

**A Study of  
Older Irish People's  
Experiences of Health  
& Social Care Services  
in Leeds...**



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<b>Acknowledgements</b>	4
<b>Forward</b>	5
<b>Summary</b>	6
<b>Introduction</b>	7
<b>Recommendations</b>	8
<b>The Irish community</b>	9
<b>In Britain</b>	9
<b>In Leeds</b>	10
<b>The study</b>	12
<b>Findings</b>	12
<b>Conclusions</b>	20
<b>References</b>	22

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Special thanks is due to all those who participated in this research. We thank all those men and women for their patience and tolerance of our intrusion into their lives. We were impressed by their resilience and fortitude and think that if this work helps improve services for Irish people in the future; it will be a fitting tribute to them.

Finally, thanks is due to Healthy Leeds Special Grants panel for awarding the grant for this work. It demonstrates a strong commitment to improving service provision for the Irish in the city.

The need for culturally sensitive practice with Irish people is something that Leeds Irish Health & Homes has campaigned for since its inception in 1996. We feel this is most important when looking at issues of care for older members of our community. It is well documented that as people get older their need to have comfortable and familiar cultural reference points and practices helps them to cope with isolation, loss and ill-health.

Information in this report will help add to a growing (however still miniscule) body of evidence, which shows the positive impact of culturally sensitive support for Irish people.

The two major findings of the research show a need for culturally sensitive support for older Irish people being discharged from hospital and the need for a sitting service for Irish people with dementia. These are issues that LIHH have been aware of for some time and which would be complimented by the service model that currently exists within LIHH.

When LIHH was established our main aim was to help people live independently through the provision of supported, furnished accommodation. Focussing on Irish people who found themselves in vulnerable situations our philosophy of offering tailored packages of support to help individuals realise their goals helped sustain meaningful and long-term improvements in people's health and well-being. We were then able to extend our services to the wider Irish community in terms of one-to-one support to overcome issues of isolation, poor health and lack of access to services. We developed various social groups aimed at breaking down isolation, building relationships as well as life-skills and confidence. We run a weekly luncheon group for the over-55's; we offer a number of activity groups such as walking and an arts group and have members groups such as a women's group, a carer's group and a fortnightly social group meeting in south Leeds. The aim primarily is to help people re-establish a sense of community or family within these structures. Now with the help of a grant from the Big Lottery Fund we have been able to establish a volunteer programme within LIHH to develop a befriending scheme for older people, which is proving a well-utilised resource.

As an Irish organisation, our commitment to raising awareness of Irish issues remains high and this report is consistent with that objective. It is by no means a definitive piece and offers only one perspective, but importantly older Irish people from a variety of backgrounds have been asked about their experiences. The report highlights that regardless of background, as Irish people get older in Leeds and have recourse to use Health and Social Care services, they are not aware of the services available to support them at the time of need. It also highlights that the way in which those services pay attention to their cultural background is severely lacking.

This qualitative research project profiled the experience of older Irish people with Leeds health and social care services over a six-month period. It was funded through a grant from the Healthy Leeds Special Grants programme. Leeds Irish Health and Homes (LIHH) carried out the research in partnership with NHS Leeds, Adult Social Care, Leeds City Council and Leeds Metropolitan University. The aim was to understand the needs of the aging Irish in Leeds and their experience of accessing health and social care services.

The objectives were:

**1/ To explore their expectations and the extent to which their needs were being met.**

**2/ To identify any cultural barriers to care, gaps in service provision and make recommendations for future practice.**

A total of thirty five people; ten men and twenty five women over the age of sixty-five participated in unstructured interviews led by two Irish people with experience in the fields of health and social care. The data demonstrate that there is general lack of understanding of the needs of the Irish community and that the failure to understand cultural issues in particular contributes to poor quality care. Poor follow-up care after hospital discharge and strong reliance upon family were identified as issues to be addressed. Respite for carer's particularly for those caring for someone with dementia was identified as an important issue. People from lower socio-economic groups or living in more deprived areas perceived their care was poorer than that of others living in more affluent areas. Many older people in the Irish community are more likely to be living in these deprived areas on low incomes.

This research is unique in that it is the first and only time that the people from the Irish community in the city have been asked about their experiences in this way. It is the first chance the Irish community has been given to express their views on the services that they receive. It has shown that there is a lot of good work taking place in Leeds in both the statutory and voluntary sectors. It is hoped that it will be used to direct future service development proposals to meet the needs identified. Both NHS Leeds and Adult Social Care, through the Local Area Agreement Targets and the Older Persons Strategy, are committed to helping older people maintain independence in their own home, to improving the assessments for care packages and improving prevention services in the community.

Good practice in care occurs at a number of different levels. Perhaps the most important starting point for the provision of good quality care for older Irish people is recognition by statutory providers and commissioners of the need for data on the Irish community (Tilki 2003). A 'White Irish' ethnic category is now routinely included in information collected during ethnicity monitoring. The Department of Health in its guidance as of 2005 requires that data on Irish people are not aggregated within the overall 'White' category, to ensure that health disparities do not go unrecognised.

There is a lack of knowledge amongst older Irish people generally about services, the type of help they are entitled to receive and their reluctance to engage with the services available. This is probably responsible for the extremely low expectations amongst this group.

It is recommended that NHS Leeds and Adult Social Care consider when commissioning services how they might bridge these gaps for the Irish community and by doing so meet the targets set in their Strategic Plan. In order to achieve that, they should:

- **Commission specific social care support services to support older Irish people discharged from hospital.**
- **Through support, training and funding provide a sitting service for Irish people with dementia through a volunteer befriending project.**
- **Fund the production of a resource pack and DVD that could be used as part of the induction and diversity training of Health and Social Care staff.**
- **Engage LIHH in providing training to staff on the health and cultural needs of the Irish community.**
- **Include in service specifications the need for providers to demonstrate how they meet the cultural needs of the communities they serve.**
- **Recognise the added value that culturally sensitive services provided by LIHH and the Tuesday club at the Irish Centre in overcoming social isolation and providing cultural support.**
- **Explore ways of supporting these day clubs to make improvements to their existing services. Support the provision of extra resources to meet the more specialist needs of people with dementia, for example.**
- **Further examine some of the underlying reasons for the reluctance of the uptake up statutory services such as homecare.**
- **Actively explore more innovative ways to ensure that families and carers in the Irish community are provided with the information they need about the services available.**
- **Commission culturally appropriate support services such as support groups, respite services, sitting services for families and carers to help them with their caring duties.**
- **Implement a system of data recording and monitoring to better understand the extent of the problem of dementia in ethnic groups like the Irish.**

## **The Irish in Britain**

The Irish who came to Britain between 1930s and 1980s and worked in teaching, health care and in factories and most significantly the largely unregulated construction industry, left a legacy in terms of the physical health of the community. The nature of the work they undertook, mainly in construction was physically demanding and often with no health and safety guidelines resulted in many deaths and long term limiting conditions. Sheer economics forced many to continue working long after they were able. Premature retirement due to occupational injury and degenerative wear and tear left them dependant on basic state benefits. For men in particular a lifetime in the informal economy meant no pension.

Overall, the mortality of first generation Irish people exceeds that of all residents of England and Wales by about 30% for men and 20% for women. Irish people are the only migrant group whose life expectancy declines on emigration to England. Irish born people are more than twice as likely to be hospitalised for mental distress. Admissions for Irish born men are more than triple the figures for English people and other minority groups' (Meltzer. H. et al. 1995). Irish people are over-represented in most diagnostic categories, but the figures for depression and alcohol related disorders are particularly striking. Men born in the Republic of Ireland have nine times and woman seven times, the rate of alcohol related disorders when compared with the general population (Walls, 1996). Rates of abstinence from alcohol are higher in Ireland than in Britain. Amongst migrants, the Irish are no more likely to consume alcohol than the indigenous population. However, those Irish people who do drink alcohol do so at generally higher levels than their British born counterparts (Greenslade et al. 1994).

Irish rates of suicide are also high. From 1988 to 1992 the Irish rate for suicide and undetermined death was 53% in excess of the native born rate (Balarajan, 1995). A study undertaken in London, covering the period between 1991 and 1993, found a significant misclassification of immigrant suicides. The authors of this report calculated the Irish rate as being higher by a factor of 2.2 (for men) and 2.9 (for woman) than the rate for native-born people (Neeleman, J et al. 1997). Between 1999 and 2003 suicide and undetermined death in Irish men was 39% higher than average and for women it was 40% higher (De Ponte, 2005).

The Count Me In Census is an annual measurement of the ethnicity of all inpatients in NHS and independent mental health and learning disability hospitals and facilities in England and Wales. The 2008 census demonstrates that the aging profile of Irish inpatients is much different to any other ethnic minority group. Irish admissions were more likely to be aged 50 and over and less likely to be under 24. Of the Irish people admitted 43.6 per cent were over the age of 65 years compared to the much lower rates of 33.6 per cent for White British, 31.6 per cent for white other followed by 14.5 per cent for Black Caribbean and 14.1 per cent for Indian.

## **The Irish Community in Leeds**

According to the 2001 census 1.2% of the population of Leeds identify themselves as White Irish, which translates to 8,578 people. A report produced for the Federation of Irish Societies states that this is probably an underestimation. It suggests that the population of Yorkshire and Humberside could be between 2.0% and 2.4%, which would make it the second largest ethnic group in the region (FIS, 2001).

According to the NHS Strategy (2008) the health of the people in Leeds is generally worse than the England average. Compared to the national average for England, Leeds has significantly worse values for 24 key public health indicators. Further analysis of the data presents a picture of Leeds as a city with significant inequalities in health. For example, people living in the most deprived wards of the city live on average nine years fewer than people in the least deprived wards. Leeds' BME communities including the Irish are concentrated in particular geographic areas of the city, with almost one third of the city's BME population residing in just three wards (Gipton & Harehills, Chapel Allerton, and Hyde Park & Woodhouse). The Strategy also indicates that older people tend to under-use health checks. They also tended not to report problems of poor quality care whilst in hospital ranging from malnutrition, bedsores and negative attitudes and their uptake of community-based services was poor. This is consistent with the findings of research into health issues of the Irish community in the city.

Fifty one percent of the Irish population are now over 50 years of age, which will have implications for future health and social care provision. Across the city 15.5% of the economically inactive people in the general population in the 16 to 74 age group are not working because they are permanently sick or disabled; 22% of the Irish fit into this category (Census, 2001).

The 2001 census identifies 109,548 people over the age of 65 in the city. Using the figure of 1.2% as the percentage of Irish people in the population, that would mean that there were 1,314 Irish people in the city in that category. It is estimated that the number of people over 65 who develop dementia can be calculated at about 7%, which means that there may be 92 Irish people in the city with the condition. Leeds Alzheimer's Association in 2006/07 received 398 referrals of whom 4 (1%) were Irish. The organisation said that they have 7000 people with dementia on their records altogether, 1.2% of that would be 84 Irish people (Mulligan, 2007).

Since April 2006 GP's have been paid to keep a register of people on their list with a diagnosis of dementia and between then and July 2008 their registers show 3,147 patients who have been diagnosed with the condition. That would mean that there were 37 Irish people known to their GP's with dementia although lack of ethnic monitoring makes this uncertain. In addition there is no coordination of the information in a way

that would enable us to understand the full nature and extent of the problem (Mulligan, 2007). Targeting Irish health would help NHS Leeds to meet its targets on a number of key areas for health improvement.

## **Literature**

Research has shown repeatedly that Irish people in Britain have excessive rates of admission for all diagnostic categories of mental illness, (Walls 2004) and consistently and significantly higher rates of psychological ill-health (Erens et al 2001), particularly depression and anxiety (Sproston and Nazroo 2002, O'Connor and Nazroo 2002).

A number of recent studies in other places identify health issues that are also common to the Irish community in Leeds. Evidence is available to make the case that the health needs of the Irish are in many respects different from those of the host community and therefore need special attention by service providers. While there has been no previous research specifically on older Irish people in Leeds, there are relevant reports on care of older people, including the Irish communities in other cities. Leeds Irish Health and Homes has produced several documents recently on the local Irish community (Mulligan, 2006, 2007, 2009). Brent Irish Advisory Service (BIAS) commissioned a piece of research in 2006 that raised many of the issues found in this study. They recommended that there should be a greater inclusion of an Irish dimension in the planning and delivery of services, within the equality agenda. (Walls, 2006).

A study in Birmingham in 2006 explored the experiences of Irish people using the mental health services in the city as well as the views of health practitioners in the statutory and voluntary sectors. It found a lack of engagement between service providers and the Irish people who use them. That service providers had limited information about Irish people and their culture and that while the services provided were wide ranging they were not delivered with Irish people in mind. It recommended attention be paid to the development and maintenance of a resource that provides details of agencies that help Irish people particularly those with mental health problems (McGee, P. 2007).

## **The study**

The project was funded to gain better, first hand information on the needs of older people in the Irish community. The research used an inductive qualitative approach to explore the experiences of 35 people over the age of 65 years from the Irish community. The group consisted of first, second or third generation Irish people of both sexes who were interviewed either in their own home or at one of the day centres they attended. Interviewees were invited by letter to participate and a small group self-referred. Interviews lasted approximately thirty minutes and people were interviewed only once. They could have a friend or relative present if they wished and all gave their written consent. Interview notes were coded and kept separately to protect anonymity. All information given was treated in strictest confidence. The unstructured interviews gave people an opportunity to freely express their views on the services that they received. It was also the first time their views were sought on health issues. Three professionals from health and social services were also interviewed to give insight into the extent of the awareness amongst care service providers of the need for culturally sensitive care provision for Irish people.

The aim was to understand the needs of the aging Irish community in Leeds, their experience of health and social services, and the extent to which their needs are being met.

The objectives were to explore the expectations and compare their experiences in accessing health and social care services and to understand any cultural dimension to that. Arising from this, the research sought to identify gaps in service provision and to make recommendations for future practice.

## **Findings**

Many of the themes that emerged are categorised under four main headings and are listed below:

### **Satisfaction with services**

### **Cultural issues**

### **Expectations of family**

### **Contribution of the Irish community organisations**

Within the themes were sub-categories regarding resources, staff shortage, financial cost, pro-active staff, mis-diagnosis, and variations in service provision according to postcode. Other issues that impacted upon service access were social isolation, loneliness and restricted mobility. Cultural topics like music, traditions, humour, and identity were also noted.

## **Satisfaction with services**

The initial response of some of the older people interviewed was that services were good and the NHS was doing its best but they then went on to catalogue a list of problems and in some cases disasters that they had experienced. One man had received repeated mis-diagnoses of a condition from a Leeds hospital. A change of GP resulted in a referral to Bradford where a CT scan showed that he had had a stroke, sometime in the past.

**“They told me at Bradford that if my condition had been properly diagnosed and treated when I was first referred, I would probably not be as badly disabled as I am now”.**

This man now walks with the aid of crutches and despite his experiences has a cheerful disposition and good sense of humour.

Some told of how they self-financed their own care provision. One woman said: **“I have no complaints”** she then went on to relate how, as her husband had become more dependent and needed alterations to the house, her son had to do the structural modifications and she had financed it. She was surprised and annoyed to find that as she turned sixty years of age, she lost her carer’s allowance. She said,

**“That can’t be right, can it”?**

Some people felt discriminated against because of where they lived. They believe that the moving of the medical services from the area meant that people had to endure longer waiting times for treatment.

**“I had to wait seven years for an operation on my knee. Doctors seem to see people in poor areas as less important in relation to access to certain treatments. Poor areas also have a high ratio of refugees and asylum seekers which also put pressure upon the services”.**

One respondent related how she was unhappy with the level of care she received from Home Care Services.

**“I think the manager is only bothered about her budget. They’re in here twice a day but I only get a shower once a week. It’s all down to money”.**

One woman reported that the care her husband received in hospital was very poor:

**“He was an inpatient for a month on a medical ward receiving physiotherapy. The physio was excellent but the nursing care was very poor. My husband is incontinent and he only had one bath and two showers during the four weeks he was in hospital. I think that he should have had better hygiene care. I was very disappointed with the care he received and the follow up was also not good. I was a nurse and that was not the sort of care I was trained to give”.**

This woman went on to say:

**“We received a grant to help with alterations to our home but it didn’t cover the whole cost of the work so we had to borrow the rest, which will be repaid when we die”**

She was saddened by the low level of care her husband received and had no explanation for it apart from possibly, the changes to the NHS generally and deterioration in the quality of nurse training.

A woman who had worked in health care and expected that she would receive support after her operation said,

**"I do not have a lot of faith in social services, I worked in a hospital and I know what should have happened. The doctor used to visit when people had come out of hospital and check they were OK at home, that doesn't happen anymore, nobody visited me to see how I was. I was told I would have to go on a waiting list and ask for a referral. I didn't"**

Some people interviewed had no knowledge of how to access social care services, one woman said,

**"After my surgery the hospital staff didn't assess my needs and I didn't know about the support available".**

Another woman said that she didn't get the care she needed because she just didn't know how to work the system,

**"I had a car crash and had a very bad limp so I applied for a car sticker from social services but I was asked if I could walk to bus stop, I suppose I can if I need to but it is very painful, I didn't want them to think I was complaining so I said I could get to the bus stop and I didn't get the sticker, I didn't give the right answer to them I suppose".**

Another woman mentioned after her operation that she has no knowledge of how to get support for after care and perceives that she would have to know how to 'work the system',

**"I never applied for any help after my operation I wouldn't want to apply and I don't know how to even if I wanted to. I think you have to be born into the system to claim for it all".**

One man said that he needed social services support and rehabilitation advice after surgery however, the referral had taken so long that he feared that the good work the consultants and specialists had done in the hospital would be undone as he wasn't sure what he could and couldn't do in his own home. He said,

**"The health care was excellent but the support from social care was nil, it took the cream off it"**

One woman said,

**"My Consultant was useless I felt like I was not getting anywhere in the NHS so had a private consultation. I was diagnosed and referred back to the NHS. I was in traction and after the operation I was treated really poorly. I waited to see the consultant for weeks with no pain management appointments available. I was waiting for referral on the waiting list, it felt like forever".**

Another said,

**"For 2 years I was in extreme pain. It took the doctors 2 years to get diagnosis. I don't blame them for the delay but it was horrible having to wait that long for a diagnosis"**

## **Expectations of Services**

A woman who retired from a career in public services said:

**"I feel that many of the problems I encountered was as a result of stereotyping and prejudice against people like me because I live in a deprived inner city area. I think that the moving of the medical services from this area meant that people here had to endure longer waiting times for treatment".**

Some people said that they appreciated the difficulties hospital and social services staff have with lack of resources and budget cuts. One man reported:

**"I received good support from the health service. I think the doctors and nurses were overworked and under pressure".**

One woman was disillusioned with the services she and her husband received. She had no rationale for this. She said:

**"I am satisfied that some of the care we received was good but I have serious problems with other aspects of it. I don't know why this is".**

Alternatively some people believed they received good care because of where they lived. One woman who's husband's has dementia is generally happy with the level of care he is receiving but thinks that it would help if someone could take him out for walks. She believes that the care she receives is better because she lives in a good area of the city.

**"Fortunately we have very good GP and he was quickly diagnosed with dementia although waiting lists were a problem. He attends a day centre for older people every Wednesday, he has a sitter who comes in each Monday and he goes to the Friday club every week."**

## **Cultural Issues:**

### **Service Users**

Many of those interviewed made reference to their cultural identity. Culture and cultural identity is very important to older Irish people. This is a major issue for service providers as lack of such considerations may be a barrier to service uptake by Irish people. It is important therefore that services are delivered with cultural sensitivity as a key component. Some felt that it had impacted upon the support they received from health and social care services. Irish health and social care professionals were a comfort in some cases as was care professionals recognising their Irish surname or accent.

One man was reassured by an Irish surgeon recognising his Irish surname and reassured him that he would be well taken care of.

**"The Consultant was a wonderful man, he treated me as one of his own and told me he would take good care of me, I knew it was because of my Irish connection".**

One person mentioned that having a consultant from Dublin helped her to be at ease with her condition. She was anxious about her treatment.

**“I dreaded Chemotherapy, the consultant came from home [Dublin] and even when there were disasters [during treatment] he had a sense of fun, it was an awful disease but he helped me look on the positive”**

One individual related that whilst recovering from major heart surgery she was appreciative of the majority of the staff being first or second generation Irish some of whom went to school with her children. She said that she made no difference with the staff and all the English nurses were lovely.

**“Majority of my visitors were Irish or their parents were and went to school with the nurses and staff on duty, they never turned away our big family because they understood Irish families. Even if some of them were only part-Irish, I had a soft spot for them. English nurses were just as nice, but it is important to see one of your own”.**

A woman whose husband had dementia was concerned about the future and what sort of care he will receive, as he has been an Irish musician since he was a child. She said,

**“I am afraid that he will not get access to Irish music and other cultural aspects of his life if he has to go into a home”.**

Only one individual felt that the way she was treated was because she was Irish. Claiming that her ethnicity was not recognised she said,

**“That doctor doesn’t know me. He knows nothing about my background, where I’m from or what I’m about”.**

Those respondents who expressed pleasure at having met an Irish doctor or other health professional highlight the importance for some people of having Irish professionals in the system of health and social care.

## **Service Providers**

The interviews we conducted with Health and Social Care professionals reinforce the importance of utilising cultural awareness as an aid to good care.

A home care manager felt that in an area of the city where the Irish have a large presence, as many as forty or fifty percent of the workforce could be from the Irish community. She said,

**“As a result of their awareness, Irish workers gave a better service to the Irish clients than other workers. For example, they persuaded some male clients to go into sheltered accommodation where this had proved impossible previously. In some cases they have managed, on their own initiative, to reunite clients with their family back in Ireland and a few men even eventually returned to Ireland”.**

A care support service manager receives referrals come from Mental Health Teams or Health Care Professional. Her service provides an assessment for between six to eight weeks and then moves the client on to the most appropriate service provider.

She was very interested in the work of LIHH and expressed a willingness to work closely with us in the future:

**“I am confident that my staff are aware of the need for a cultural element of care for Irish people but we are limited in our capacity to provide it”.**

This senior caseworker with social services was aware of LIHH and has input from one of our workers at present. She says that many of the home care workers in the area are from the Irish community and believes that they are using their cultural sensitivity to help the clients without realising or identifying it. Many of the clients who are socially isolated still talk of Ireland as their home. She is very enthusiastic about joint ventures with LIHH to improve the working practice of her department.

**“I am aware that there is a lack of knowledge among staff generally and would be very keen on training in Irish awareness. There is a monitoring system in operation at present but I’m not sure how effective it is”**

### **Expectations of Family Care**

The concept of duty or obligation is deeply embedded in families and communities. It was evident through the interviews that obligation affects how older Irish people think and has an impact on the decisions they make about their health and social care. There was a strong feeling amongst some of those interviewed that their family should be responsible for their care. Where this was the case they did not seek help from the statutory authorities. Some respondents prefer the support of their family and opt out of support from statutory services in favour of the family, even though they know the support the family provides may not be appropriate to their needs. Strong family support was given by some people as the reason they had not accessed social services. It seems that even though some were at times in need of more intensive support, they still relied on their families instead.

We should point out here that the burden on carers is enormous and last year the National Audit Office reported that around two thirds of all those with dementia are looked after in the community by informal carers who receive little or no support in some cases and save the exchequer in the region of £5 billion a year (NAO, 2007). It would be a mistake therefore, to assume that those who reported that their families looked after them didn’t need any other kind of help:

**“My grandfather always looked after my grandmother, we all did, they lived in the family home. I have no need for social services although, bathing is hard now that my husband is deceased, but I manage and my family help me out”.**

Another person stated that the Doctor she visited was aware that she once had a large Irish family and that she felt isolated:

**“My family have grown up and are busy. My husband died and I was very lonely, my Doctor encouraged me to join the Tuesday Lunch Club, we have a good chat and it is fun”.**

A woman who lived in a flat attached to her daughter's house said she had no need for intervention from social services; she was taken to visit her sister in Leeds every week by her daughter on her way to work. They attend the day club together every Friday.

**"I receive no care from social services I attend the Friday day club run by LIHH with my sister and I get collected again by my daughter on her way home."**

Another said she was offered homecare and follow up care but refused it saying that the family would look after her.

One woman mentioned that her family members moved in with her to look after her husband during his illness,

**"He had no assessment from hospital to check if I was OK looking after him at home but it was OK, my family moved in with me to help out, so I'm OK"**.

Another woman mentioned that her family provide the support she needs instead of social services,

**"I am a great grandmother, I live alone but I never feel isolated, I do value social services but I would never use them because I have a young family who I see regularly if I need anything."**

One woman's belief system was that it was shameful to even think about asking social services for support. She explained that when she was a full time carer for her husband during his period of illness,

**"I helped him do everything; he refused to let me ask for social services' help and said he really didn't want it. As my duty to him as his wife I am entitled to look after him, not social services."**

Another woman went on to explain that she felt torn because she was ill herself she could not provide the best care for her husband. She explained how her children who were born in Leeds had a different outlook on social services,

**"My children encouraged me to apply for carers allowance £35 per week. I eventually filled in the forms and got that but my husband wasn't happy and said we didn't need it"**

Several of those interviewed mentioned they were offered homecare and follow up care but refused on the grounds that the family would look after them. One man said that he was planning his own rehabilitation after major surgery. He had told social services he did not need their support as he had his wife for help. However, he did mention that his wife is not in good health so he wonders what would happen if he needed care in the long term,

**"I taught myself to take gentle strolls again, I'm never monitored. I got great care in hospital and when they asked if I had someone who could look after me I said my wife, but she isn't in too brilliant health"**.

One woman refused social care support,

**"Even though I couldn't breath very well, my husband was alive at the**

**time so I didn't use social services' help, we managed without them... home help has become home care and I don't want that. Bathing is hard but I just manage because my husband is deceased now. I'm very independent".**

Another woman speaking about her husband's condition said,  
**"After his second heart attack... We were visited by the after care service and the social service worker asked if we needed home care, I said he didn't need it because our family would do it. All the family was around and helped out, we got through and all mucked in, that's just what you do".**

She went on to mention that she would not be confident that the hospital could take care of her husband,

**"The nursing care wasn't great, next to his bed we saw a man on the floor, my family had to tell nursing staff to help the patient, that could have been my husband, thankfully he has his family to look after him".**

It was felt by one woman who had worked in social services and retired in the last ten years that the outreach role of social services had declined, leaving the isolated Irish older people that she knows of with little or no support in place. She said,

**"A lot of the Irish people I used to see on my rounds had no family and social care was a life line to them, these people need social care support now more than ever. But I am losing touch with what there is available, it is totally different to what I saw when I was in social care".**

It is important to recognise that the burden of these expectations on carers, who themselves may be elderly, can be enormous. There is a strong gender element in that, even if there is family around, the burden of care invariably falls on a daughter.

### **Contribution of Irish Community Organisations**

During the interviews there were a lot of positive comments made about Irish voluntary and community organisations that cater for Irish cultural needs. The Tuesday club at the Leeds Irish Centre and the Friday club provided by Leeds Irish Health and Homes were particularly well regarded. The Tuesday club is a weekly social event attended by approximately two hundred people. There are various forms of entertainment with an Irish flavour. A lunch is provided and people are able to maintain contact with other people from the Irish community. The Friday club in Harehills is attended by approximately thirty people. It provides social care for older Irish people from the local area.

A woman who's husband has Alzheimer's disease said that he is happy at the Tuesday club because of the activities such as the music, the people and the general Irish ambience.

**"There should be more day care along the lines of the Tuesday club. He is**

**content to stay here and seems happy. It's because of the atmosphere which is relaxed and friendly".**

She is also always there as well and works as a volunteer helping out with the lunch. She is presently waiting for social services to come and assess him and see what they can offer.

**"I could do with a sitting service or someone to take him out for walks and to places of interest. A volunteer perhaps would be useful to spend time with him and more day care along the lines of the Tuesday club would be useful."**

Another woman, whose husband had dementia, had similar concerns. She is worried about the future and what sort of care he will receive, as he has been an Irish musician since he was a child. She is afraid that he will not get access to Irish music and other cultural aspects of his life in permanent care.

## **Conclusion**

Time constraints meant that this is only a snapshot of the some of the health issues affecting the Irish community in the city. Every effort was made to obtain as comprehensive a picture of the problems experienced by the older Irish population in Leeds as possible. The methodology may have missed some important aspects of the views of Irish people, for example it was surprising that no one raised the issue of religion or spirituality during the interviews given the importance of religion to Irish people's lives.

This report makes recommendations for commissioners and all those who work in health and social care. Especially those providing services to older people of which a proportion will be from the Irish community. Some recommendations highlight general issues around access to services faced by older Irish people, which at times are common to the mainstream population.

Most recommendations highlight the need for cultural awareness and cultural sensitivity in commissioning and providing services to the older generation of this ethnic minority group. The recommendations, we believe, would make culturally sensitive care for Irish people possible. It is **vital** that they receive culturally appropriate support at the time of need. Those concerned with planning discharge or provision of services need to be more inquisitive and proactive. At practice level more questions should be asked about exactly how a family will manage. At policy level there should be a requirement for more community consultation rather than assuming that people choose not to access a service.

The study found that individual professionals were aware of Irish people's needs. In addition, it was recognised that Irish members of staff used their own ethnicity to facilitate therapeutic relationships. However, too much of this good work depended upon the good will of staff.

Findings from other research indicated that, up until the present, evidence of organisational commitment to change has been difficult to find. It is hoped, therefore, that these recommendations will help to alter that.

When asked what services they would like, most carers did not know what would improve their situation. Some identified specific areas where help could be useful at very little cost to allow them to continue following their own activities or interests. The expectations of most were very low in relation to what they would or could receive. It is therefore important that service providers consult regularly with Irish organisations to identify measures to overcome the inability of some older Irish people to access the relevant services they need. Most do not know what is available and are unwilling to ask for things they may not think they are entitled to. Some of the recommendations are general and may require more discussion to tailor them to the local conditions. Closer contact between Irish organisations and the statutory authorities to draw up protocols for dealing with older people from the Irish community could prove fruitful in this regard. That would be a useful way of addressing the issues of cultural service provision and access to services. More research of this kind would add to the body of knowledge with regard to the health issues that impact upon the Irish in Leeds and help to reduce the health inequalities that prevail in the Irish community.

There is no doubt that some of the problems related to the researchers in this study could be alleviated by simple, practical and cost-effective measures. Some carers indicated how such solutions could make their lives better in meaningful ways with the minimum of cost. It is important to reach those people who rely heavily upon their family for support. These families need practical help to continue providing care if they are not to succumb to the pressures associated with the burden of care.

This research found that Irish staff and staff with Irish connections were seen as positive aspects of service provision. Whilst this may be seen as useful it does not in itself make for cultural sensitivity and cannot be relied upon to enhance care across a range of services. Therefore the statutory services, through their diversity-training programme for all staff, should ensure that white minorities such as the Irish are included. They should engage organisations such as LIHH to work in partnership to develop such training resources and facilitate and deliver it. Policy makers need to ask why LIHH and Irish Centre luncheon clubs are so popular while other services are not being accessed.

This work raises the hope that, by the groups involved in service planning, working closely together in the future, more effective care services can be designed for Irish people. It should be possible for older Irish people to live fulfilling lives and continue to contribute to the rich diversity of this vibrant city.

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