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Ethnic minority populations and child psychiatry services: an Irish study

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Abstract

Background

Ethnically, Ireland has diversified greatly over the last twelve years changing from a country of emigration to one of immigration. Blanchardstown, a western suburb of Dublin, is one of the most ethnically diverse areas, with the youngest population in Ireland.

Aims and Methods

This study aimed to examine any differences in referrals, clinical diagnoses and administrative outcomes of immigrants and Irish children referred to Blanchardstown Child and Adolescent Mental Health Service (CAMHS) over the period of one calendar year.

Results

Blanchardstown CAMHS received 202 referrals in 2007. There were 132 (65.5%) Irish and 65 (32.2%) immigrant children referred to the service. Nigerians accounted for more than a half of all immigrant children. Family doctors referred the majority of Irish children (58.4%; 77); non-Irish children were referred mainly by teachers (51%; 33) ($p<0.05$). In 2007 Blanchardstown CAMHS offered appointments to 116 families. Non-attendance rates at first appointments were similar in both groups (22.4% vs. 22.6%; $p>0.05$); more immigrant children, however, dropped out following an initial appointment (16.1% vs. 2.4% $p<0.05$). More non-Irish than Irish children were diagnosed with Axis-1 diagnosis (66.7% vs. 53.4%; $p<0.05$). The two most common Axis-1 diagnoses among both non-Irish and Irish children were Attention Deficit Hyper-Activity Disorder and Pervasive developmental disorders.

Conclusions

Immigrant children accounted for a substantial minority of children referred to Blanchardstown CAMHS. The psychiatric problems of immigrant children most often came to light through schools. More non-Irish children compare with Irish had an Axis-1 disorder.

Key words:

Child and adolescent mental health services, ethnic minorities, immigration, Ireland, ethnic diversity

Introduction

Ethnically, Ireland has diversified greatly over the last twelve years, changing from a country of emigration to one of net immigration. From 1848 - 1950 over six million adults and children emigrated from Ireland, and many more left Ireland in the 1970s and 1980s, when the country experienced sharp rises in unemployment (Broderick, 1994). In the 1990s the “Celtic Tiger Economy” started to attract foreign investment to Ireland and brought in migrant workers and asylum seekers. A streamlined working visa-work authorisation system was specifically designed to cater for designated employment sectors where skill shortages were acute; and Irish immigration law provided relatively easy entry for IT specialists, health-care workers, and other critical-skill categories from outside the European Union (Quinn, 2005). In 1995, net migration showed a deficit of only 1900, and with each subsequent year, more people have come to Ireland than have left it (Central Statistics Office, 2003). In 2004 ten new countries joined the EU, and immigration from eastern Europe has increased significantly since then (Central Statistics Office, 2007). Ireland quickly became one of the highest European Union recipients of immigrants as a proportion of its population, placing it on a par with France and the Netherlands, countries with long histories of immigration and colonial pasts (Loyal, 2006). The last (2006) Census results reflect a high level of inward migration, with foreign nationals from 188 different countries comprising 10 % of the population (400,000 people).

Some regions in Ireland have experienced higher levels of immigration than others. Blanchardstown, a western suburb of Dublin, is the fastest growing and one of the most ethnically diverse areas in the country. From 2002 to 2006 the population has increased by 25% to reach 63,120 persons, and the population of Blanchardstown is now larger than several Irish counties. In 2002, just 6928 (12%) people living in

Blanchardstown were immigrants. By 2006 this number had risen to 15,270 (almost 24%); this is more than twice the national average of 10%. Indeed 65% of the increase in Blanchardstown's population over the past four years is accounted for by residents who give a nationality other than Irish (Loyal, 2006; Central Statistics Office, 2007). Nigerians (12%), Poles (8.2%), followed closely by Lithuanians (6.84%) represent the largest numbers of school-age foreign nationals in Blanchardstown (Loyal, 2006; Central Statistics Office, 2007).

Another distinctive characteristic of Blanchardstown is its extraordinarily high children profile compare to the rest of the country: the pre-school population of Blanchardstown has risen 49% since 2002 (Loyal, 2006; Central Statistics Office, 2007; Ryan, 2008).

In response to this extremely rapid population expansion Blanchardstown Child and Adolescent Mental Health Service (CAMHS) was established. Given the ethnically diverse population it serves, there is a clear need for Blanchardstown CAMHS to be culturally responsive. In such services, the therapist must be knowledgeable about and sensitive to the patient's ethnic background, and able to apply interventions and service appropriate to culturally diverse health needs.

The development of culturally-responsive mental health services requires information regarding the characteristics of ethnic minority populations in the actual service-using community, including racial-ethnic variations in referral source, diagnosis, and service types. Such information may inform the allocation of resources to promote service access and to meet unique service needs of specific groups in the effort to provide effective treatment to all populations (Yeh et al., 2002).

Aims

This was a retrospective study, which aimed to examine differences in referrals, clinical diagnoses and administrative outcomes of immigrants (first and second generations) and Irish children and adolescents referred to Blanchardstown CAMHS over the period of one calendar year.

Methods

Data was collected in a standardised way, and the following details were recorded: demographic characteristics (sex, age, ethnic origin, legal status in the country; Community Care (social services) involvement; biological parents' relationship; referral details; (referral date, referring agent, reasons for referral); clinical diagnosis (all the diagnoses were made by child and adolescent psychiatrists, registrars in child and adolescent psychiatry, psychologists on the basis of the International Statistical Classification of Diseases and Related Health Problems 10th Revision(World Health Organization 1992)); and administrative outcome (did not attend, dropped out early (attended once only), late drop-out (attended more than once but family unilaterally terminated treatment), agreed termination, and treatment still ongoing. Ethnicity was defined on the basis of parents' birthplace. Relevant data were collected from *Pintpoint* (the clinics' appointments management system), from referral letters, from the referral book, and from clinical notes. To perform the analysis, the statistical software package, *Statistical Package for Social Sciences-16* (*SPSS-16*) and, appointments management system, *Pinpoint* were used.

Groups were compared regarding a number of characteristics using Student's t, and Chi-Square tests as appropriate. Significance levels of 0.05 were used.

The Irish Health Service Executive's Ethics Committee approved the study.

Results

Two hundred and two children living in Blanchardstown area were referred to the Child and Adolescent Mental Health Service in 2007. The majority (65.2%) of children referred to the service were Irish (please see Table 1 for more details). Nigerians accounted for more than a half of all immigrant children (51%; 33), and Romanians accounted for the second largest immigrant group (7.6%; 5).

Table 1 about here

Five children were of mixed ethnicity. Seven children from non-Irish families had refugee status and three had asylum-seekers status (an asylum seeker is a person seeking to be granted protection as a refugee outside their country of origin, and is awaiting the determination of his/her status; if granted this status, the person is recognised as a refugee and is no longer an asylum seeker). Forty four children had previously been referred to the mental health service. The majority (N=37) of re-referred children were from immigrants families.

More than two thirds (77.7%) of all referred children were male. The male-female ratio was even higher among immigrants (5.4:1). The mean age of immigrant children was six years, and that of Irish children was 9.5 ($p<0.05$). More non-Irish (70%) than Irish children (68%) were growing up with both parents, though the difference was not statistically significant ($p>0.05$) (Table 2).

Table 2 about here

Community Care (social services) had been involved with seven immigrant families and five Irish families before children were referred to the mental health service.

Irish children were most commonly referred with inattention-hyperactivity, behavioural problems, and depression. Non-Irish children were most commonly

referred because of concerns regarding ADHD, behavioural problems and ASD (autistic spectrum disorder) (please see Table 3 for more details).

Table 3 about here

A family doctor referred most of the Irish children (58.4%, 77), whereas more than half (51%, 33) of non-Irish children were referred by teachers (Table 4).

Table 4 about here

Blanchardstown CAMHS offered appointments to 141 families (99 Irish and 42 non-Irish) referred in 2007. Some referred children were not offered appointments because referrals were deemed as inappropriate (for example because the child attended school in Blanchardstown but lived outside it, because the child lived in Blanchardstown, but had an official address in another area of the city, or because the referral was not centered on a mental health concern). Some parents did not indicate a willingness to attend by returning a consent form.

The non-attendance rate at first appointment was similar in both groups (21.2% vs. 21.4%, $p>0.05$), however more immigrant children dropped out following an initial appointment (3% vs. 19.1%, $p<0.05$) (more information on administrative outcomes can be found in Figure 1).

Figure 1 about here

Hence a total of 111 children (78 Irish and 33 non-Irish) referred to the service in 2007 attended and were assessed (Table 5). More non-Irish than Irish children had an Axis 1 diagnosis (63.6% vs. 51.3%, $p<0.05$). Two most common Axis 1 diagnoses among non-Irish and Irish children were Disturbance of Activity and Attention, and Pervasive Developmental Disorders. No immigrant child was diagnosed with depression, which was the fourth commonest diagnosis among Irish children (Table 5).

Table 5 about here

Discussion

This is the first Irish study to look at characteristics of ethnic minority populations attending CAMHS in Ireland. It reflects the dramatic socio-demographic changes of Blanchardstown: one third of children referred to the service were immigrants. Several earlier studies conducted in other countries (Stern, Cottrell et al., 1990; Hillier, 1994) have suggested that ethnic minority groups are under-represented among referrals to CAMHS. The present study found out that some ethnic groups were highly over-represented and some were under-represented. Although Nigerians form the largest ethnic minority in Blanchardstown (12% of school-age foreign nationals in Blanchardstown), they were over-represented among referrals (more than a half of all immigrant children referred to the clinic were Nigerians). The second and the third largest minority population (Polish and Lithuanians) were hugely under-represented (only one Lithuanian child and two Polish children were referred). The under-representation of particular minority groups in mental health clinics has attracted considerable attention and is often explained in terms of unmet needs (Malek 2004). However under-representation does not necessarily imply inequity in access to health service, and a population based study would be helpful to clarify this. Unfortunately, perhaps due to relatively recent changes in the country's ethnic profile, population-based studies for common child mental health problems and ethnicity have never been carried out in Ireland. Another way to address the question would be to explore attitudes to and experience of CAMHS among Polish and Lithuanian families living in Blanchardstown.

This study found that immigrant children referred to CAMHS were younger than their native peers. Similar findings have been reported by several other studies (Roberts and Cawthorpe 1995; Malek 2004). When referral patterns were analyzed for different agencies and professional groups, it has been found that the psychiatric problems of immigrant children most often come to light through schools. Most Irish children in our study were referred by their family doctor. In the UK Daryanani et al. have also found that general practitioners are more likely to refer white children whereas education services tend to refer black children (Daryanani et al. 2001). Several other studies have reported similar findings (Roberts and Cawthorpe, 1995; Yeh, McCabe et al., 2002).

The reason for this difference may be that newcomers tend not to have a designated family doctor (immigrant population should be targeted in health education to get them to register with GP's) and, as most CAMHS (including Blanchardstown) do not accept self-referrals, a school is the most convenient referral pathway. On the other hand, a behaviour seen as problematic by the school may be considered normal by parents, and this could explain why more immigrant than Irish families failed to attend after the first appointment. It may also be that immigrant families found the service less suitable than Irish families, and disengaged early for this reason.

When reasons for referral were analysed it was found that many more immigrant children were referred for autistic spectrum disorders (ASD) and aggression, whereas more Irish were referred for deliberate self-harm behaviour, depression and other emotional difficulties. The different reasons for referrals could explain why immigrant children were significantly younger compare to Irish.

A systematic review performed by R.Goodman et al. revealed a heterogeneity in the mental health of children from different ethnic groups, including within the groups “Black” and “South Asian”(Goodman, Patel et al., 2008). The present study employed a relatively small clinical sample and could not, therefore, discover heterogeneity in the mental health of children from different ethnic groups. However the most common diagnosis among Nigerian children referred to Blanchardstown CAMHS was PDD, and Goodman et al. too reported that autistic disorders were disproportionately common among the Afro-Caribbean patients (Goodman and Richards, 1995).

Conclusions

Immigrant children account for a substantial proportion (albeit a minority) of children referred to Blanchardstown CAMHS. The psychiatric problems of immigrant children most often come to light through schools. More non-Irish than Irish children present with an Axis-1 disorder.

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Table 1: Ethnic origin of children referred to Blanchardstown CAMHS in 2008

Ethnic origin	N	%
Angolan	1	0.5
Bosnian	4	2
Congo	4	2
Indian	1	0.5
Irish	132	65.2
Lithuanian	1	0.5
Mixed ethnic origin*	5	2.5
Moldavian	2	1
Nigerian	33	16.3
Pakistani	2	1
Polish	2	1
Romanian	5	2.5
Russian	2	1
South African	1	0.5
Scottish	1	0.5
Ukrainian	1	0.5
Unknown	5	2.5

*in all cases, except one, one of the parents was Irish.

Table 2: Ethnicity and demographic characteristics

Ethnic origin	Gender		Average age	Parents relationship		
	Male	Female		Married or co-habiting	Divorced or separated	Other
Irish	75.8% (100)	24.2% (32)	9.5	62% (82)	26% (34)	12% (16)
Non-Irish	84.6% (55)	15.4% (10)	6	70% (46)	19% (12)	11% (7)
Unknown	40% (2)	60% (3)	8	40% (2)	40% (2)	20% (1)

Table 3: Ethnicity and reasons for referral

Reasons for referral	Ethnic origin	
	Irish % (N)	Non-Irish % (N)
Attention-Deficit Hyperactivity Disorder	19.7% (26)	21.5% (14)
Anorexia nervosa	1.5% (2)	0
Autistic Spectrum Disorders	5.3% (7)	12.5% (8)
Aggression	2.3% (3)	10.8% (7)
Anxiety	4.5% (6)	1.5% (1)
Attachment difficulties	1.5% (2)	1.5% (1)
Been bullied at school	1.5% (2)	0
Behavioural problems	17.4% (23)	23.1% (15)
Behavioural problems and learning difficulties	1.5% (2)	1.5% (1)
Depression	9.8% (13)	1.5% (1)
Developmental regression	0	1.5% (1)
Deliberate self-harm	4.5% (6)	0
Dyspraxia	0.8% (1)	0
Emotional difficulties	7.6% (10)	1.5% (1)
Inappropriate sexual behavior	3% (4)	1.5% (1)
Learning difficulties	2.3% (3)	6.2% (4)
Multiple developmental problems	0.8% (1)	3.1% (2)
Obsessive Compulsive Disorder	2.3% (3)	0
Oppositional Defiant Disorder	2.3% (3)	3.1% (2)
Panic attacks	1.5% (2)	1.5% (1)
Parental separation and conflict	1.5% (2)	0
Psychosis	0.8% (1)	1.5% (1)
School refusal	2.3% (3)	0
Selective mutism	0	1.5% (1)
Sleep problems	0.8% (1)	3.1% (2)
Substance abuse	1.5% (2)	0
Suicidal ideations	1.5% (2)	0
Temper tantrums	1.5% (2)	1.5% (1)

Table 4: Occupation of referral agent and ethnicity of children referred to CAMHS

Referral agent	Ethnic origin	
	Irish % (N)	Non-Irish % (N)
Area Medical Officer	2.3% (3)	4.6% (3)
Adult Psych. Team	0.8% (1)	0
Child Psych. Team	1.5% (2)	3.1% (2)
Clinical Psychologist	3% (4)	3.1% (2)
Comm. Social Worker	2.3% (3)	3.1% (2)
Ed. Psychologist	4.5% (6)	1.5% (1)
Family Doctor	58.4% (77)	12.3% (8)
General Hospital	3.8% (5)	1.5% (1)
Other	9.1% (12)	7.7% (5)
Public health nurse	0.8% (1)	1.5% (1)
Paediatrician	2.3% (3)	7.7% (5)
Speech & Language Therapist	1.5% (2)	3.1% (2)
Teacher	9.8% (13)	50.8% (33)

Table 5: Ethnicity and Axis 1 diagnoses

AXIS 1 disorder	Irish N=78	Non Irish N=33
None	48.7% (38)	36.4% (12)
Conduct disorder	5.1% (4)	3% (1)
Eneuresis (non-organic)	1.3% (1)	0
Tic disorder	0	3% (1)
Pervasive developmental disorder (PDD)	10.3% (8)	24.4% (8)
Anxiety disorder	2.6% (2)	3% (1)
Obsessive Compulsive Disorder	2.6% (2)	0
Reaction to severe stress	1.3% (1)	3% (1)
Oppositional Defiant Disorder	2.6% (2)	3% (1)
Adjustment disorder	5.1% (4)	6.1% (2)
Depression	5.1% (4)	0
Anorexia nervosa	1.3% (1)	0
Hyperkinetic conduct disorder	1.3% (1)	3% (1)
Disturbance of activity and attention	12.7% (10)	15.1% (5)

Figure No 1. Ethnicity and administrative o