Hickman, M. (1995) The Irish in Britain: racism, incorporation and identity. *Irish Studies Review*, **10**, 16–20.

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Sir: Bracken *et al*'s (1998) editorial was interesting but lacked scientific validity, for two reasons.

First, the authors failed to justify why being Irish-born constituted an 'ethnicity'. Ireland is a multi-ethnic English-speaking country made up largely of people from Celtic, Norse and Anglo-Saxon backgrounds. In this respect it does not differ substantially from any other part of the British Isles. I can see little validity in the claim that the Irish make up a more distinctive racial, linguistic, anthropological or cultural group than those of any other region within the UK or the Republic of Ireland do. The ethnicity of the White communities in Dublin and London probably bear more similarity than those of Newcastle and London. Nationality is not the same as ethnicity.

Second, it is not valid to compare the English health statistics of those born in Ireland with those born in England. A more valid comparison would be to compare Irish immigrants to those from Tyneside, Cornwall or South Wales who have migrated to other parts of the British Isles. I would suggest that migrated communities emanating from any of these poorer areas would share similarly poor mental health statistics. This would suggest that socio-economic and migrational factors are of more importance than specifically 'ethnic' ones.

The underlying assumptions made by Bracken *et al* are that being Irish represents a distinct ethnicity, which suffers relatively poor mental health. They fail to justify either of these views.

Bracken, P. J., Greenslade, L., Griffin, B., *et al* (1998) Mental health and ethnicity: an Irish dimension. *British Journal of Psychiatry*, **172**, 103–105.

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Authors' reply We wholly agree with Dr Haley regarding the significance of gender when considering the mental health of Irish migrants in Britain. Irish women constitute an invisible minority within an invisible minority as far as mental health needs are concerned, although the literature on the experience of Irish women is less well-established than Dr Haley suggests. Our article was intended to highlight the neglect of Irish mental health needs in Britain as a whole and it was written in the hope that drawing attention to these needs might engender further research and intervention.

Dr Sandford's comments demand slightly more attention. His first assertion, that Irish migrants do not constitute a distinct ethnic and cultural minority within Britain, must be rejected. The fact is that they meet the principal criteria for defining such status as established by the Race Relations Act 1976 and subsequent judgements (Hickman & Walter, 1997) and are recognised as an ethnic group by both the Commission for Racial Equality and numerous statutory bodies within Britain. Dr Sandford's position implies a crude reductionism conflating 'biological race' with culture and ethnicity. Perhaps his view might be different if Irish people had green skin.

Regarding the suggested comparison of Irish migrants with indigenous internal migrants, we can only remark that it is commonplace in migrant health research to compare the health status of migrant groups with that of the indigenous population as a whole (e.g. Balarajan, 1995). Certainly in studies of physical health and mortality this is accepted practice (e.g. Marmot *et al*, 1984). Internal migration might indeed have a bearing on mental health, but Dr Sandford's suggestion becomes meaningful only if we accept his first contention that Irish migrants do not constitute a distinct group within the British population as a whole. The question of socio-economic factors remains open since, to our knowledge, no research exists which might explicate matters in the case of mental health. Available research does not support Dr Sandford's view that migration or socio-economic factors may be more significant than ethnic or cultural status in explaining the high excess mortality among the settled children of Irish migrants (Raftery *et al*, 1990; Harding & Balarajan, 1996).

Epidemiological research which has employed simple ethnic categorisations, such as White, Asian and African/Caribbean, has been successful in demonstrating differential health experiences among minorities in Britain. However, the major thrust of our paper is that such categorisations are not only simple, but simplistic, and tend to conceal as much as they reveal. There is a growing consensus among health researchers that the standard classification, based as it is on notions of racial difference, is inadequate and needs re-thinking. In two successive decades Irish-born people had the highest rates of psychiatric in-patient admission of any country-of-birth group within England and Wales, and among the highest rates of suicide and parasuicide. These findings have been almost wholly ignored by service providers and practitioners in psychiatry.

Balarajan, R. (1995) Ethnicity and variations in the nation's health. *Health Trends*, **27**, 114–119.

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Hickman, M. J. & Walter, B. (1997) *Discrimination and the Irish Community in Britain*. London: Commission for Racial Equality.

Marmot, M. G., Adelstein, A. M. & Bulman, L. (1984) *Immigrant Mortality in England and Wales 1971–78*. London: HMSO.

Raftery, J., Jones, D. R. & Rosato, M. (1990) The mortality of first and second generation Irish immigrants in the UK. *Social Science and Medicine*, **31**, 577–584.

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Risk of sudden death on high-dose antipsychotic medication: QTc dispersion

Sir: Since the publication of the 'Consensus statement' on the use of high-dose antipsychotics (Thompson, 1994), psychiatrists have been performing electrocardiograms (ECGs) on their high-dose patients. The rationale behind this is that it will detect conduction abnormalities, especially QT prolongation, associated with an increased risk of sudden cardiac death. It is recognised that the risk of a conduction abnormality due to medication is dose-related and is greatest with phenothiazines. Although more common at higher doses, QTc prolongation (>440 ms) is found in patients on the full range of antipsychotic dosages (Warner *et al*, 1995). There is also evidence to suggest that patients can have