Mind

Statistics 3: Race, culture and mental health

How to define ethnicity

Ethnic monitoring only became mandatory in publicly funded mental health services in 1995. Therefore, little reliable data has been available on how minority ethic groups are treated by mental health services in England and Wales. The Healthcare Commission concludes in its Count me in report that poor ethnic monitoring 'shows both lack of understanding of the value of having such data for planning services, and removes from services information that is needed to ensure that individual patients receive culturally sensitive and relevant care.'

However, people who do record and monitor ethnicity frequently find it a complex task. One reason for this is that individuals' and groups' perceptions of what group they belong to will vary according to views and perceptions held by the individual and by society. For example, some people of African origin who are born in the UK might perceive themselves as Black African; others might prefer to classify themselves as Black British. People from the Indian subcontinent might want to define themselves as, for example, Gujaratis or Punjabis; but in the 2001 Census they were offered the options of 'Indian', 'Pakistani', 'Bangladeshi' or 'other Asian'.

How ethnicity is defined will change over time; for example, because of social and political attitudes. Some years ago, the term 'Black' was unacceptable, whereas now it is a term used by the individuals belonging to this group. In 1976, Office of Population Censuses and Surveys referred to the minority ethnic population as 'the population of New Commonwealth and Pakistan ethnic origin.'

As perceptions and attitudes change it is important to note that an ethnic group classification can only be valid and meaningful for the time and context in which it is used.

An individual's perception of what ethnic group he or she belongs to may be different to the perception of what group that person is seen as belonging to by the person who is recording and monitoring ethnicity. The National Institute for Mental Health in England (NIMHE) suggests that self-identified ethnicity should be documented routinely.

Ethnicity, rates of mental illness and admission to psychiatric hospitals

Both past and recent research suggests that some groups - notably Black Caribbean, Black African and other Black groups - are over-represented in psychiatric hospitals.

The high numbers of African Caribbean people being diagnosed with schizophrenia is well documented, with some studies reporting between two to eight times higher rates of diagnosis compared to the White population.
Data from the 2001 Census showed that men from Black and White/Black mixed groups had the highest rates of admission to psychiatric hospitals. They were three or more times likely than the general population to be admitted. Women from the Black and mixed White/Black groups were two or more times likely than the general population to be admitted to psychiatric hospitals.

White British, Chinese and Indian men were less likely than the average population to be admitted.

Men from Black Caribbean, Black African, and other Black groups were more likely than other groups to have been detained under the Mental Health Act 1983.

Studies have shown that Irish people have higher rates of mental illness than the general population. [9] The Irish are often overlooked because they are White. Yet studies have found that Irish-born people living in the UK have a higher rate of suicide than any other minority ethnic group living in the country. [10]

The reliability of statistics on ethnicity and mental health

Statistics can appear very convincing, simply because most people interpret numbers as facts. However, the story behind the numbers may be more obscure than the figures indicate.

Some research suggests that although more Black Caribbean people are treated for psychosis, this may not indicate that they are more likely to have such an illness. Rather, it could be that the way they express their symptoms is interpreted in such a way that they are more likely than others to be prescribed treatment for these symptoms. [11]

Further, research indicates that more African Caribbean and other Black people with psychosis are being admitted to hospital for treatment because of the way they initially got in contact with the mental health services. Evidence suggests that they are more likely to have been in contact with the police or other forensic services prior to admission. They are also more likely to have been referred to treatment by a stranger rather than by a relative or a neighbour. It is important to note that this happens despite the fact that they are less likely than White people to show evidence of self-harm and are no more likely to be aggressive to others before admission to a mental health hospital. [12]

Research also suggests that although there is no evidence indicating that African Caribbean people are more likely to be aggressive than their White counterparts, staff in mental health hospitals are more likely to perceive them as potentially dangerous. Evidence also suggests that psychiatrists are more likely to consider this group as potentially dangerous to others. It is therefore possible that African Caribbean people are more likely to be diagnosed with psychosis because of bias among those who treat them. [13] Research in the US shows similar results. [14]

Ethnic origin and psychosis

Psychotic illness affects a very small portion of the population - around one person in 200 in the UK. [15] Because of the small numbers, it has been difficult to produce statistics that accurately
reflect any differences between ethnic groups. Although the figures below indicate some differences in the prevalence of psychosis, it is important to note that only the difference between Black Caribbean women and White women can be considered as statistically significant. [16]

**Estimated annual prevalence of psychosis by gender**  [17]

<table>
<thead>
<tr>
<th>Percentage of UK population</th>
<th>White</th>
<th>Irish</th>
<th>Black Caribbean</th>
<th>Bangladeshi</th>
<th>Indian</th>
<th>Pakistani</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>1.0</td>
<td>1.0</td>
<td>1.6</td>
<td>0.6</td>
<td>0.9</td>
<td>1.4</td>
</tr>
<tr>
<td>Women</td>
<td>0.7</td>
<td>1.0</td>
<td>1.7</td>
<td>0.6</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Total</td>
<td>0.8</td>
<td>1.0</td>
<td>1.6</td>
<td>0.6</td>
<td>1.1</td>
<td>1.3</td>
</tr>
</tbody>
</table>

The above figures are from the Fourth National Survey of Ethnic Minorities (FNS). As expected, it shows a higher rate of psychotic illness for Black Caribbean people than for White people, with Black Caribbean people being twice as likely as White people to be diagnosed with psychosis.

However, the difference is much lower than previous studies have indicated. More importantly, previous studies have indicated that the rate of psychosis is particularly high among Black Caribbean men. The FNS study suggests that the difference was largely due to higher rates of psychosis among Black Caribbean women.

The study further showed that those from a poorer background were more likely to suffer from a psychotic illness. This was the case for Black people as well as for White people. It also emerged that those living in inner cities seemed at higher risk. [18] These findings support the theory that mental illness is related to living conditions rather than ethnicity or race.

**Ethnic origin and neurosis**

Neurosis is much more common than psychosis. As the table below indicates, there are some differences between different ethnic groups.

**Any neurotic disorder in past week for men and women by ethnic group**  [19]

<table>
<thead>
<tr>
<th>Percentage of UK population</th>
<th>White</th>
<th>Irish</th>
<th>Black Caribbean</th>
<th>Bangladeshi</th>
<th>Indian</th>
<th>Pakistani</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any neurotic disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>11.6</td>
<td>18.4</td>
<td>13.8</td>
<td>12.9</td>
<td>12.1</td>
<td>12.6</td>
</tr>
<tr>
<td>Total</td>
<td>19.9</td>
<td>18.6</td>
<td>19.8</td>
<td>12.3</td>
<td>23.8</td>
<td>26.0</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Men</td>
<td>Women</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Depressive episode</strong></td>
<td>15.8</td>
<td>18.5</td>
<td>17.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.3</td>
<td>18.1</td>
<td>19.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Any Anxiety Disorder</strong></td>
<td>3.0</td>
<td>3.9</td>
<td>3.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.6</td>
<td>1.4</td>
<td>4.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Obsessive Compulsive Disorder</strong></td>
<td>0.3</td>
<td>0.6</td>
<td>0.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>0.6</td>
<td>2.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>All Phobias</strong></td>
<td>1.8</td>
<td>1.9</td>
<td>0.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>0.3</td>
<td>2.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Panic Disorder</strong></td>
<td>0.5</td>
<td>2.0</td>
<td>1.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.7</td>
<td>1.7</td>
<td>0.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Generalised Anxiety Disorder</strong></td>
<td>0.5</td>
<td>1.5</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.9</td>
<td>3.5</td>
<td>1.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Neurotic disorders such as depression and anxiety are not considered as serious or disabling for the individual as psychotic disorders such as schizophrenia or manic depression. However, as the neurotic disorders are far more common, they affect more people, and have a much greater impact on the community. It is estimated that they account for one third of days lost from work due to ill health. [20]

Although the neurotic disorders are more common - around 15 per cent of the population in the UK may be affected at any time - few studies have attempted to find out how different minority groups have been affected by these disorders. Most research has focused on the rarer psychotic disorders.

### Depressive episodes

The above table indicates that, among men, White and Pakistani subjects reported depressive episodes most often (2.4 per cent). However, it is important to note that as the numbers reported are small, the differences between the groups cannot be considered statistically significant.

Irish men reported the highest level of neurotic disorders (18.4 percent); however, they reported fewer depressive episodes (1.8 percent) than men from all other groups, except Indians. [21]

The highest levels of depressive episodes were reported by Pakistani women (6.3 per cent) and Indian women (5.7 per cent). Both these groups show a much higher rate that their male counterparts. In other ethnic groups there were no significant gender difference. Bangladeshi women showed the lowest rate (1.6 per cent).

### Anxiety disorders

The highest rates of anxiety reported were from Irish men (5.9 per cent) and Indian women (7.3 per cent).
Mixed anxiety depressive disorder

The lowest rate of mixed anxiety depressive disorder among men was found in the White (7.4 per cent) and Pakistani (7.1 per cent) groups. However, the differences between the men were not statistically significant.

Pakistani women reported the highest rate (17.0 per cent) and Bangladeshi women reported the lowest rate (9.4 per cent) of mixed anxiety depressive disorder. The differences between women in the other groups were not statistically significant.

Endnotes


This factsheet was written by Inger Hatloy. Updated December 2006.