Among Irish women, admission rates were higher than rates among White British women among females aged 19 and under, and particularly elevated among those in their 40s and increasing among those in their 60s. Among those females in their 40s who were admitted, Irish women were admitted 1.3 times more often than White British women, among women admitted in their 50s, Irish women were admitted 1.4 times more often than White British women and among women in their 60s, Irish women were admitted 1.8 times more often than White British women.

**Table 18: Sex and age-standardised admissions by comparing White British and Irish ethnic groups in England, 2003-2004**

	White British	Irish
All		
10-19*	68	73
20-29	272	303
30-39	315	355
40-49	285	449
50-59	206	293
60-69	199	324
Males		
0-19	39	39
20-29	325	443
30-39	336	373
40-49	275	516
50-59	185	296
60-69	179	253
70+	388	333
Females		
0-19	38	41
20-29	219	180
30-39	294	336
40-49	294	385
50-59	226	306
60-69	218	388
70+	424	331

Source: Mental Health Minimum Data Set (MHMDS), Health and Social Care Information Centre

**Table 19: Rates per 100 000 population by selected ethnic group, standardised by age and gender in London, 2003-2004**

	White British	Irish	Indian	Black Caribbean
<hr/>				
All persons				
All ages	287	467	146	553
All males	289	562	185	723
All females	286	375	113	413
All persons				
20-29 years	320	402	176	914
30-39 years	393	480	264	765
40-49 years	426	838	189	914
50-59 years	332	537	168	354
60-69 years	248	451	129	399
Males				
20-29 years	352	740	256	1404
30-39 years	428	624	386	1096
40-49 years	428	1010	207	1367
50-59 years	300	564	50	397
60-69 years	249	584	127	380
Females				
20-29 years	248	131	124	547
30-39 years	358	336	151	538
40-49 years	424	732	143	647
50-59 years	364	564	92	421
60-69 years	253	393	132	417

Source: Mental Health Minimum Data Set (MHMDS), Health and Social Care Information Centre

Examining the data for London, the crude admission rate for the Irish is 60% higher than White British people, while the rate for Black Caribbeans is 90% higher. When the crude London rate is examined by gender, Irish men were 1.9 times more likely to be admitted than White British men, while Irish women were admitted 1.3 times more often than White British women. The excess rate for Black Caribbean women in London was 1.4 times that of White British women. Black Caribbean men were admitted 2.5 times more often than White British men. The table below compares the sex-standardised admission rates among Irish and White British people from Brent and selected other London boroughs. Irish males and females have higher rates in all of these boroughs when compared with White British people.

**Table 20: Sex standardised admission rates per 100 000 population of White British and Irish ethnic groups, for selected London boroughs, 2003-2004**

	White British	Irish
<i>Brent</i>		
All	169	273
Male	184	340
Female	155	210
<i>Camden</i>		
All	316	1202
Male	308	1346
Female	305	1066
<i>Haringey</i>		
All	367	860
Males	390	1143
Females	344	812
<i>Islington</i>		
All	331	994
Males	306	799
Females	374	1385

Source: Mental Health Minimum Data Set (MHMDS), Health and Social Care Information Centre

## Mental hospital admissions: London Borough of Brent

**Table 21: London Borough of Brent residents crude and sex-standardised admission rates per 100 000 population by ethnicity, 2003-2004**

	Rate
White Irish	273
White British	169
White Other	166
Asian	137
Black	420
Sex standardised rates by ethnicity	
	Rate
<i>White Irish</i>	
Males	340
Females	210
<i>White British</i>	
Males	184
Females	155
<i>White Other</i>	
Males	177
Females	156
<i>Asian</i>	
Males	135
Females	111
<i>Black</i>	
Males	512
Females	346

Source: Mental Health Minimum Data Set (MHMDS), Health and Social Care Information Centre

There were 630 mental health admissions of Brent residents during 2003-2004 (Source: Mental Health Minimum Data Set (MHMDS), Health and Social Care Information Centre). The majority of these admissions were of people from Black backgrounds (35%, including Black Caribbean, Black African and Black Other). 21% were from White British backgrounds, 16% from Asian backgrounds (including Indian, Pakistani, Bangladeshi and Other Asian), and 8% these admissions were of Irish people. Below these data are sex-standardised. They show a higher admission rate among Irish people compared with the White British (1.6 times higher). Irish males were admitted 1.8 times more often than White British males, and Irish females 1.4 times more than White British females.

The admissions data were not available for breakdown by age in Brent, but such numbers broken down by age would anyway be too small to be meaningful. Data are available however for North West London Strategic Health Authority in which Brent is situated, which are broken down by age group.

There were 5420 admissions in North West London SHA during 2003-2004. 44% these admissions were White British people, 18% were Black people, 10% were Asian people and 6% were Irish people. Below these data are standardised per 100 000 population by ethnicity. This table below shows that Irish people had 1.5 times higher admission rates than White British people, and a much higher comparative rate among Irish men (1.9) than Irish women (1.1) when compared with the White British.

**Table 22: Rates per 100 000 by selected ethnic groups and sex in North West London Strategic Health Authority area, 2003-2004**

	White British	Irish	Asian	Black
All	270	403	172	646
Males	291	547	207	871
Females	250	277	137	459

Source: Mental Health Minimum Data Set (MHMDS), Health and Social Care Information Centre

**Table 23: Age-standardised admissions rates per 100 000 population North West London Strategic Health Authority by selected ethnic groups, 2003-2004**

	White British	Irish	Asian	Black
20-29 years	253	336	234	1159
30-39 years	393	448	245	1094
40-49 years	412	863	226	1090
50-59 years	338	386	170	588
60-69 years	239	341	187	286

Source: Mental Health Minimum Data Set (MHMDS), Health and Social Care Information Centre

The table above shows that among those aged 40-49 years that Irish people were more than twice as likely as White British people to be admitted during this year in the NWLSHA area.

### **Brent Mental Health Service (BMHS) data on ethnicity of clients**

Data from Brent (community) mental health services were gathered to see whether data on Irish use of community data corresponded with the pattern of Irish over-representation in hospital due to mental health problems. The data below show that overall, Irish proportions using Brent Mental Health Services are slightly above what would be expected, given the size of the Irish population.

**Table 24: Current Brent Mental Health Service caseloads by ethnicity and sector**

	All cases	Irish cases	White British cases
<i>Sector</i>			
Brent East	883	109 (12.3%)	211 (23.9%)
Brent North West	1251	53 (4.2%)	274 (21.9%)
Brent South	813	73 (9.0%)	173 (21.3%)
All 3 sectors	2947	235 (8.0%)	658 (22.3%)

Ethnicity of referrals received by BMHS from 1/1/05 to 1/12/05 - There were a lot of missing data (ethnicity was not known about in 777/2080 (37.4%) referrals). Of those for whom ethnicity was recorded, there were 6.8% referrals of Irish people and 25.3% referrals of White British people. Data were also provided on referrals by ethnicity and age from September 2005-November 2005. Again there were a great deal of missing ethnicity data - 43.7% cases where ethnicity is not known (234/535 cases) during this three month time period. Of those for whom ethnicity has been recorded, overall White British, Black people and Irish people were referred in numbers which might be expected given their representation in the wider population, and Asian people were under-represented. 137 referrals were aged 46-65 years, and of these, ethnicity was known in 73 cases. Of these 73 cases, 17 were White British, 12 Irish, 16 Asian and 12 Black people. Given wider population distributions, Irish people are over-represented in this age group of referrals.

**Table 25: Referrals to Brent Mental Health Service by ethnicity from September – November 2005**

	White British	Irish	Asian	Black
Proportion of referrals to BMHS during Sept-Nov 2005	25.2%	8.6%	17.9%	22.9%
Proportion of each ethnic group in Brent population	29.2%	7.0%	27.7%	19.9%

Excellent ethnicity data (only 4.1% cases where ethnicity was not known) were available for inpatients to Park Royal Centre for Mental Health in Brent. Of these inpatients, 6.5% are Irish, 18.7% White British, 10.6% Asian and 45.5% are Black inpatients. Given the ethnicity composition of Brent, these admissions for Irish people are what would be expected (7.0% Brent's population is Irish), White British people are under-represented (29.2% Brent's population is White British), Asian people are very under-represented (27.7% Brent's population is Asian), and Black people are highly over-represented (19.9% Brent's population is Black).

## **Travellers' mental health**

Data on Travellers' mental health is more difficult to obtain because of a lack of ethnic monitoring of Travellers. Parry et al. (2004) found in their study that 44% Traveller women reported anxiety problems which was significantly higher than Traveller men, 30% of whom reported anxiety problems. 74 Traveller women reported anxiety problems compared with 27 comparator women. 26 Traveller men reported anxiety problems compared with 6 comparator males. There were also significant differences between Travellers and non-Travellers reporting depression. 27% Traveller women reported problems with depression, as did 11% Travellers men. These gender differences among Travellers point to particular concerns about the mental health of Traveller women.

Parry et al. (2004) compared the health status of Irish Travellers with other Travellers. They found no statistically significant differences between Irish Travellers and others over a range of symptoms, with one statistically significant exception: there was a greater prevalence of anxiety symptoms among Irish Travellers. 47% Irish Travellers suffered anxiety compared with 31% non-Irish Travellers (English, Scottish Welsh). 25% Irish Travellers reported anxiety/depression compared with 18% other Travellers, and 12% Irish Travellers reported being extremely anxious compared with 5% other reporting extreme anxiety.

## **Rates of Accidents**

Given the high mortality due to accidents among Irish-born men, the preponderance of Irish men in the construction industry, and the high prevalence of permanent sickness/disability, it would be expected that there is high prevalence of non-fatal (as well as fatal) accidents among Irish men in particular. No data were found on accident prevalence among the first generation, but the Health Survey for England does provide data on accident rates among a sample which are predominantly second generation Irish. Among men, Caribbean, Irish and White British men and women had highest observed annual accident rates compared with all other groups. Highest annual accident rates were found among Caribbean, Irish and White British men aged 16-34 years and higher rates within these groups among manual workers. Irish men

and White British men were most likely to experience major accidents at work (Erens et al. 2001). It is likely that if this study focused on the migrant generation that accident rates would be higher among the Irish, given that the employment profile of Irish migrants is poorer than the second generation Irish.

Among Travellers, Parry et al.'s (2004) study showed that Travellers had a higher prevalence of accidents in the previous six months than non-Travellers, although this difference was not statistically significant.

### **Other morbidity**

Some information about health conditions disproportionately affecting the Irish can be gleaned from the hospital admissions data which are available from 2002-3 (Source: Admissions for selected primary diagnoses and causes of London residents by ethnicity, April 2002-March 2003, London Health Observatory). However, there is a great deal of missing ethnicity data, so any findings noted here should be treated with caution.

In London during 2002-2003 Irish hospital admissions for tuberculosis (TB) were 2.6 times the rates for White British people. Brent has one of the highest TB rates in the country (Brent PCT 2005), but it was not possible to access local data on notified TB cases among the Irish. Concern about TB among the local Irish population was expressed by workers at BIAS. London hospital admissions data also show that Irish hospital admissions for chronic liver disease were 2.1 times the rates for White British people (Source: Admissions for selected primary diagnoses and causes of London residents by ethnicity, April 2002-March 2003, London Health Observatory).

### **Health Behaviours**

Health behaviours are inevitably part of the explanation for the relatively poor health of the Irish, both first and second generation in England. While sometimes a research focus on health behaviours has implied that the Irish are responsible for their poor health, as though Irish health should not also be the responsibility for policymakers and practitioners in the same way as other minority groups, so too has an Irish

community concern with stereotyping of Irish people distracted from addressing the fact that many people within the Irish community in England have problems with a range of dependencies, including nicotine, alcohol and other drugs which invariably are damaging health, affecting morbidity, and precipitating the development of particular diseases and mortality.

Considering the types of diseases suffered and the causes for the highest mortality among Irish, it would seem impossible to seriously deny that particular health behaviours are implicated in Irish health. One problem though which the Irish community are sensitive to, but which health policymakers and practitioners rarely appear to recognise, are the social contexts of Irish lives in England which promote the development of unhealthy behaviours: the general relative socio-economic disadvantages among large sections of the Irish community in terms of housing, homelessness, particular types of manual labour, the stresses and isolation of migration, etc, as well as the hostility faced by many sections of the Irish community in a range of social contexts; in neighbourhoods, in prisons, in relation to public services, in employment, etc., which are likely to influence the development and persistence of unhealthy behaviours.

In what follows, research evidence on the Irish population on a range of health behaviours is reviewed: alcohol, smoking, and drug use, diet, exercise and sexual health and fertility.

### **Misuse of alcohol**

The research evidence presents a complex picture of Irish use, non-use and misuse of alcohol. Alcohol misuse is linked to physical and psychiatric morbidity as well as mortality among the Irish. There is significant over-representation of Irish-born people in psychiatric admissions for alcohol disorders (Cochrane and Bal 1989, Walls 1996), and the Irish-born are over-represented as users of community-based alcohol agencies (Luce et al. 2000).

Luce et al. (2000) carried out a national census of all UK specialist alcohol agencies in 1999 and found that Irish people make up 6.7% clients in English treatment

agencies and they compared this proportion of Irish clients with the percentage of the Irish population of England in the 1991 Census which was 1.6%. Irish representation among those using alcohol agencies nationally was thus more than four times what might be expected.

Luce et al. found that the 'typical client' was still a middle-aged man, 'the client group showed evidence of social disadvantage and dislocation, with high rates of marital breakdown, unemployment, homelessness, sickness and invalidity' (Luce et al. 2000:117). They noted that the mean age of clients was 41.5 years. Half the sample was living in rented accommodation and many were living in insecure accommodation: 11% were living in hostels and Bed and Breakfast accommodation, 7% were homeless or of no fixed abode, and a large proportion of clients were receiving sickness or invalidity benefits. The main presenting problem was concern about 'psychological well-being' (47%), followed by concern about physical health (25%). The high numbers of Irish people accessing alcohol services in England at national levels have been replicated at local levels (Kennedy and Brooker 1986, Walls 1996) in London studies. Data discussed later reveal excessively high proportions of Irish clients at Brent Alcohol Counselling Service and at Brent Community Alcohol Service.

It has already been noted that many of the cancers among the Irish are attributable to use of alcohol. Harrison et al. (1997) analysed SMRs for alcohol-related mortality among different groups. They found that the SMR for Irish people during 1989-91 for alcohol-related mortality was 252. The Irish had consistently high mortality and they also found evidence that it this had worsened over time: at worst it could have increased by 46.7% over a 12 year period and remained over twice what would be expected over a 12 year period.

Greenslade et al. (1995) in analysing patterns of alcohol use from the General Household Survey (GHS), found that the Irish first and second generations are no more likely to drink than their British counterparts, but if they consume alcohol at all, they are more likely to do so at higher levels than their British counterparts. This work also drew attention to the high rates of excessive drinking among Irish females, and higher rates of consumption among the second generation. They found that social

class did not entirely explain excessive drinking among the Irish and suggested that problem drinking went beyond economic factors and was likely to be affected by social isolation, insecure housing, employment below level of education, racism, etc. Harrison et al. (1997) also noted that alcohol problems among the Irish were found in people in highest as well as lowest socio-economic classes and that alcohol problems among the Irish might be related to acculturation stresses and discrimination against the Irish affecting Irish material disadvantage.

The Health Survey for England 1999 on ethnic minorities found over-use of alcohol among the Irish first and second generations (Erens et al. 2001). In the general population, 12% women reported being non-drinkers compared with 10% Irish women and while 7% men from the general population were non-drinkers only 5% Irish men were non-drinkers. 46% men in the general population drank more than the government recommended guideline of no more than 3 to 4 units per day and White Irish men were more likely than any other ethnic group to drink in excess of the recommended limit (58%). The proportion of women drinking more than government recommended guidelines (no more than 2 to 3 units per day) was 29% for the general population, and highest at 37% for White Irish women.

While there is 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 et al. 1993). However, the evidence here suggests that alcohol problems are more widespread among the Irish population, affect both sexes and are also clearly intergenerational.

### **Alcohol problems among the Irish in Brent**

Some measure of the extent of alcohol problems among the Irish in Brent is discernable from the numbers of Irish people accessing Brent Alcohol Counselling Service (BACS) and Brent Community Alcohol Service (BCAS). During the first 11 months of 2005 Brent Alcohol Counselling Service saw 124 clients. 40.3% these clients were Irish. The next largest group of clients are described as ethnically 'UK'

(32.3%), 12.9% clients are of African, African Caribbean and Black British ethnicity and 8.1% clients are Asian.

The largest sex/ethnic client group attending BACS during this time was Irish men. 26.6% all clients were Irish men, compared with 17.7% UK men, 6.5% Asian men and 3.2% African, African Caribbean and Black British men within the client group. 45.8% all male clients are BACS were Irish, compared with 30.6% all male clients from the UK. This statistic is remarkable given that only 7.9% all males in Brent aged 16+ are Irish, which suggests that Irish men are nearly six times more likely to use this service than might be expected from population figures.

13.7% all clients were Irish women and 14.5% all clients were UK women. 9.7% all clients were African, African Caribbean and Black British women while 1.6% all clients were Asian women. 32.7% female clients were Irish and 34.6% female clients were from the UK. 23.1% female clients were from African, African Caribbean and Black British backgrounds and only 3.8% female clients were Asian women. Again, only 7.9% all females in Brent aged 16+ are Irish, so this suggests that Irish women are over-represented more than fourfold (4.1 times) among female clients using this service.

From April 2003-March 2004 28% clients of Brent Community Alcohol Service (BCAS) were White Irish males, and 5% clients White Irish females. During 2004-2005 40% clients were Irish (6% Irish females, 34% Irish males). From 2003-2004 32% clients were White British (21% males White British; 11% females White British) and from 2004-2005, 20% clients were White British males and 10% were White British females. The table below shows these statistics and gives comparison with the size of these various sex/ethnic populations aged 16 and over in Brent.

Irish males aged 16 and over in Brent comprise 3.8% population of Brent during 2001 and 34% clients of BCAS during 2004-5. Therefore they are 9 times more likely to be clients that might be expected. White British males in 2004-5 are also 1.3 times more likely to be clients of BCAS than might be expected. Irish women are 1.5 times more likely and White British females less likely (0.6) to be clients at BCAS. Among men

and women, it is Irish men and women who are most over-represented among the client group of BCAS.

**Table 25: % Attendance at Brent Community Alcohol Service of Irish and White British by sex, 2003-2005 compared with general population distribution**

	Irish		White British	
	Males	Females	Males	Females
2003-2004	28%	5%	21%	11%
2004-2005	34%	6%	20%	10%
2001 Census 16+	(3.8%)	(4.1%)	(15.7%)	(15.7%)

## Smoking

Previous research has shown that there are high rates of smoking among the migrant Irish in Britain (Balarajan and Yuen 1986), and smoking is a serious risk factor for a number of diseases which show high incidences and cause mortality among the Irish community in England and Wales, most notably lung cancer. Smoking is also a behaviour which is highly associated with a range of socio-economic disadvantage. The Health Survey for England (1999) sampled the first and second generation Irish and found that 27% men in the general population smoke, but this was highest among Bangladeshi men (44%) and Irish men (39%). 27% women in the general population smoke, and smoking rates were highest among Irish women (33%). Women from all other ethnic minority groups were much less likely to smoke than women in the general population.

In the 8-15 age group, 19% boys and 21% girls reported ever having smoked a cigarette. Compared with the general population, Irish girls were more likely and Indian, Pakistani, Bangladeshi and Chinese children less likely to report ever having smoked. The highest smoking rates among young Irish girls is an obvious cause for concern. 25% Irish boys had smoked and 30% Irish girls by this age. For girls in the general population 4% girls aged 8-10 and 33% girls aged 11-15 reported having tried smoking. Among Irish girls 2% those aged 8-10 and 46% those aged 11-15 reporting having tried smoking.

## Irish men and smoking

Further detail from the Health Survey for England shows that Irish men were the least likely never to have smoked. Only 32% Irish men had never smoked compared with 42% in the general male population who had never smoked and 46% Bangladeshi men who had never smoked. Irish men were slightly less likely than the general male population to be ex-smokers (29% versus 31%). Among men aged 16-34 years, 50% Irish men smoked compared with 35% men in the general population and 37% Bangladeshi men in this age group. 42% Irish men aged 35-54 years smoked compared with 30% similarly aged men in the general population. Among men aged 55+, 25% Irish men were current smokers compared with 17% similarly aged men in the general population.

Irish men, compared with men from all other minority groups were much less likely to be light smokers and much more likely to smoke the heaviest. While the Brent PCT Public Health Report 2005 commented upon the high rates of smoking among Bangladeshi men, it would seem that the prevalence and heavy nature of smoking among Irish men should be a greater cause of concern among local health providers. 40% Irish men smoke 20 or more cigarettes per day compared with 14% Bangladeshi men who smoke as heavily. 23% Irish men are light smokers (smoking less than 10 cigarettes per day) while 50% Bangladeshi men are light smokers.

In the general population there is a clear association between smoking and socio-economic disadvantage. Among Irish male manual workers the standardised risk ratio for smoking was 1.61 (44% male Irish manual workers smoked) compared with 31% nonmanual Irish males who smoked, although this class pattern was less extreme than in the general male population where 34% male manual workers smoked and 19% male nonmanual workers smoked. Examining household income and smoking revealed a similar pattern: Irish men in the lowest income tertile had the highest standardised risk ratio for smoking (2.27 compared with 1.61 for Bangladeshi men in the lowest equivalised household income). However, among those in the highest income tertile, Irish men also had the highest risk ratio for smoking (1.31 compared with 0.85 for men in the general population).

## **Irish women and smoking**

Irish women have highest prevalence of smoking compared with all women. While 33% Irish women were current smokers, 27% females in the general population smoked, 9% Chinese women, 6% Indian women, 5% Pakistani women and 1% Bangladeshi women smoked. In the 16-34 age group, Irish women were as likely as women in the general population to smoke (36%), however in older age groups, Irish women were much more likely to smoke than all other women. Of women in the 35-54 age group, 36% Irish women smoked compared with 30% women in the general population, and among those aged 55+, 25% Irish women smoked compared with 15% women in the general population. Irish women were slightly more likely than women in the general population to be ex-smokers (25% versus 22%) and much less likely than women in the general population never to have smoked (42% versus 52%). As with Irish men, Irish women were more likely to be heavy smokers than the general population.

There was a clear relationship between social class and smoking among Irish women: 39% Irish females in manual households smoked compared with 27% Irish females in nonmanual households (figures for females in the general population were 32% and 21% respectively). Irish females in lowest and highest income households smoked more than females in the general population.

## **Travellers and smoking**

High smoking rates have also been recorded among Travellers. Among the Travellers studied in Parry et al.'s (2004) research, 57% (166/293) Travellers were current smokers compared with 22% (56/260) comparators. 18% Travellers were ex-smokers compared with 23% comparators.

## **Stopping smoking**

Latest NHS figures show that between April and June 2005 in England, 1% those who set a quitting date for stopping smoking were Irish. This seems low given the size of the Irish population in England (Health and Social Care Information Centre, Statistics

on NHS stop smoking services in England April 2005 to June 2005). Given the high rates and heavy nature of smoking among both Irish men and Irish women, as well as the high mortality from smoking related causes, it would seem that the targeting of interventions to reduce smoking among the Irish should be a priority. Parry et al. (2004) observe that Tower Hamlets PCT had a cessation project which was specially targeted at the Bangladeshi community which considered the socio-cultural contexts of smoking. Given the smoking prevalence outlined here among the Irish generally, as well as Irish Travellers, it would seem that there are sensitive models which Brent PCT might explore in order to address the ethnic minority communities in Brent who are most likely to smoke.

## Drug Misuse

During 2004-2005 844 residents of Brent were in contact with structured drug treatment services. In 2003-2004 686 Brent residents were in contact with structured drug treatment services (with Drug Action Teams or DATs) and recently published ethnicity data are available for this latter year (National Drug Treatment Monitoring System 2003/2004, published 2005). There were 656 valid records. Of these 11.6% were Irish and 10.7% were Black clients. The table below shows the numbers and percentages of Brent residents from different ethnic groups receiving drug treatment services, and compares these percentages with overall Brent population statistics.

**Table 26: (Numbers) and % using Brent Drug Treatment Services by ethnicity, 2003-2004**

	Irish	White British	Asian	Black
% clients of DAT teams	(76) 11.6	(227) 34.6	(82) 12.5	(70) 10.7
% Brent population	7.0	29.2	27.7	19.9

Source: National Drug Treatment Monitoring System 2003/2004, published 2005, and 2001 Census

The percentage of Irish people getting treatment for drugs in Brent is the highest in all of the regions of England (the next highest proportion of Irish clients is in Camden

where the Irish comprise 6.7% those getting drug treatments. 4.6% Camden's population at the 2001 Census were identified as Irish). 6% all Irish in England receiving drug treatments live in Brent while only 3% all Irish in England live in Brent. Nationally the Irish do not appear to be over-represented among those receiving drug treatment (1.2% those nationally receiving treatment are Irish and the Irish comprise 1.3% England's population).

The National Drug System data available were not age-standardised. In examining the extent to which the age structure of the Irish population is implicated, the following table gives the percentages of different ethnic groups aged between 16 and 49 years as likely to represent the core age group of drug users. This table makes the Irish representation among clients of Brent's DAT even more stark.

**Table 27: Comparison % drug users with population figures for those aged 16-49 years in Brent**

	Irish	White British	Asian	Black
% clients of DAT teams	(76) 11.6	(227) 34.6	(82) 12.5	(70) 10.7
% Brent population aged 16-49 years	5.7%	27.3%	29.0%	19.3%

National Drug Treatment Monitoring System 2003/2004, published 2005, and 2001 Census

During the period of 1/1/2003-17/11/2005 from the total of 822 clients attending Addaction in Brent, 6% (n=53) of clients were of Irish origin and 85% these Irish clients were males. 45% were aged 19-34 years. Alcohol was specified as the primary drug of use among the largest proportion of these Irish clients (21 persons) followed by crack/cocaine and ecstasy/heroin (18 persons).

The high prevalence of Irish people receiving treatment through statutory and voluntary services for alcohol and drug misuse suggest that in Brent, the Irish deserve particular attention with regard to reducing the prevalence of addictive behaviours. The research profile indicates that even though the Irish access treatments, that excessive over-representation of Irish among those with alcohol and drug problems

over time, does not point to any obvious reduction in engagement in these forms of unhealthy behaviours, and suggests that early education and awareness of the risks associated with alcohol and drug problems might be targeted at the younger Irish to attempt to discourage and reduce the development of substance dependency.

## Diet

The 1997 report on Irish health in Brent and Harrow noted that there was little information available about exercise and diet within the Irish community (Brent and Harrow Health Authority 1997). Since then the Health Survey for England 1999 on ethnic minority groups included the Irish (a sample of Irish which was approximately 4/5 second generation Irish), and these findings are detailed below. The nature of the sample means that the findings will not detect differences between Irish first and second generations which may exist.

Poor diet is implicated in a number of causes of high mortality and illnesses of high prevalence among the Irish community. Hirani and Primatesta (2001) observe in their chapter Eating Habits in the Health Survey for England, 'There is evidence to suggest that dietary modifications such as a reduction in salt intake and a diet rich in fruits and vegetables, with reduced saturated and total fat, can substantially lower blood pressure, the most important risk factor for cardiovascular disease (CVD). High fat and energy intake raises cholesterol levels: high cholesterol levels have been associated with obesity, abdominal obesity, and non-insulin dependant diabetes mellitus. It has been shown that consumption of antioxidant vitamins through dietary sources such as fruits and vegetables, flavonoids (other dietary antioxidants), oily fish and fibre from fruits and vegetables (in particular from cereals and grains can protect against the development of CVD. Hence, it has been suggested that changes in the diet of the population through education and information, and adequate access to, and availability of, a wide range of healthy foods, can aid to reduce the risk of CVD' (Hirani and Primatesta 2001).

More has probably been written about the Irish diet in the past. By the beginning of the nineteenth century the dependence on potatoes had expanded in Ireland, and prior to the Famine of the mid-nineteenth century, potatoes because of their nutritious value were considered largely responsible for the Irish being one of the tallest, healthiest

and most fertile populations in Europe. Even in the eighteenth century, Adam Smith commented on the Irish in London that, 'the strongest men and the most beautiful women in the British dominions, are said to be, the greater part of them from the lowest rank of people in Ireland' and ascribed these attributes to a reliance on the potato, 'no food can afford a more decisive proof of its nourishing quality, or its being particularly suitable to the health of the human constitution' (Kinealy 1997:49-50).

Whether the potato today has any greater significance in the diet of the Irish than the White British, it is not possible to say without adequate research. The 1997 report notes that boiled bacon and some breads are popular among some Irish people. Work in Ireland has focused on the Irish having a diet high in animal fat and low in protein (Cook 1990). Kelleher and Hillier (1996) have observed that the Irish diet focus is on fresh foods, not canned or processed foods, and not on things like a high fibre diet.

The findings from the Health Survey for England on diet do show levels of fat and fibre consumption among the Irish indicated below, alongside other features of what is considered to constitute a healthy diet today.

Fat consumption - Among men, the proportion with an adjusted high fat score was highest among Irish and Bangladeshi men (22% and 21% respectively) and lowest among Indian men (11%). Irish and Bangladeshi men had the highest adjusted mean fat score (33 and 32 respectively). Among women, the highest proportion with an adjusted high fat score was among Bangladeshi women (27%), followed by Irish women (14%). Indian (8%), Chinese (9%) and Black Caribbean (9%) women had the lowest proportions.

In almost all minority ethnic groups, adjusted mean fat intake was slightly higher among younger informants (16-34 years) than among those in the two older groups, 35-54 and 55 and over. Irish men were an exception to this pattern (Irish men aged 55 years and over had a higher adjusted mean fat score than those in the middle and younger age groups). Adjusted mean fat intake declined with age among women in almost all minority ethnic groups, except among the Irish where those aged 55 years and over had a slightly higher adjusted mean fat score (31) than those in the middle (28) and younger (29) age groups.

For almost all minority ethnic groups, the prevalence of adjusted high fat score was higher in the younger than middle age groups. The exceptions were among the Irish women where the prevalence of high fat intake in the older age group (22%) was nearly twice that in the middle (11%) and younger (11%) age groups. The prevalence of adjusted high fat score was significantly higher in manual than non-manual social classes among Indian and Irish men.

Fibre intake - Irish and Indian women were less likely than other groups to have low fibre intake, having the highest mean fibre scores (33% and 33%) and the lowest proportion with a low fibre score (41% and 42%). The proportions of other minority ethnic groups (Black Caribbean, Pakistani, Chinese and Irish) with a low fibre score ranged from 53% to 72% among men and from 62% to 73% among women.

Overall, there were no clear patterns in mean fibre score by age in either sex among almost all minority ethnic groups. The exceptions were the Irish where an increase in fibre intake with age was seen in both sexes.

Among men, the largest difference in prevalence of low fibre score between manual and non-manual social classes was among Irish men; 56% those in non-manual social classes had low fibre consumption compared to 49% those in manual social classes.

Fruit intake - Among women, proportions eating six or more portions of fruit per week were 44% for Irish women, 37% for Black Caribbean women, 28% for Indian women and 24% for Pakistani women. Only 23% Irish men ate fruit six or more times per week.

Consumption of vegetables - A fairly low proportion of Irish men ate vegetables six or more times per week compared with men from other minority groups. The proportions who reported consuming vegetables six or more times a week were higher for Bangladeshi men (30%) than for Black Caribbean men (18%), Indian men (23%) and Irish men (22%). Higher proportions of Irish women than men (38% versus 22%) reported eating vegetables six or more times per week.

Consumption of sweet and savoury snacks - The proportion of Irish men (22%) who reported consuming sweet and savoury snacks six or more times a week was higher

than that of other minority ethnic groups and the proportion who reported rarely or never eating cakes and pastries was lower among Irish men (17%) than men in other groups. Among women, the proportion who reported consuming cakes and pastries six or more times a week was significantly higher among Irish women (6%) than among Black Caribbean women (2%), Indian women (2%) and Chinese women (1%).

Salt intake - Black Caribbeans were less likely to add salt during cooking (men 83%, women 81%), and Irish considerably less (men 66%, women 59%). The Irish compensated for this by adding salt at table, this proportions being higher than for other groups. Among Irish men, the proportion adding salt at table was 53%, the next highest being Pakistani (39%) and Indian men (35%), followed by Bangladeshi (29%), Black Caribbean (28%) and Chinese men (25%). Also, if Irish men and women added salt at table, more than half of those added it without tasting, whereas South Asian and Chinese groups added it after tasting (Black Caribbeans being evenly divided in this respect).

There was little difference by sex in the proportion adding salt during cooking, except that Irish men were more likely (66%) than Irish women (59%) to do so. In all groups except Bangladeshis, the proportion of men adding salt at the table was higher among men than women, the difference being particularly large in the case of Irish men (53%) and women (39%). Among Irish men and women, the practice of adding salt during cooking was more common among those aged 55 and over than among younger groups.

These findings of Hirani and Primatesta (2001) appear to suggest that measures to reduce Irish fat intake, salt intake at table, intake of snacks and increase fruit and vegetable intake among Irish men might help to improve Irish health. High fat intake among the older Irish men, and in particular Irish men doing manual work is particularly concerning.

## Exercise

Exercise rates among Irish men and women appear to be relatively good compared with the general population and most other ethnic minority groups.

Irish men had activity patterns broadly similar to those of men in the general population. Men's observed levels of participation in heavy manual/DIY in all ethnic minority groups (except Irish men) were notably lower than the 30% for men in the general population.

Irish men had higher the average ratios for doing heavy housework (1.30) and heavy manual DIY (1.08) and for walking (1.21), but slightly lower than average ratios for sports and exercise (0.92) and exercise from occupational activity (0.85). 33% Irish men compared with 33% men in the general population took part in high levels of activity FIX. Compared with men in the general population, Irish men had higher relative levels of high activity among those aged 35 and over. Among those aged 34 and under, Irish men had higher levels of inactivity (11%) than men in the general population (8%), even though rates of high activity were higher in this age group for Irish men compared with most other ethnic minority groups.

Irish women had higher than average exercise ratios for heavy housework (1.06), heavy manual DIY (1.51), walking (1.22), sports and exercise (1.17) and occupational activity (1.09). 26% Irish women had high levels of activity compared with 21% women in the general population. Compared with women in the general population, Irish women had higher levels of high activity among those aged 16-35 years and similar levels of high activity to the general population from age 55 upwards.

Among both men and women, levels of high activity were slightly more common among Irish men and women in manual classes. Irish women in manual classes had the highest ratio for high activity (1.30 compared with 1.06 in the general female population). Although there were high levels of activity among Irish men compared with others, there was a high inactivity rate among Irish men (1.37), although this was nowhere nearly as high as among men from the main south Asian groups (2.18, 3.71, 4.34). Irish women had the highest ratio of all women participating in vigorous

activity (1.03) and the significantly lowest ratio of inactivity (0.73) (Erens et al. 2001).

### **Sexual health, family size and fertility**

Most published data on sexual health to date use only a White category so it is not possible to ascertain sexual health among the Irish in England.

The majority of the Irish in England are Catholic, and thus are prohibited by the Church from using ‘artificial’ methods of birth control. However, data in England show that among the Irish Catholic migrant population in the 1970s, the Irish Catholic birth rate fell markedly during the first half of the 1970s, suggesting that Catholic women were clearly using contraception (Caulfield and Bhat 1981), which is supported by smaller surveys on use of different methods of contraception among Catholics, mothers born in Ireland, and others, from 1967 to 1975 (Bone 1973, Cartwright 1978, Woolf 1971). These surveys showed high proportions of Catholic women using artificial as well as ‘natural’ forms of contraception. It is important to note that by the 1960s, Catholic doctrine on birth control was tackled by a Commission, which resulted in the encyclical *Humanae Vitae* in 1968, following on from the Second Vatican Council, which started in 1962. It is often said that by the time of *Humanae Vitae*, which prohibited the use of artificial methods of birth control, but not ‘natural’ means, many Catholics felt that birth control was an issue for families to decide, and evidence clearly suggests that Catholics in Britain adopted a range of contraceptive methods. In the absence of evidence to the contrary, it is likely that these trends have continued.

By the time of the 2001 Census, in one family households nationally, the Irish have lower proportions than White British in all categories that include dependent children (Howes 2004), which may be partly age-related. However, with regard to Brent, as has already been noted, Irish couple households compared with White British households were more likely to contain non-dependent children and more likely to contain two or more dependent children. It is not possible without wider data to examine further the reasons for Irish family size or household composition or the extent to which any of these recent patterns vary by locality or whether they reflect increasing use of artificial contraception among Irish mothers as noted during the

1970s. The Health Survey for England did not find any great difference in usage of the contraceptive pill between Irish women (25%) and women in the general population (27%).

Traveller women have very high numbers of children. In Parry et al.'s (2004) study, Traveller women had a mean number of 4.3 children and matched comparators had a mean of 1.8 children.

### **Irish access to other services in Brent**

The Irish representation within local community mental health services, alcohol and drug treatment services and housing/homelessness services in Brent has already been discussed. Here, additional available data on other services is presented, which have relevance to the health needs of the Irish.

### **Adult access to social services**

In 2004-05 the total number of Irish service users of adult social services in Brent was 460, of which 374 accessed community based services, 30 were in LA residential care, 29 in independent residential care, and 27 were in nursing care. 385 of these Irish service users were clients with physical disabilities, 33 had learning disabilities, 33 had mental health problems, 4 were substance misusers, and 5 were vulnerable people. The total number of service users in Brent in 2004-05 was 6965, thus the percentage of Irish service users was 6.6% (Quality & Support Division, Brent Council).

### **Children's services**

28 young Irish people (2% total) were dealt with by Brent Youth Offending Service (YOS) for offences between April 2004 and October 2005. 93% these young Irish were male. On the 30th September 2005, three children of White Irish origin were on Brent's Child Protection Register, representing 2% all children on the register and 25 children and young people were 'Looked After' of White Irish origin, representing 6% all children currently looked after by Brent. This latter figure is high when

compared with Census figures of Irish children.

### **Snapshot survey of clients using the services of Brent Irish Advisory Service (BIAS)**

A description of the services provided at BIAS is given in the Director's foreword at the beginning of this report.

BIAS conducted a one week survey of its clients from Wednesday 23<sup>rd</sup> November 2005 for one week. The response rate represents approximately one third of BIAS' total client group during this time, as those in prison and many elderly clients and other who used BIAS' services during that week did not respond to the survey for various reasons, including health reasons. Only a minority of Irish Travellers who used BIAS' services during this week responded. The survey gathered basic demographic information, data on housing, employment, migration status, ethnicity, and reasons for contacting BIAS, including level of satisfaction with BIAS' services. Information gathered also included data on health problems and health services being accessed. The total sample size was 52.

Among those who responded, 67.3% were aged 45 years and over, with 42.2% clients aged 65 years and over. 54.9% clients were female. 91.5% clients were Irish migrants. 56.1% these clients had lived for more than 40 years in the UK. 74.5% described their ethnic identity as Irish and 13.7% described their ethnicity as Irish Traveller. 79.7% had been born in Ireland.

65.4 % clients were resident in Brent and the rest lived in other surrounding London boroughs, mainly in Harrow. 33.3% owned their own homes, 35.4% rented from the council or housing associations, 14.6% lived in privately rented dwellings, 4.2% lived in hostels, 4.2% lived on a Travellers' site and 2.1% were homeless. 24% rated the quality of their housing as not good or poor. 28% those in council housing rated their housing as not good, and 30% those in housing association and 29% those in the private rented sector rated their housing as poor. 92.2% of the sample were currently unemployed, 76.5 % lived in dwellings without children and 49.0% lived alone.

Those who lived alone were most likely to live in council housing or in the private rented sector.

The most common reasons for seeking the services of BIAS was for advice housing, site (Travellers' site) and homelessness issues (43%), for advice on welfare benefits (24%) and for advice on health issues (20%) and to access social and cultural services offered by BIAS (20%). Other reasons for seeking advice included advice on legal issues, moving to Ireland, domestic violence, counselling services, council tax problems, and employment, education and training concerns.

### **BIAS clients and health problems**

20% those seeking advice during this time sought advice about health problems. Additionally 68% all the clients who responded to the survey claimed to have health problems. 50% these claimed their health problems related to both physical and mental health, 32% said they had only physical health problems and 18% only mental health problems. 52% the overall sample claimed to suffer from a long-term illness or disability, which stopped them doing the things they would like to do. 33% total sample suffered from depression, often alongside other psychological and physical problems. High prevalence of anxiety (21%) was recorded among the total number of respondents. 10% reported having alcohol problems. Other health problems reported were general problems of old age, diabetes, high blood pressure, sciatica and disc problems, hepatitis, drug problems, lung dysfunction, arthritis, asthma, suicidal tendencies, mobility problems, chest pain, angina, cirrhosis of the liver and stomach ulcers.

In this client group, 52% reported that they had a limiting long-term illness or disability. Those on the 35-44 year age group claimed high levels of illness/disability (39%) compared with 35% those in the larger 55-74 year old age group. Reporting of depression was marked among younger people, and anxiety a greater problem for older people. 60% males reported limiting illness/disability compared with 44% female clients. 71% those who lived alone reported health problems. 80% those seeking advice on health problems were male, as were the majority seeking advice on disability (80%). 65% those seeking advice on housing and homelessness issues were

male. Those who had lived in the UK from 10-29 years reported greatest rates of mental health as well as mental health and physical health problems.

### **BIAS client access to health services**

The majority (54%) were receiving treatment for their conditions, and of these 43% were receiving only GP services, while 25% were receiving both GP and hospital treatments. 88% were satisfied with the type of health care they were receiving. Those who lived alone were much more likely only to be receiving treatment from GPs (46%) compared with others (36%), and more likely to be receiving support from GPs, hospital and voluntary sector groups (38%) than others (14%).

### **Client satisfaction with services of BIAS**

Of those who answered a question on satisfaction with BIAS' services, 71% respondents felt that the service they received from BIAS was 'very good' and a further 28.6% rated the service provided by BIAS as 'good'.

### **General profile of disadvantage among clients of BIAS**

This small survey of BIAS clients reveals a very disadvantaged population in terms of health, housing, and employment disadvantage. Although the majority are accessing statutory services because of health problems, it is clear that particular groups (males, those living alone) needed BIAS services for support in dealing with health problems and had a greater reliance on the voluntary sector for services.

The high levels of reporting of psychological as well as a range of physical problems, mirror concerns raised in the wider literature about the extent of and range of health problems among the Irish, both locally and nationally, although the BIAS client group also clearly represents those facing extremes of disadvantage compared with the general Irish population in Brent. BIAS appears to be easily accessed by those Irish most in need. However, it is evident that from the range of clients presenting with health problems that BIAS is dealing with clients with complex health needs often living in situations of relative social, housing and economic disadvantage.

## **Culturally sensitive service**

While the resources available to BIAS are limited in terms of dealing with the volume of need, satisfaction with BIAS services appears to be very high. A part of the reason for the success of BIAS with Irish clients is inevitably the fact that this is an Irish service which caters knowledgeably and sensitively with the needs of Irish people in Brent. The importance of cultural competence in service provision is increasingly regarded as important in the work of all those providing health services (NIMHE 2003). The Irish, along with other communities, value and benefit from services which recognise and respect their cultural difference in the provision of care. Being treated with respect as people and as Travellers, is an issue which is particular importance to Irish Travellers whose health and health care access are relatively worse than the Irish more generally.

Concerns about the health of the Irish community in England are often allied to concerns about whether or not treatment is accessible, sensitive and non-discriminatory. In the next section, these issues are discussed further, in particular Irish use of GP services, which are for many people, the first and only point of access to health care

## **General issues around consulting about health issues among the Irish**

The Health Survey for England in 1999 showed that Irish men had lower than average GP consulting rates and Irish women had a significantly higher age-standardised ratio for consulting (1.25). However, among young men (aged 16-34 years), it was Irish men who had the highest annual GP contact rate compared with all other minorities and the general population. Given the high levels of disability and permanent sickness among Irish males, it seems surprising that Irish men aged 35-54 as well as those aged 55+ had the lowest annual GP contact rates compared with all other minorities and the general population.

Among women aged 16-34, Irish women were most likely to have consulted their GPs in this age group compared with all other minorities and the general population. Their annual contact rate at this age was 7.5 compared with women in the general population who had a rate of 5.5 in this age group. Irish women, unlike Irish men

were more likely to have higher than average GP contact rates when aged 55 and over.

Although the Health Survey for England found that people overall from manual classes, and in particular women, were more likely consult their GPs more than people in nonmanual classes, this pattern did not hold for Irish people in the Health Survey for England. Both Irish men and women from manual classes were **less likely** than Irish men and women from nonmanual classes to consult their GPs. It should be re-iterated that the Health Survey for England sample mainly consisted of the Irish second generation. Recent on consulting patterns among only the first generation or migrant group are not available, so it is not possible to assess whether these patterns found in the Health Survey may vary by generation. This is an important point, as it is more likely that Irish migrants who are identified by others as such by Irish accents, may thus identified, face problems in accessing proper care. Much of the evidence noted below on negative experiences of health care refers to the migrant Irish.

There is evidence that vulnerable and often stigmatised groups such as Travellers, people who are homeless or have alcohol problems, are 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. Parry et al.'s (2004) work revealed that 16% (41 people) of Travellers were not registered with a GP compared with only 1 comparator. 38% Travellers living on trailers on empty land and 37% those who travel all year were not registered. Compared with non-Travellers, Travellers were less likely to have visited GPs in the past year, and more likely to have gone to Accident and Emergency departments or seen health visitors compared with others.

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, many 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.

Research has been carried out on Irish mental health which examined concerns about accessing GP services because of mental health problems. A recurring expressed concern was that GPs fail to deal with mental health issues underlying presenting alcohol problems among Irish people. There was 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. It was also clear that many Irish people preferred to access voluntary sector services than statutory services, particularly when dealing with alcohol problems.

This research also showed that there was a concern within the Irish community about widespread major tranquilliser abuse among Traveller populations, which is perceived to be an easy way to quickly dispatch Travellers from GP surgeries, rather than give access to alternative help and support. More broadly, the general lack of alternatives to medication or wider a range of treatments for common mental disorders mentioned is 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 the Irish counselling initiatives which do exist are invaluable in dealing with distress among Irish people, but in the London borough of Brent, necessary specifically Irish counselling services are not available.

More broadly, Irish community workers and users, in common with the wider population face enormous difficulties in negotiating health systems, due to delays and complexities of services. It has been suggested 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 significantly high suicide rates, and therefore a key to their reduction. Also, there has been 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 and the inflexibility of providers, all militate against some Irish people effectively using specialist services (Walls 2004a).

## **Turning findings into action to improve health**

General recommendations are outlined at the start of this report which focus primarily on greater inclusion of an Irish dimension in the planning and delivery of services, within the equality agenda, the promotion of wider community and health service understanding of the Irish community and its health needs, and building the capacity of the Irish sector to more effectively address the health of its members.

Specific health interventions, targets and actions which might be achieved locally to benefit the health of the Irish population in Brent, would have to be locally consulted upon, planned and supported. Given the range of data sources drawn upon in this research, covering many areas of health among the Irish in Brent, it is only possible here to provide a brief summary of some of the key areas of health concern, which appropriate actions should be focused upon, in order to improve Irish health with the support of the local Irish community. Actions should be focused upon the following key areas of health concern in Brent:

1. Relative disadvantages, in particular housing/homelessness problems
2. Suicides among the general Irish population; poor mental health
3. Cancers among the first and second generations
4. High rates of permanent sickness/disability and limiting long-term illness in Brent
5. High prevalence of addiction problems: alcohol, nicotine and other drugs in Brent
6. Irish Traveller health
7. The health of Irish elders

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## **Appendix 1: Organisations which contributed to this research**

Abbeyfield Society

Addaction

Brent Alcohol Counselling Service

Brent Community Alcohol Service

Brent Council – various departments

Brent Housing Partnership

Brent Irish Advisory Service

Brent Primary Care Trust

Brent Travellers' Education Service

Coss ECHG

Cricklewood Homeless Concern

Cyron Housing Co-operative

De Paul Trust hostels

English Churches Hostel

Health and Social Care Information Centre

Innisfree Housing Association

Irish Centre Housing

Irish Travellers' Movement

London Health Observatory

Network Housing Group/Stadium HA

Paddington Churches Housing Association

St. Christopher's

St Mungo's Hostel

Willow Housing