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# DIGGIN' DEEPER

A report on the health  
inequalities experienced by the Irish Community in  
Leeds

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## **FOREWORD**

This report is published by Leeds Irish Health and Homes. It is based on the findings of its Health Outreach Project, which is funded by Heath Action Zone (HAZ) & Leeds City Council Joint Finance. Despite evidence of health inequalities little research has been undertaken on the health of the Irish. Their experiences have been largely absorbed by the white British experience. This has resulted in a lack of provision of services that are directed at the Irish or that are sensitive to their specific experiences and culture.

The aim of the report is to improve the knowledge of service providers about health difficulties amongst the Irish community, the specific services that they lack and to make recommendations as to how best to address these inequalities.

### **Key Recommendations**

In summary, this report suggests 7 key recommendations that need to be addressed for the Irish community with regards to present health inequalities.

- 1. Long term funding provision for a team of outreach workers for the Irish community.**
- 2. Adequate provision of day care/drop-in facilities.**
- 3. Creation of Irish specific posts within statutory and voluntary agencies.**
- 4. Training for staff in the statutory and voluntary sector about the health needs of the Irish community.**
- 5. Improved ethnic monitoring of the Irish community.**
- 6. Action to be taken on the recommendations of the current BME forums that exist within Leeds.**
- 7. The inclusion of the Irish community within action plans of Government health and social care initiatives.**

It is important to emphasise that this is a report and not a work of research. The Health Outreach Project has merely drawn from the experience of direct client work, in addition to the experiences and observations of other team members within Leeds Irish Health and Homes and the clients that utilise their services. The responses from G.P. practices that contributed to the Health Needs Survey also helped to underpin the recommendations that the report highlights. There is empirical supporting evidence, though given the absence of effective monitoring of Irish health needs, these show only part of the overall

picture. It has been necessary therefore to draw from the large amount of anecdotal evidence that exists, and clearly shows, the extent of health inequalities within the Irish community in Leeds. For the purposes of making recommendations, it must be emphasised that only information that can be quantifiable, and where direct need can be proven, has been used.

Despite a slow start, many professionals being unsure as to how the service could be of use to their clients, the Health Outreach Project has become well received and is now used regularly as a source of information as well as a referral point.

The Health Outreach Project has, through the floating nature of its work, been able to be more creative and responsive to individual need than more static support systems. Nonetheless, the extent of support that can be offered by one individual where the needs within a community are high is limited. The main recommendations from this report are therefore that there must be greater recognition of Irish need in terms of training of health and social care sector staff and an increasing of the monitoring of the Irish across medical, housing and social care providers. This also includes the creation of Irish specific posts within the statutory and voluntary sector so as to avoid ghettoisation.

Recommendations highlighted in the various national service frameworks and the N.H.S. plan need to be implemented to address inequalities where they exist and to ensure that health and social care is, where possible, flexible to the needs of the Irish community.

The report is not exhaustive but constitutes the beginning of a process to document the lives and experiences, as well as the health and social care needs of the Irish population in Leeds. The range of issues that it raises deserve to be studied in individual detail but the report does, I believe, offer some insight into problems long undocumented in Leeds.

The story of the Irish in Britain is one that will be recognised by many other immigrant communities as being similar to their own. The extent to which these experiences become entrenched and offer a positive or negative template for subsequent generations is largely to do with representation or the lack of it. The Irish communities across Britain remained quiet for many years, probably not out of choice but as a tactic for survival. The repercussions of this are that the Irish have been slow in demanding services that better represent their needs. Hopefully this report will go some way into redressing that imbalance.

*J. O'Dwyer*

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## **INTRODUCTION**

In 1999, the Health Action Zone initiative commenced in Leeds with the specific aims of:

- **Reducing health inequalities;**
- **Removing barriers to access; and**
- **Tackling the root causes of ill health.**

This happened in conjunction with the development of new Government initiatives aimed at improving the way in which health and social care was planned, delivered and evaluated. These included:

- **The NHS Plan,**
- **The Primary Care Trust initiatives,**
- **The Modernisation of Social Services Agenda,**
- **The National Service Frameworks on Mental Health, Older People, Coronary Heart Disease and Cancer.**

All of these recognised the need to work innovatively in order to reduce inequalities, barriers and costs in the way that health and social care was delivered.

Within this was a specific recognition that Black & Minority Ethnic (BME) communities were doubly disadvantaged because health and social care service providers often overlooked their cultural needs. This was evidently true for the Irish community.

The first report into the Irish community by the Commission For Racial Equality in June 1997, 'Discrimination and the Irish Community in Britain' highlighted concerns that Irish people's needs were not taken into account, often due to an ignorance of cultural factors and stereotyping; it made recommendations for National and Local Government, as well as Benefits, Health and Social Care agencies. Its primary focus was that the needs of the Irish community in Britain remained 'invisible' because there was either no, or very inconsistent, ethnic monitoring of them as a separate group. This was true in Leeds and often when asked, planners and providers of services had no data regarding the needs of the Irish community. Even when there was data available, there did not seem to be any planning of services related to the information being held.

Further research, such as the Health Survey For England 1999 established a link between the Irish community's experience of life in Britain and poor health and social care statistics.

Information being relayed through the housing and outreach work of Leeds Irish Health & Homes was highlighting the number of Irish people with health

difficulties who were not accessing health and social care support so were therefore using services at a time of crisis and highest cost to these agencies.

It was found that:

- Irish people, especially single people and the elderly, were experiencing major health inequalities.
- Approved social worker statistics for Leeds showed a referral rate to psychiatric services as almost double the actual number of Irish recorded in the community (2.5%)
- There was a disproportionately high incidence of homelessness.
- There was a disproportionately high incidence of alcohol abuse.
- A very low take up of support services in comparison to the size of the community
- Irish people were accessing services at acute stages of illnesses and through A&E departments as opposed to using primary care agencies.
- D.S.S. statistics (1995) showed that Irish people in Leeds had a 55% longer bed-stay in hospital than other communities.

A successful bid was made to the HAZ and Leeds City Council Joint Finance in 2000 and a Health Outreach Project was established. There were three specific aims to the work:

- 1. To improve the links into health, housing and social care of Irish users.**
- 2. To provide agencies with the opportunity to develop more awareness and understanding about the needs of vulnerable Irish people.**
- 3. To provide a report on the barriers to accessing health and social care for Irish community in Leeds.**

## **BACKGROUND**

### **LEEDS IRISH HEALTH & HOMES**

Leeds Irish Health & Homes commenced its services in 1996 after securing 9 months pilot funding through Leeds Social Services. This was in response to evidence, both empirical and anecdotal, which showed that the Irish community in Leeds had disproportionately higher rates of homelessness, mental health and physical health difficulties compared to the indigenous population and indeed, compared to other ethnic minority communities. It also noted that unlike the response to the needs of other minority communities, who by no means had their needs adequately addressed, there was no culturally sensitive support specifically aimed at Irish people within any statutory or voluntary sector services. To all intents and purposes, the Irish were an 'invisible' client group.

LHH began primarily as a provider of supported housing to single Irish people vulnerable to homelessness, mental and/or physical ill health. Our first scheme of 8 units of accommodation in partnership with the Ridings Housing Association received such overwhelming demand that further housing units were taken on. Our latest development of a specialist Health and Housing Scheme in 2002 has brought the current total to 62 units in management.

As the only provider of support services to the Irish community, we quickly became a referral point for needs which we were not yet meeting. Much of this demand came from isolated older Irish people, for whom there again was no alternative provision.

A project to address this need commenced in September 1999 after funding was secured through the Irish Government's Díon Fund, Leeds City Council Joint Finance and Leeds Urban Initiative. Providing outreach support to a wide-range of service-users on a number of different issues this project now supports over 60 people on a regular basis.

A number of initiatives such as a video, a day club, an activities group, a women's group, a community newsletter and the development of an Irish Community Forum have also encouraged other Irish people to become aware of and use our services.

With the addition of the Health Outreach Project, Leeds Irish Health & Homes services now reach out to over 300 people on an annual basis.

It should be still noted that the only providers of culturally sensitive support for the Irish community in Leeds remain firmly fixed within the Irish voluntary sector.

## COMMUNITY PROFILE

Irish people have been emigrating from Ireland to Britain in significant numbers since the 1820s with the arrival of thousands of labourers and their families who played a large part in the construction of the canal and railway networks. This period also witnessed the mass migration of Irish weavers to the textile districts of Northern England, of which Leeds was one of the most prominent. This followed the abolition of the protective tariff on the import of English textiles into Ireland, which practically destroyed the Irish cloth industry.

'The newcomers had to face much bigotry and hostility, not simply because they were poor, with strange accents and seen by English workers as competitive in the labour market, but also because most of them were Roman Catholics' (The Ham Shank – Mary Patterson, University of Bradford, 1993)

Subsequent emigration from Ireland in the 1940s, '50s and '60s brought new generations of Irish to Leeds. Again the men amongst these new arrivals were employed largely in the construction and allied industries, as the indigenous population needed supplementing to meet the demands of post-war reconstruction. The women were employed largely in the service industries and a great many in the newly expanding National Health Service.

The 1980s brought a new wave of Irish emigrants to Britain fleeing high unemployment in Ireland and attracted by the work available during the housing boom.

The 1991 census of Great Britain showed that the Irish represent the largest single ethnic minority in Britain. The figures for other ethnic minority groups include second and third generations in their numbers, whilst the Irish figures include only those born in Ireland, thereby excluding all subsequent generations. In Leeds the 1991 census identified the Irish as the third largest ethnic minority with 9767 Irish born head of households (1.3%). Taking into account the above, a revised estimate of the Irish population would be closer to 35000 (4.6%).

The Irish, like any other community are not homogenous, and the experiences of individuals vary widely. Also the lack of educational opportunities amongst older generations contrasts hugely with the attainment of those Irish who emigrated in the 1980s to Britain. However research, examined in greater detail later in the report, shows that the Irish, already unique amongst ethnic groups in having a life expectancy that declines on arrival in Britain, also displays stoicity in health that continues through the generations and across economic groups.

The Irish were late in organising themselves into coherent community groups unlike representatives of other ethnic minorities and consequently there was little pressure on the statutory and voluntary services to include an Irish dimension in the planning of their services. Nonetheless it became apparent to many that even with little accurate statistical information to refer to the Irish were still over represented in many areas of health and social need.

## **DEVELOPMENT OF THE PROJECT**

The Health Outreach Project was the first time that specific health inequalities within the Irish community had been considered. There were no existing reference points with which to link into, so the project constituted the start of much needed documentation and monitoring of the Irish situation with regards to health.

It was decided that there should be three areas providing the focus for the work. These were:

- 1. To assess the usage of primary care health and social care agencies by the Irish community.**
- 2. To make primary health and social care agencies aware of the project for referral purposes.**
- 3. To identify gaps in the current provision of health and social care for Irish people with health difficulties.**

Within the first month of the commencement of the project, leaflets and other advertising for the Health Outreach Project were produced and distributed. All statutory providers of health and social care were contacted as were the major organisations within the voluntary sector with social care remits. Local G.P. practices were also made aware of the service, as were local churches.

One of the prime reasons for the setting up, and gaining of funding for the post were the statistics quoted previously showing that the Irish community had a much longer average bed stay while in hospital. Coupled with findings showing the extent of Irish use of A&E this suggested that many Irish people were not accessing primary health care in an appropriate manner but were instead by-passing G.P. practices and using secondary level services when health problems became more acute.

With the above in mind it was decided that a good way of assessing the extent of Irish use of general practices and whether there was any noticeable trends of ill health prevalent amongst the community was to conduct a Health Needs Survey amongst the general practices.

Given the demands on time of G.P.s, and the probable absence of monitoring data, the scope of the survey was limited (See Appendix 1). The intention however was less about backing up the findings of national epidemiological statistics and uncovering definitive statistics about the health of the Irish in Leeds, as establishing which areas reported noticeable trends amongst the Irish. The rationale being that this would allow Leeds Irish Health & Homes to better plan and target their resources with possible links being established between the organisation and individual surgeries in terms of direct referrals and/or as a source of information. The hypothesis being that the sources of the referrals would in many cases have a direct social care as opposed to medical need.

## THE HEALTH NEEDS SURVEY

All 140 G.P. practices in the Leeds area were sent a copy of the Health Needs Survey along with information detailing the concerns of Leeds Irish Health & Homes. The response by Primary Care Trust sector is noted in the table below.

<b>P.C.T. AREA</b>	<b>NUMBER OF PRACTICES</b>	<b>RESPONSE</b>	<b>FOLLOW-UP</b>
<i>WEST</i>	16	4	0
<i>SOUTH</i>	30	7	0
<i>NORTH WEST</i>	34	18	5
<i>EAST</i>	30	14	2
<i>NORTH EAST</i>	30	15	6
<b>TOTAL</b>	<b>140</b>	<b>58</b>	<b>13</b>

**RESPONSE TO SURVEY FROM PRACTICES – 41%**

## **WHAT THE RESULTS OF THE SURVEY HAVE SHOWN**

The returns from G.P. practices provided varied responses. Those surgeries that highlighted particular areas of concern tended to be based in the inner city areas of the North East and East Leeds Primary Care Trust boundaries.

The following areas of ill health were seen to be more prevalent amongst the Irish, particularly in the Harehills, Chapeltown and Chapel Allerton areas:

- **ALCOHOLISM**
- **OBEISITY**
- **HIGH BLOOD PRESSURE**
- **HEART DISEASE**
- **TUBERCULOSIS**
- **RESPIRATORY DISEASES**

The Irish living in these areas were also seen to be more prone to schizophrenia and depression. Amongst older Irish males poor nourishment and isolation were identified as being a particular problem.

The results can be interpreted in a number of ways. Firstly the areas mentioned have large immigrant populations and so it is possible that individual practices in these areas are more accustomed to responding to requests for information about community health profiles. Secondly, given the economic profiles of these areas and the associated health problems found in areas of social deprivation it is possible that the information given merely provides an outline of the health of the poorest section of the Irish population and that these results could be replicated amongst the poorer sections of any of the ethnic groups or that of the indigenous population.

While either or both of the above interpretations may be true it is also the case that the practices in these areas were asked to provide information about health trends amongst the Irish which were noticeably more pronounced than of those within the general population. The fact that a wide range of illnesses, both of a physical and mental nature were highlighted suggests that the health problems of the Irish need to be addressed in a more pro-active manner.

**‘ The failure to recognise the Irish as a distinct group means that disadvantages and discrimination may not be recognised. This in turn makes it difficult to develop policies and practices to tackle past and present discrimination.’**  
**(Discrimination and the Irish Community in Britain-C.R.E. 1997)**

The most positive response from general practices came from those within the North West, North East and East Primary Care Trust areas with percentage response rates of 53%, 50% and 47% respectively. The response rates for the West and South Primary Care Trust areas were 25% and 23% respectively. No general practices in the latter two areas produced any information that suggested a follow-up letter or visit would be useful.

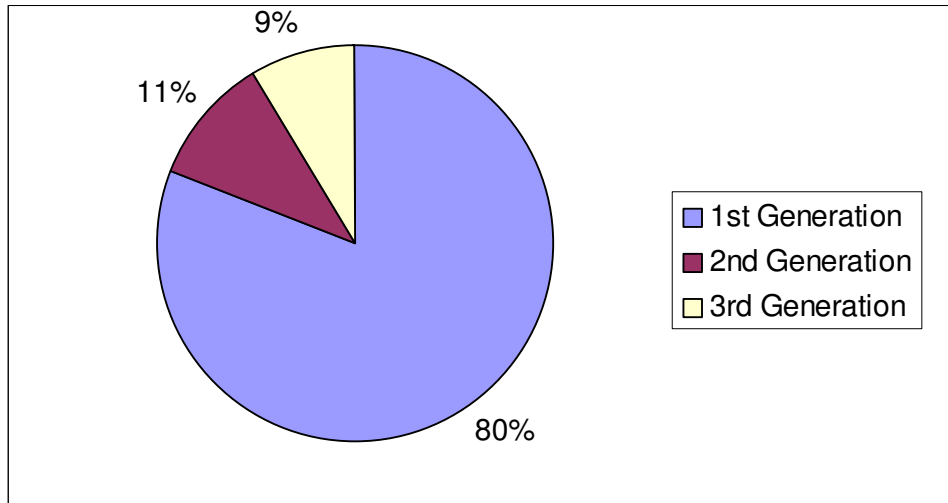
Most of the identified health problems related to single elderly males, with late presentation, lack of family support and isolation being commonly raised as being factors that further compounded the health issues. An explanation of this is the large numbers of Irish men who emigrated from Ireland to Britain in the 1950s and 1960s are now of retirement, or are approaching retirement age.

The social outlets that existed in the past no longer exist or are not appropriate to someone with health problems. There is a pressing need to create new meeting places for this client group so that necessary preventative work can take place, but that is delivered in a culturally sensitive manner.

## HEALTH INEQUALITIES THROUGH THE GENERATIONS

As can be seen from the chart below, referrals to the Health Outreach Project have been overwhelmingly from the first generation of Irish immigrants, and as was shown earlier in the report, largely from those people that emigrated from Ireland in the 1950s and 1960s to Britain in search of work.

### REFERRALS TO THE HEALTH OUTREACH PROJECT BY GENERATION



Referrals from second generation Irish people have up to press only comprised 11% of referrals, though this percentage is increasing. One of the reasons for this could be the inability of referrers to detect any Irish ethnicity in their clients without the identifying tag of an accent. The Commission for Racial Equality (CRE) describes racial discrimination in Britain as being **'constructed on the basis of a black-white dichotomy'** (CRE, 1997). This suggests that while other ethnic groups are allowed to express themselves in terms of their ethnicity through the generations on account of their skin colour, assumptions are often made about the Irish on account of the physical similarity with the indigenous population.

While many of the 2<sup>nd</sup> generation identify more with their country of birth this doesn't diminish the extent to which their chances of experiencing ill health or homelessness will be decreased. This may be partly explained by the relative immobility of the social class structure but does not provide all the answers. While the greater proportions of Irish immigrants occupied the lower rungs of the social strata, with the consequence that future generations were more likely to find themselves in the same economic position, this doesn't offer any insight into the specific problems of overrepresentation across several diagnostic categories of illness or the levels of homelessness.

**'It is estimated that 11% of people sleeping on the streets of London are Irish' (Housing Services Agency, 1999).**

' The causes of psychological illness in Irish people have been identified with colonial rule and the catastrophic conditions deriving from famine in the nineteenth century. In particular, the scourge of unremitting emigration, resulting from famine, has formed a background against which speculative theories of inferiority, alienation and mental illness have been constructed. In particular, the long-standing idea that Irish people exhibit high rates of schizophrenia, both in Ireland and abroad, is discussed.

Contemporary studies that suggest that these elevated rates do not correspond to international diagnostic criteria for schizophrenia are introduced. Rather, these enhanced rates may reflect a malaise which resembles schizophrenia but which is really a product of historical disposition. The importance of these factors is underscored by the previous neglect of Irish people, considered as an ethnic minority, as well as the particular distaste which many Irish people display towards such a notion'.

**Mental illness and Irish people: stereotypes, determinants and changing perspectives. Clarke L.**

Due to the physical similarities to the host community it takes a concerted effort on the part of 2<sup>nd</sup> or 3<sup>rd</sup> generation Irish person to maintain the cultural framework that sustained previous generations. To a large extent this takes the form of choosing allegiance between the country of ethnic origin and the host country. While the 'melting pot' theory holds credence in terms of the natural cross-cultural affiliation that every immigrant community eventually contributes to, this is rendered as theft if not accompanied by positive recognition of roles played in community and nation building by the many immigrant groupings that have made Britain their home. The difficulty for those not born in the country of ethnic origin and maybe two generations removed, is that while you may identify with either the homeland and culture of your parents or your country of birth, this doesn't necessarily mean that you will be automatically recognised by either. This is not a situation that is unique to the Irish community but one that has parallels in many traditions. The obvious dangers inherent in large groups with citizenship rights feeling that they don't belong offer a portent in terms of social mobility, rootlessness and the underclass.

The problems affecting large parts of the Irish community are not all resulting from the reception that they received on arrival in Britain and their subsequent experiences here. Certainly most second generation Irish would concur with the description of their upbringing as being overly romantic in nature certainly in terms of the misty eyed view of life in rural Ireland and the traditions that formed a soundtrack for this. The notion of the family being told that they would be moving 'back home' the next year and this being a constant though ever shifting certainty that rarely came to fruition will also be familiar to many. It is difficult to maintain a balanced sense of purpose in life and to plan for the future if the social mores you are raised to adhere to don't correspond entirely with those of the dominant tradition. This is particularly so when problems between the two cultures require allegiances to be declared.

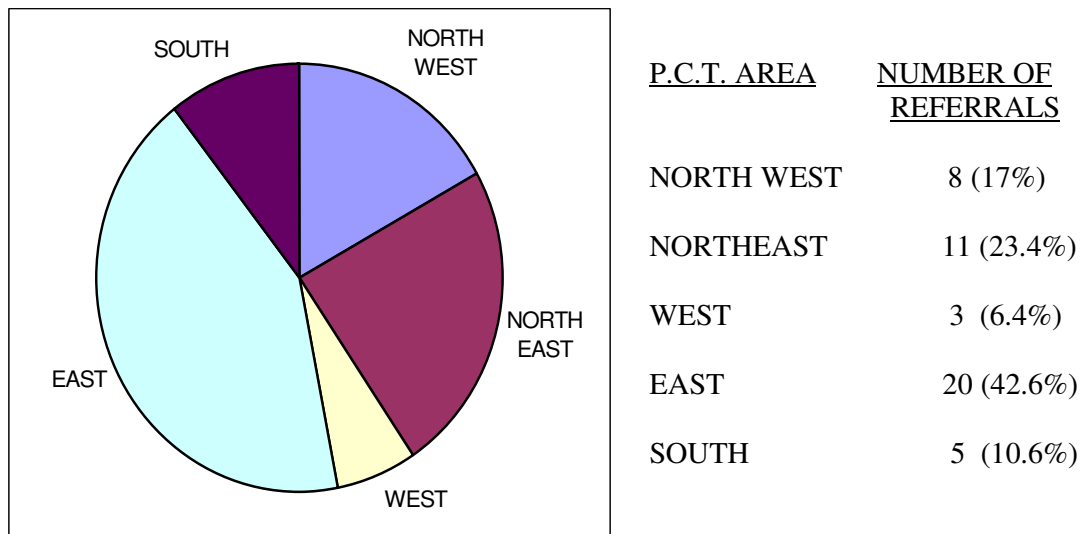
' The evolution of ethnic identity through generations is influenced by the interaction with the social, economic and political environments of the host community. The importance of these changes over generations on health are poorly understood and may have important implications for issues related to diet, smoking, health behaviours and work exposures'.

**Mortality of third generation Irish in England and Wales: longitudinal study. S Harding, R Balarajan.**

## ASSESSMENT OF CLIENT WORK

The number of clients worked with since the Health Outreach Post started is 47. Of these **32 (68%)** were male and **15 (32%)** were female. The differences in referral rates between men and woman were to be expected and are also broadly representative of referrals to other branches of the organisation such as the Housing Support Service.

### REFERRALS BY PRIMARY CARE TRUST AREA



The above statistics broadly represent those areas where the Irish have settled in Leeds with some minor aberrations. East Leeds is undoubtedly the area where the Irish have settled in greatest numbers though when estimated P.C.T. figures relating to age and ethnicity are examined, the North West area highlights a larger Irish population than in the North East.

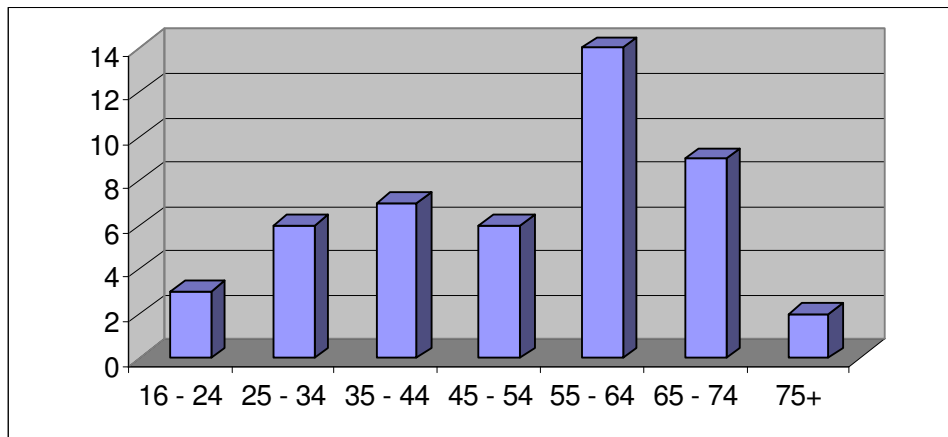
### ESTIMATED IRISH POPULATION BY P.C.T AREA

<b>North West</b>	<b>2496</b>
<b>West</b>	<b>1149</b>
<b>North East</b>	<b>2079</b>
<b>South</b>	<b>1641</b>
<b>East</b>	<b>2632</b>

(Estimated Ethnicity By Age and P.C.G. Area – 1999 Data)

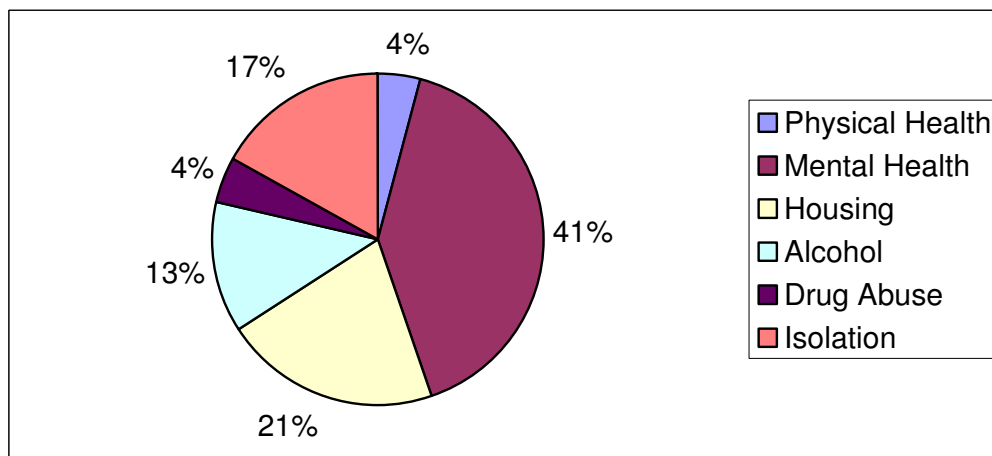
The higher rates of referrals from the North East P.C.T. area over the North West can be easily explained. For one the geographical location of the organisations base and the supported tenancies are in closer proximity to the North East. Secondly, the North East contains a greater proportion of the inner city areas that are economically poorer and in need of the type of support services offered by Leeds Irish Health And Homes.

## AGE PROFILE OF REFERRALS



The above graph shows that while referrals have been received across the whole adult age range the greater number have been drawn from those individuals in their late forties up to those of pension age and beyond.

## INITIAL REASONS FOR REFERRAL



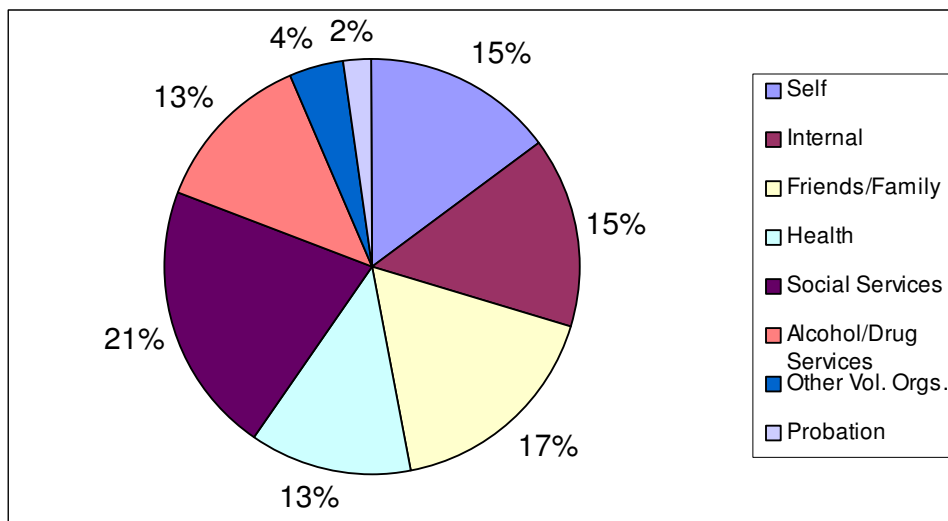
The above chart shows the initial reason for referral from various sources. The reality is more complex than this however. In most cases the particular circumstances of the individual referral is more likely to be an amalgamation of several of the above. While mental health features heavily amongst reasons for referral, housing obviously takes precedence in client assessment. It is rarely possible to undertake effective work with an individual while they continue living in sub-standard accommodation.

Similarly the effect of isolation and dislocation from the wider community, particularly acute amongst older referrals, is often accompanied by alcohol misuse, sometimes as a consequence of the isolation, often as a precursor.

Whether an important factor in the initial referral or not, almost all of the more elderly clients had poor physical health, often related to types of work and the associated lifestyles. Common ailments include arthritis, and as a consequence usually poor mobility, and respiratory problems.

Those clients with drug problems have tended to be younger. The limited number of referrals received in this category reflects the average age profile of referrals. However, as the profile of the organisation has increased so have the number of enquiries with regard to offering support to people in this category.

### **SOURCES OF REFERRALS**



One positive aspect of the post is the wide spectrum across which referrals are received. There is almost an even split between referrals from the statutory services and those received from self/friends/family. This reflects the efforts that have been put in to raise the profile of the post both within the wider social care sector and within the Irish community. Those referrals from health tend to be from hospital social work departments and are often the consequence of discharges being blocked due to insufficient family/social support and inadequate accommodation. Individuals with multiple admissions due to lifestyle factors also comprise some of the referrals from this area.

Those referrals from the social services have tended to be as requests for additional support where the client has proved resistant to the more traditional referrers options such as day centres etc. In that respect the role of Health Outreach has been to tailor a more culturally sensitive support structure in relation to the clients needs.

Many of those individuals that refer themselves to the Health Outreach Service do so because they are aware of friends/acquaintances who have availed of the services on offer and have found it less formal and more

accepting than other social care providers. This may be despite never having used these services in the past. The perception being that an Irish organisation would be more attuned to the needs of the Irish. This viewpoint is particularly evident amongst the older male referrals to Health Outreach.

The numbers of individuals referred to Leeds Irish Health and Homes by the drug and alcohol services has always been steady and this reflects a continued problem within the community. In some respects the need to counter the perceptions of the 'Irishman as a drunkard' stereotype has returned the issue to the margins but it is one that still persists and one in which resources will have to be further allocated in the future.

## **CASE STUDIES**

The names of the clients profiled below have been changed, as have some personal details to protect their identity.

### **JAMES**

James was born in Mayo in 1929. He left Ireland in 1947 aged 18, initially moving to Scotland to pick potatoes having followed two of his brothers there. James said that at first he wrote home on a regular basis, sending money back home to his parents. He didn't visit home again until his father died in 1951 though this wasn't a good time for him. He intended to stay for two weeks but returned to Scotland after only five days. James didn't indicate what problems he encountered or why he returned so soon but aside from an equally brief visit home for his mother's funeral in 1963 this was to be his last visit home to Ireland.

James, over the next three decades worked and lived in many towns and cities throughout Britain, mostly labouring on building sites with the occasional factory job in the winter. James has good and bad memories of his working life, the best being the comradery of fellow workers and the 'craic' that could be found wherever the Irish congregated in the Irish bars and clubs.

James never married but was in a relationship for several years in the late fifties /early sixties. Since then there were the occasional 'dalliances' but 'nothing serious'. 'It was difficult to meet and keep a woman with all the moving around' said James, and besides 'I started drinking heavily around this time'. It wasn't such a problem at first just a way of meeting other people.' 'Wherever Irish people met there was a bar'. After a while however James said that he started to miss the odd day at work. This combined with feelings of depression at having virtually severed links with his family made James start to drink even more.

James started using night shelters for the homeless around the country in the 1970s. These were often 'horrible places' 'full of people who should have been in hospital or looked after somewhere'.

By approx 1980 James was sleeping rough on a regular basis or stayed at various 'drinking houses'.

James physical health had started to deteriorate; he suffered badly with arthritis and developed diabetes. After several incidents in which he 'nearly died' through neglecting himself James went through two detox programmes before finally giving up drink in the late 1980s.

James, with support, has pulled his life around to a large extent over the past few years. He was encouraged to make contact with members of his family, which he had put off doing for many years, and recently visited Ireland for the first time since 1963. He has made plans to visit again in the near future.

## **MAEVE**

Maeve is aged 42 and was born in the north of Ireland. She left home when she was 23 to live and work in London. Maeve was abused as a child, a period in her life that she attributes to her developing mental health problems in her late teens. An older member of the extended family abused Maeve and although this had ended many years previously she felt that she had to leave her hometown as she found it 'suffocating'. Maeve found office work in London and for a time she felt 'liberated' and developed a close circle of friends, many of them Irish. However, after the death of her brother in a work accident Maeve became unwell again. There were a number of hospital admissions around this time.

Things improved after a while and Maeve began a relationship with someone she had been friendly with for many years and they married when she was 28. The marriage, though initially a happy one, started to deteriorate when her husband had an affair. They separated for a short while before getting back together again but things 'never recovered after that'. They split up for good when Maeve was 31.

Maeve moved to Leeds in 1993 with one of her friends from London who was starting a college course. She became unwell again however and this started another period of hospital admissions.

Maeve was referred to Leeds Irish Health And Homes' Outreach Team in 2001 and says she 'appreciates the support' because 'it takes the pressure off a bit'. With help, she was successful in applying for funding to help pay for a guitar, which she has resumed playing after many years. She also received help in finding better accommodation and started an art course at a local college, which she enjoys.

Maeve, while still experiencing periodic bouts of depression, hasn't had a hospital admission since she started receiving regular support. She also feels that her relationships with her friends have improved, as she no longer has to rely on them so much for support.

## **OTHER HEALTH RELATED ISSUES AFFECTING THE IRISH COMMUNITY**

### **DAY CARE**

From the onset of the Health Outreach Project, one omission from the range of services offered by Leeds Irish Health and Homes became apparent. This was the issue of day care for the Irish community, particularly those elderly members who were becoming increasingly isolated from the rest of their community. Many of these people were hesitant to use the services already on offer and by nature disinclined to ask whether the Irish community could tailor such services to their needs. In particular it was found that Irish men were especially under-represented as users of the network of day centres and associated services for the over 55s. A small Irish group was in existence but this was incorporated into the running of another day club and offered little plans for expansion in terms of scale or activities. In conjunction with the Irish Elders Outreach Project and after much researching into the demand for such a venture a suitable venue was found at Montague Burton Day Centre in Harehills.

Initially it was thought that the Irish Day Club would attract only the most cursory attention from men and that women would provide the bulk of the membership. Whilst this was the case at the onset, the Club has retained most of those men that showed an initial interest and has continued to attract new male members. This was especially encouraging given the lack of outlets for the older members of the community outside of the traditional venues of pubs, clubs and work. For those members that are single the Day Club provides much needed social contact and entertainment in a healthier environment than was previously on offer.

The Irish Elders Day Club, which runs every Friday, offers food and refreshments, Bingo, raffle and regular entertainment by traditional musicians in an informal and welcoming atmosphere. There is an average weekly attendance of between 10 to 20 members and we are just about to conduct a review of members' views on any additions to the activities.

On another level, the club has been successful in that it has allowed tenants of Leeds Irish Health and Homes to take part in voluntary work with members of their own community thereby gaining confidence, self-worth, and for some, a way back into the world of work which looked lost.

We have been able to begin to attract long-term funding through Leeds Social Services, with additional monies from Díon and the Drop-in/Outreach Budget for the possibility of expanding activities, which will then allow us to encourage more members.

## **TRAINING INITIATIVES**

Leeds Irish Health And Homes recognises that it is limited by its size in terms of the support that it can offer to the entire Irish population in Leeds. To this end one of the roles of the Health Outreach Project has been to provide training/advice to a wide range of agencies, particularly in the social care field. This was also one of the stipulations of the funding received from the Health Action Zone. Training has been provided to social services staff on two occasions as part of multi-cultural training days, as well as to medical students on two occasions as part of the communications skills section of their course. In addition to this, talks have been given to General Practitioners and social services departments after interest was expressed. The latter two examples have usually been in response to recognised demand for services from Irish clients.

## **TRAVELLERS HEALTH**

The health of travellers has long been recognised as representing a 'black hole' in terms of statutory health provision in this country. While efforts have, and continue, to be made by concerned individuals and professionals to redress the imbalance that exists between travellers and the wider community, little headway has been made in terms of real improvements in terms of access to, and delivery of, the kinds of services that travellers have long campaigned for.

The wholly inadequate site provision, and the lack of facilities on those sites that do exist, combined with lack of access to health care and health education both serve to make difficult any attempt to make inroads into the statistical certainty that travellers will experience poorer health than the settled communities. While small changes to health provision and better-tailored access to primary healthcare would no doubt be welcomed, real change will only be forthcoming when health and housing needs are addressed simultaneously. The two areas are interlinked, and as was mentioned earlier in the report, without security of tenure and an adequate home environment, real progress in terms of individual, family or community health will be minimal.

Leeds Irish Health and Homes are not involved with providing support directly to travellers for a number of reasons. Chief amongst them is the need for representation to emerge from the travelling community themselves. Support by proxy only serves to further disenfranchise communities and leaves them impotent in terms of the championing of their culture their lifestyle and the need to ask questions of themselves. This can only be addressed when respect is guaranteed and tokenism and short term strategic options are not part of the equation.

The organisation is aware that a significant proportion of the traveller population in Leeds are Irish but feel that any support offered would have to be directed to the community as a whole so as not to create further divisions.

Nonetheless there may be specific issues around Irish identity that we may be able to support individuals with. Certainly, there is an opportunity within the Leeds Irish Community Forum for issues pertaining to the health of travellers to be addressed, and to be presented to relevant bodies in the context of wider Irish community health requirements.

Leeds Irish Health and Homes has had few requests from individual travellers for support since its inception and only one to the Health Outreach Service. This could be representative of the fact that travellers receive as much criticism from the settled communities in Ireland as they do across Britain. Alternatively, given Leeds Irish Health and Homes' emphasis on housing and accessing the more traditional routes to health provision, maybe we are seen as not relevant in terms of providing services, which are largely geared towards the settled community.

Traveller's health has attracted more attention over recent years largely due to travellers themselves demanding involvement in decisions that affect their own lives. Increasingly demands have been made for specific funding to be made available for travellers to create services themselves that are more responsive to the needs of travellers. At the time of going to press Leeds Justice For Travellers have received funding for a Community Development Campaign Worker to assist in the development of support groups and outreach work.

## **WHERE DO WE GO FROM HERE?**

### **FINAL THOUGHTS**

It could be remarked, given the older age profile of the Irish community in Leeds, that this report, amongst others, loses its relevance by virtue of its findings. That is, the real need for community focused health and social care provision was when the Irish communities around Britain were at their most vibrant; when plans for the future could have been put in place to avoid the pitfalls that we now know were to the detriment of so many Irish immigrants. In other words, 'closing the stable door after the horse has bolted'.

In actual fact health planners could without much difficulty have predicted the health of those immigrants who entered Britain in the 1950s in the 1960s. The types of work that particularly the men undertook combined with the associated transient lifestyles could not have resulted in anything but the health and social difficulties we witness today.

With the upturn in the Irish economy over the last few years and with renewed confidence in Irish identity and in presenting Irish culture to a worldwide audience the result has been that many Irish people have returned home, often with their families. This has resulted in many of the most vibrant stalwarts in the Irish cultural field joining the exodus and leaving the communities left behind often in a state of flux. This has been accompanied by the closing down throughout Britain of many of the Irish social clubs, even in the larger cities and towns where many would have thought their existence relatively secure.

However it would be foolish to imagine that the 'Celtic Tiger' has banished the concept of the Irish experience of unrelenting emigration for good. The likelihood is that Ireland will not be able to sustain the levels of job creation necessary over the longer term. For these points to be addressed in any meaningful way there needs to be real unity between Irish groups claiming representation if any progress in terms of achieving the said goals is to be made. Any progress has to recognise that representation doesn't occur in a vacuum and that the health of a community is covered by the whole spectrum of need, the cultural, spiritual, housing and social care requirements and that all of these have to be available if the communities health is to be addressed in any real way.

The confidence in the way that many Irish see themselves today is palpable. There is a well-established linkage between culture and economic prosperity. It is also true however that the poorest people who maintained links with, and fostered the traditions during more difficult times are often those within the community that are now presented as being surplus to requirements. The travellers are a good case in point. Renewed confidence and greater affluence means that more people can participate openly in their culture without embarrassment. This often ignores the fact that the traditions were, in darker days, life enhancing and a necessary part of life rather than just entertainment.

The detailed results of the Census held in 2001 will be published in February 2003. The inclusion of the separate Irish category for the first time will give us the clearest idea yet of the size of the Irish community and consequently the extent to which community services will have to reshape and re-evaluate their work to take account of changed perceptions and new realities.

The British Government's acknowledgement of the Irish as a separate ethnic minority with specific needs mirrors the work that has been going on by the Irish Government in supporting their community abroad.

The Díon Commission was set up by the Irish Government in 1984 to investigate and provide assistance to those overseas emigrants whose experiences of leaving Ireland and settling in Britain were not always positive.

The Irish Government has to be commended for the support they have already provided to:

- Cultural and social groups and networks.
- Those providing social care and supported housing.
- Day care facilities, particularly for the more isolated and older members of the community.
- Help with relocation to Ireland or with holidays.

A recently published report of the 'Task Force on Policy regarding Emigrants' to the Irish Minister for Foreign Affairs, Brian Cowen, T.D recommended the adoption of policy objectives designed to:

- Ensure, as far as possible, that Irish people who emigrate do so voluntarily and on the basis of informed choice, and are properly prepared to live independently in different societies.
- Protect and support the Irish abroad, particularly those who emigrate involuntarily and those who find themselves marginalized or at risk of social exclusion.
- Facilitate the return to Ireland and reintegration into Irish society of emigrants who wish to do so, especially the vulnerable and the elderly.
- Support the Irish abroad who wish to express and share the Irish dimension of their identity.

It should be noted however that Irish community-focused services must not be expected to rely on, their main funding support coming from the Irish Government. Irish people have worked here, paid national insurance, taxes and contributed fully in other ways. They have a civil right to receive decent health and social care which adequately addresses them as individual human beings primarily, and secondly as members of a community with historical mores, beliefs and experiences which shape the way they perceive themselves and their right to support. Statutory funding bodies in the U.K should adequately provide for this need.

## KEY RECOMMENDATIONS

- 1. The work undertaken by this project, the development of positive plans for the future and the identification of service gaps should be a signal for the securing of additional long-term funding for a team of Outreach workers who can begin to develop initiatives to cover the plethora of need.**

Leeds Irish Health and Homes in response to the realities of the failure to include the Irish previously, have shown on a consistent basis that there is a need for the services that we provide. The high rates of self/family referral indicates that Irish people in Leeds will use a service that they trust and which they feel points them in the right direction to help them get the support they need.

The funding of new initiatives, as with this project, is often short-term, which does not allow for the development of long-term objectives. Work aimed at prevention can sometimes be undervalued, as the question can be put, if the work didn't happen, would the problem occur anyway? This has often been a form of debate when considering the 'hidden' needs of the Irish community.

It is important to emphasise that the request for expansion of funding is not an attempt to subsidise one community at the expense of another. The recognition by Government of the disadvantage experienced by Black & Minority Ethnic communities also recognises the benefits of those communities responding to their own needs. It is cheaper to provide care on a community basis than it is to wait until individuals and families fall through the health and social care net and have to be treated/supported long after they had an ability to respond effectively to primary care interventions.

- 2. Adequate day care and drop-in facilities need to be provided for the Irish community in Leeds. Evidence from our work and other Irish organisations shows the positive impact that the provision of social centre support can have on isolated members of the Irish community. Funding is needed to develop a fully resourced social support centre to meet the needs of all the vulnerable members of the Irish community, young and old.**

Through our experiences with our clients we have seen the impact that difficult life experiences and cultural isolation have had on the physical and mental well being of our community. Whilst Leeds Irish Centre primarily serves the Irish community as a social outlet, and is recognised for the outstanding work it does in the Irish community, the need to develop facilities that offer vulnerable Irish people the choice of support networks is essential. Our service highlights the need for a drop-in facility that advises, supports and encourages people to break the cycle of isolation and ill health they may experience.

**3. There is a need to avoid ghettoisation. Irish specific posts within the statutory and voluntary sector services need to be created to complement community provision.**

As with the recognition for culturally sensitive practice with other communities, the need to respond to Irish people in a way that deals with them sensitively is paramount. Other agencies within Leeds now need to accept responsibility for ensuring that their services meet the cultural needs of members of the Irish community.

**4. There needs to be training for staff in the statutory and voluntary sectors in recognising those who would benefit from support from an Irish organisation. This should be a compulsory part of training for both new and existing workers.**

All too often agencies fail to recognise that the Irish community are the largest ethnic minority in the U.K. This then limits recognition by workers of the Irish need and experiences. There is also a need to support people of subsequent generations who regard Britain as their home but who still like to recognise and give expression to their roots. As with other minorities an English accent does not always clearly define cultural heritage.

It is currently recognised by all agencies that culturally sensitive training is essential to improve access for BME communities. We want to see greater inclusion of the Irish situation within training packages. Leeds Irish Health and Homes have produced a video called 'A Long Way from Home'. This examines the experiences of Irish migrants and how our organisation has helped tackle these. We recommend this as a training tool for all organisations.

**5. There is a need to further increase the incidence of monitoring of the Irish in hospitals and other medical institutions as well as across housing and social care providers to gather accurate statistical information to back up what we know anecdotally.**

After the Census 2001 allocated a specific Irish category within its survey many other agencies took the initiative to include an Irish category in their monitoring. However, further work, if not a compulsory obligation to include an Irish section needs to be addressed. Once the figures begin to be gathered action should be taken in the planning and provision of services.

**6. There is a need to work closely with other cultures with similar experiences to the Irish to further increase the voice of those calling for more culturally sensitive provision of services.**

There are a variety of forums working in Leeds at the moment assessing BME issues. Their findings and their work now needs to be recognised by statutory agencies who provide health and social care. All too often findings and

knowledge from these communities is not acted upon and the problems continue.

**7. Recommendations arising from the various National Service Frameworks and the N.H.S. Plan need to be implemented to address health inequalities within the Irish community. The emphasis on providing care that is flexible to the differing needs within communities needs to be seized upon by those providing care and support services. Those individuals that are amongst the most vulnerable are correspondingly those whose health provision is the poorest.**

Inclusion needs to be followed up by action to address the issues arising from this report. This report has begun the process of raising awareness about health inequalities experienced by the Irish community. The vast array of Government initiatives aimed at tackling social exclusion, poor health and poverty need to address Irish issues with paramount importance and not wait for a further decline in their health situation.

## CONCLUSION

These are both exciting and difficult times for the Irish communities around Britain. Confidence is high amongst representative groups, paradoxically when the community is at its weakest. Unity amongst Irish representative bodies is imperative at this time. Recognition amongst statutory bodies of the work undertaken by those that foster the cultural heritage and provide the social care networks is necessary if any real inroads into improving the health of the Irish community are to be made. There needs to be continued funding of those posts/services that have proved themselves necessary, avoiding the unrelenting cycle of competing for funding on an annual basis. Those emigrants that left Ireland in the 1950s and 1960s need support now and will not benefit from longer term strategic planning, as important as this is. The younger emigrants who continue to arrive have different needs and expectations and are often emigrating for entirely different reasons than those of earlier generations. Their need to use support services is something that must be planned for more strategically.

Leeds Irish Health and Homes have recognised the health inequalities the Irish community experience. We have acted on this through our Health Outreach Project and in turn changed the fabric of people's lives within the community. By highlighting these issues in this report we believe statutory and voluntary agencies should begin to recognise and support the further development of this service.

In order to continue to tackle health inequalities and combat social exclusion we require secure future funding. Our track record proves we have the expertise and understanding to address these issues and deliver this essential service. We hope that we will not be producing a report in 2 years time that highlights these issues again. Appropriate action is needed now!

**APPENDIX 1**

**LEEDS IRISH HEALTH AND HOMES**  
**HEALTH NEEDS SURVEY**

**1.**

DOES YOUR PRACTISE CARRY OUT ETHNIC MONITORING? **YES/NO**

IF YES, DO THE IRISH HAVE A CATEGORY OF THEIR OWN? **YES/NO**

**2.**

DO YOU MONITOR THOSE PEOPLE REGISTERED THAT DON'T USE YOUR SERVICE. I.E. BY REQUESTING ATTENDENCE FOR PERIODICAL HEALTH CHECKS? **YES/NO**

**3.**

ARE THERE ANY NOTICEABLE TRENDS OF ILLNESSES PREVELANT AMONGST IRISH PATIENTS? **YES/NO**

**IF YES, THEN PLEASE ELABORATE –**

**4.**

DO YOU NOTICE ANY DIFFERENCES IN STAGE OF PROGRESSION OF ILLNESSES AMONGST IRISH PEOPLE WHEN SEEN BY G.P's? (COMPARED TO GENERAL TRENDS) **YES/NO**

**5.**

WOULD YOU LIKE ADDITIONAL INFORMATION ABOUT LEEDS IRISH HEALTH AND HOMES?

OR

A MEMBER OF THE OUTREACH TEAM TO SPEAK WITH YOU RE: THE WORK THAT WE DO?

**YES/NO**

## References

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