COMMUNITY ENGAGEMENT PROJECT:
(The NIHME Mental Health programme)

REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSSING ON THE MENTAL HEALTH NEEDS OF OLDER IRISH ADULTS COMMUNITY IN BIRMINGHAM

BY

‘Irish Welfare & Information Centre’

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Acknowledgments

This project would not have been possible if it wasn't for the 27 participants who took part in the research. Their narratives, experiences and personal thoughts have been of great value and we could not have done this without them.

We would like to thank, each and every individual who gave up their time to help make this research take place.

Special thanks goes to, Bridie Nugent, Tony Merry, Cath Gilliver, Nasreen Akhtar, Ranjit Senghera, Michelle Bhalroo, Iestyn Williams, Professor Mairtin Mac an Ghaill, Professor Paula McGee, Bernie McFall, Jacqueline Conaty, Mary Tilki, Linda Coulson, Mike Rochfort, Barbara Lambrose, Kim Cartwright, John Ward, all the support and outreach workers who identified the participants, NIMHE for providing the opportunity for the project, the University of Central Lancashire for their support and training and the three GPs who gave up their time to discuss some of their experiences within the Irish community.

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Executive Summary

This project was funded by NIMHE and managed and supported by The Centre for Ethnicity and Health, University of Central Lancashire. It focused on the mental health needs of the older Irish adult community in Birmingham and used the Centre's Community Engagement Model. The Centre's model is aimed at getting local Black and minority ethnic community groups across England to conduct their own needs assessments. Irish Welfare And Information Centre were one of 40 community groups who took part in the National Institute for Mental Health in England's Community Engagement Programme between 2005 and 2007. The objectives of the programme were to improve equality of access, experience and outcomes for Black and minority ethnic mental health service users. The Community Engagement Programme is part of one of the key deliverables of the DRE's 5 year action plan which has been designed to deliver on 3 key aims:

- equality of access
- equality of experience
- equality of outcomes

Each group involved in the Community Engagement Programme was required to submit a report detailing the needs, issues or concerns of the community.

This research was undertaken by the Irish Welfare and Information Centre (Birmingham) which aspires to alleviate poverty, ill health and social exclusion and improve the quality of life amongst the Irish community. The team of 3 researchers were recruited to carry out a qualitative study that involved interviewing a total of 27 older Irish adults in and around the area of Digbeth. Support was given to the researchers through a steering group consisting of various community groups/ organisations and individuals who were able to direct and support the research in order to meet the overall aims and objectives of the project.

The 'Older Irish Adults Project' has kept the DRE agenda in mind and is committed to Delivering Race Equality in mental health care for the older Irish adult community, within the Birmingham statutory and non-statutory mental health services. Commitment to improving services, experiences and service outcomes for the older Irish adult community remained a priority for this project and the research has identified how services can be more culturally appropriate and specific to the community's needs and how both the statutory and CVS can help make this happen effectively. The research has enabled those groups in Birmingham, i.e. volunteers, social services and primary care, who work with older Irish service users, to have a greater knowledge and understanding of the issues facing them with regards to mental health, thus fulfilling the 'better information' building block of the DRE Paper. We have also informed how such groups can develop staff teams and, engage with statutory and non-statutory mental health services, to adapt and provide a more holistic approach in their services also fulfilling the other two building blocks of the DRE; 'better community engagement' and 'More appropriate and responsive services'.

The research was also driven by an overall aim to engage with local older Irish adults in Birmingham. By conducting a qualitative piece of research we have captured their stories, experiences and histories. These were the specific aims of our research.

- To ascertain the views of Irish elders, community groups, and appropriate agencies, as to how mental health services in Birmingham can be improved to meet the needs of the older Irish adult community, i.e. commissioning of services, planning, engagement, participation, ownership, and influencing how services are delivered.

- To identify the needs of, and the barriers encountered by, older Irish service users, community groups, and appropriate agencies when engaging with statutory and non-statutory mental health services in Birmingham.

- To find out if statutory mental health services in Birmingham have difficulty looking past alcohol dependency and/or challenging behaviour, and at possible underlying indicators of depression, schizophrenia, and personality disorders etc?, and to ascertain what difficulties they encounter in engaging with older Irish service users with alcohol dependency and/or challenging behaviour, and how this impacts on their diagnosis.
- If GP and mental health services in Birmingham are having difficulty diagnosing older Irish service users, how are they to become involved in the commissioning process and design & delivery of services appropriate to their needs?

Findings

As a result of conducting 27 semi-structured interviews with older Irish adults, we were able to pull out a number of themes regarding their experiences surrounding alcohol dependency and/or challenging behaviour and access to statutory and non-statutory mental health provision within Birmingham.

1) Knowledge and awareness in the 'Older Irish Adult Community'

- Knowledge and awareness of issues surrounding Mental Health was disproportionately poor.
- Some respondents used terms which might be considered derogatory to define the notion of mental health.
- Respondents were unclear about the difference between health and illness.
- Some participants were very honest about their mental health problems and were also aware that mental illnesses vary from one person to the next.
- Respondents showed there was a stigma towards mental health in the Irish community because of upbringing, religion and a lack of knowledge in the community.
- Knowledge of the services available was weak.
- There was awareness that more mental health services were needed for the Irish community.
- The appropriate route considered to get help for mental illnesses is initially through GPs; however, outreach, support and key workers or members of staff were more often respondent's first point of contact if help was needed.
- Awareness of alternative therapies and routes to better well being was also poor.
- Respondents were aware that the Irish community needed support to prevent boredom and isolation and that there are not enough services available to help in this area.

2) Services – the strengths and weaknesses

The common barriers in accessing services

- Reluctance to acknowledging their own mental health problems and seeking help.
- Feeling embarrassed, ashamed or distrustful.
- Not knowing where to seek advice.

Characteristics of successful services in the Irish community

- Some respondents felt that seeing a psychiatrist had benefited them.
- Getting help from psychiatrists was a slow and difficult process.
- Successful pathways to better mental health was often to do with care and support from an individual such as a support worker in which they trusted and who gave them constant motivation, friendship and guidance.
- The successful services in the Irish community that were mentioned included the 'Drop in' Centre at St Eugene's Court, the Irish welfare and some surgeries.

Dissatisfaction with primary care and mental health services by Irish people

- Some respondents said that they wanted and really needed to receive psychiatric care but were unable to get referred or actively go and seek the right help. A large number of the respondents were dissatisfied with statutory services and pointed out that a major barrier was trust.

Services that need strengthening and improving for the Irish community

- Trust is a major obstacle in the older Irish community and that one to one support is beneficial because relationships can be built up.
- There is a need for more community based services and alternative therapies.
- More integrated services that deal with older Irish adults who have alcohol dependency problems and underling mental health problems.
    - Services for older Irish adults struggling with alcohol dependency and depression need improving and adapting to meet those individuals self-medicating and who have not accessed statutory mental health services.
    - Alcohol dependent respondents had a much better understanding of their mental health concerns and were keen to seek help; this group stressed their willingness to counter their mental health problems but had limited/no opportunities to do so.
    - Doctors and GPs were, according to a number of respondents not making adequate referrals due to their alcohol dependency. Respondents felt that from their experience GPs did not acknowledge their signs of depression or milder forms of mental health problems.

3) Factors contributing to Mental Health problems in the Irish community

There is a need for a holistic approach to care in the older Irish adult community. There were a multitude of factors that caused mental ill health.

- Emigration, isolation and manual labour.
- Unemployment and boredom.
- Housing and their social environment and the link to isolation and lack of autonomy.
- Discrimination, racism and Irish stereotypes.

Recommendations

1) Better Information

- More useful and appropriate information to be made available.
- For information to promote change and improve pathways to care for older Irish persons.
- Information to reach the isolated Irish community.
- For publications and events, which seek to explain the term 'mental health' and to inform the Irish community of the services available to them.
- Information to be given to the community about their inclusion on the BME agenda.
- Statutory services such as GPs to have readily available information of the services in the CVS so Irish patients can gain support in the community.
- The Irish community organisations/members to help advise and deliver Irish specific cultural competence training to mental health professionals.
- Encourage G.P's, surgeries and statutory health services to work in partnership with the CVS.

2) Appropriate and responsive services within the CVS, statutory health services and local authority.

- More community based services such as St Eugene's court, and Irish Welfare and Information Centre.
- New services to be culturally appropriate and provide professional mental health care and to be done through a venue that promotes integration, activities, education, fun and general well being.
- A holistic ethos/whole system approach within these services that would consider the cultural, physical and mental health needs and the specific life experiences of Irish people.
- We recommend that PCTs and MHTs and local authority, to commission services from Irish community organisations to maximise the potential for community based services.
- Further investment into an integrated service that deals with dual diagnosis.

3) Community engagement

- Involve the community into higher level planning and for statutory organisations to support this.
- Actively engage service users in developing their skills to participate in schemes at all appropriate levels.

Introduction

The Centre for Ethnicity and Health's Model of Community Engagement

Background to the community engagement model

We often hear the following words or phrases:

- Community consultation
- Community representation
- Community involvement/participation
- Community empowerment
- Community development
- Community engagement

Sometimes these terms are used inter-changeably; sometimes one term is used by different people to mean different things. The Centre for Ethnicity and Health has a very specific notion of community engagement. The Centre's model of community engagement evolved over several years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health (DH) awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire (UCLan) to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The DH had two key things in mind when it commissioned the work; first, the DH wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done.

If all the DH had wanted was a needs assessment and a 'glossy report', they could have commissioned researchers and produced yet another set of reports that may have had little long term impact. However this scheme was to be different. The DH was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; however they would have proven access to the communities they were working with, the potential to be supported and trained, and the infrastructure to conduct such a piece of work. They would be able to use the nine-month process to learn about drug related issues, and how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity and Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams (DATs). It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of

areas of work. These include:

- Substance misuse
- Criminal justice system
- Policing
- Sexual health
- Mental health
- Regeneration
- Higher education
- Asylum seekers and refugees

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with:

- Young people
- People with disabilities
- Service user groups
- Victims of domestic violence
- Gay, lesbian and bi-sexual and trans-gender people
- Women
- White deprived communities
- Rural communities

In addition to the DH, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, the National Institute for Mental Health in England, the Greater London Authority, New Scotland Yard and Aimhigher.

The key ingredients of the model

According to the Centre for Ethnicity and Health model, a community engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a host community organisation. This may be an existing community group, but it might also be necessary to set up a group for this specific purpose of conducting the community engagement research.

The key thing is that this host community organisation should have good links to the defined target community[1], such that it is able to recruit a number of people from the target community to take part in the project and to do the work (see section on task below).

It is important that the host community organisation is able to co-ordinate the work, and provide an infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day-to-day activities of the project. One of the first tasks that this host community organisation undertakes is to recruit a number of people from the target community to work on the project.

The second key ingredient is the research task that the community undertakes. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects have involved communities in undertaking a piece of research or a consultation exercise within their own communities. In some cases there has been an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme run on behalf of the DH, the process and its outcomes have equal importance. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be the fist time that these individuals have undertaken a research project.

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate support and guidance. It is not expected that community groups offer their time and input for free. Typically a payment in the region of £15-20,000 will be made available to the host organisation. It is expected that the bulk of this money will be used to pay people from the target community as community researchers[2]. A named member of staff from the community engagement team is allocated as a project support worker. This person will visit the project for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers throughout the project. The University also provides a package of training, typically in the form of a series of accredited workshops.

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[1] The target community may be defined in a number of ways – in many of the community engagement projects it has been defined by ethnicity. We have also worked with projects where it has been defined by some other criteria, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. users of drug services or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with (e.g. victims of domestic violence, sex workers).

[2] This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to form an appropriate steering group to support the project[3].

The steering group is an essential element of the project: it helps the community researchers to identify the community they are engaging with, and can also facilitate the long term sustainability of the projects recommendations and outcomes. The community researchers undertake a needs assessment or a consultation exercise. However the steering group will ensure that the work that the group undertakes sits with local priorities and strategies; also that there is a mechanism for picking up the findings and recommendations identified by the research. The steering group can also support individuals' career development as they progress through the project.

[3] Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

The Community Engagement Team

The community engagement team comprises of senior support workers, support workers, teaching and learning staff, administration team and a communications officer. They work across a range of community engagement areas of specialisation, within a tight regional framework.

<table>
<tr><th colspan="4">National Programme Directors</th></tr>
<tr><td>Northern Team</td><td>Midlands Team</td><td>Southern Team</td><td rowspan="2">Senior Programme Advisors</td></tr>
<tr><td colspan="2">Senior Support Worker</td><td>Senior Support Worker</td></tr>
<tr><td rowspan="2">Support Workers</td><td rowspan="2">Support Workers</td><td rowspan="2">Support Workers</td><td>Drug Interventions Programme</td></tr>
<tr><td>Citizen Shaped Policing</td></tr>
<tr><td colspan="4">Teaching And Learning Team</td></tr>
<tr><td colspan="4">Administration Team</td></tr>
<tr><td colspan="4">Communications Officer</td></tr>
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Programme outcomes

Each group involved in the Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community. The qualitative themes that emerge from the reports are often very powerful. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

In 2005/-6 the Substance Misuse Community Engagement Programme was externally evaluated. This concluded that:

- the Community Engagement Programme had made very significant contributions to increasing awareness of substance misuse and understanding of the substance misuse needs of the participating communities. It also raised awareness of the corresponding specialist services available and of the wider policy and strategy context.

- the Community Engagement Programme had enabled many new networks and professional relationships to be formed and that DATs appreciated the links they had made as a result of the programme (and the improvements in existing contacts) and stated their intentions to maintain those links.

- most commissioners reported that they had gained useful information, awareness and evidence about the nature and substance misuse service needs of the participating organisations.

- All DATs reported positive change in their relationship with the community organisations. They stated that the Community Engagement Programme reports would inform their plans for the development of appropriate services in the future.
- A significant number of the links established between DATs and community organisations as part of the Community Engagement Programme were made for the first time.
- The majority of community organisations reported their influence over commissioners had improved.
- Training and access to education was successful and widely appreciated. 379 people went through an accredited University education programme.
- A third of community organisations in the first tranche reported that new services had been developed as a result of the Community Engagement Programme.
- The vast majority of participants and stakeholders expressed high levels of satisfaction with the project.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

- The views expressed in the report are those of the group that undertook the work, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire.

The Focus of This Particular Project

Since 2000 over 200-community groups have taken part in one or other of the Centre for Ethnicity and Health's Community Engagement Programmes.

National Institute for Mental Health in England Community Engagement Programme:

Irish Welfare And Information Centre Group were one of 40 community groups who took part in the National Institute for Mental Health in England's Community Engagement Programme between 2005 and 2007. The objectives of the programme were to improve equality of access, experience and outcomes for Black and minority ethnic mental health service users by:

- *building capacity in the non-statutory sector*
- *encouraging the engagement of Black and minority ethnic communities in the commissioning process*
- *ensuring a better understanding by the statutory sector of the innovative approaches that are used in the non-statutory sector*
- *involving Black and minority ethnic communities in identifying needs and in the design and delivery of more appropriate, effective and responsive services*
- *ensuring greater community participation in, and ownership of, mental health services*
- *allowing local populations to influence the way services are planned and delivered*
- *contributing to workforce development, and specifically the recruitment of 500 Community Development Workers.*

The focus of our 'Older Irish Adults Project' was the mental health needs of the older Irish adult community in Birmingham.

Birmingham and the Irish community

Birmingham is a culturally diverse city. According to the 2001 population Census, 32.8% (321,148) of usual residents classified themselves as been from one of the Black Minority Ethnic groups, this includes white Irish. There were 31,467 people of Irish ethnicity living in Birmingham according to the 2001 population Census, this represents 3.2% of the population of Birmingham. As a percentage share of population, Birmingham ranked at number 16 (out of 354 English Local Authorities) for people describing their ethnicity as White Irish. The Irish working age (16 to pensionable age) population in Birmingham was 55.3% compared to 59.8% for the general population. Conversely the national Irish working age population was 64.5% compared with 61.5% for the general population. Both locally (38.5%) and nationally (29.6%) the Irish ethnic group have a greater proportion of people of pensionable age when compared to their respective general populations in Birmingham (16.7%) and England (18.4%). 31.7% (9,976) of Birmingham residents describing their ethnicity as White Irish were born within the U.K, of those 2,339 (23.4%) were born in Northern Ireland. 68.3% (21,493) of Irish residents were born outside of the U.K, of those 99.2% (21,328) were born in the Republic of Ireland.

After World War II, Birmingham was a key destination for Irish immigrants. During this period, in the 50's and 60's, a reputation of the Irish immigrant was established. They were seen as low skilled manual workers. Their need for employment, due to limited opportunities in Ireland, meant Irish immigrants were able to provide a cheap and mobile workforce to the UK's labour market (Williams et al, 1996). More than half of Irish immigrants who arrived prior to 1955 were unqualified, only 2.3% had degrees (Hazelkorn, cited in Williams et al, 1996) and many have since been affected by unemployment due to the introduction of new technologies (Williams et al, 1996).

Irish Welfare & Information centre - the Host organisation

The Irish Welfare and Information centre (IWIC), based in Digbeth, aims to relieve poverty, ill health and social exclusion amongst the Irish community. It endeavours to enhance the quality of life and promote social inclusion in order to guarantee that all members of the Irish community can be equal participants in a multi-cultural society. By working together with other statutory organisations, voluntary organisations and local community groups, IWIC aim to support the most vulnerable and marginalised, provide and build up professional culturally sensitive services and give an accessible information provision to the regions Irish community.

Initial Observations

As with other minority groups the combination of social, health and cultural needs, increases the likelihood of mental distress. Social hardship and poverty disproportionately affects people from BME communities, and this is reflected in their experiences and use of mental health services, as the recently published NIMHE / Department of Health report *Inside Outside* has highlighted (2003).

According to 'The Irish Older Adults Primary Care Project' Report (2005), compiled by Edward Road Medical Centre, there are a number of factors which contribute to the physical and emotional wellbeing of Irish Patients. This project provides surgeries every Friday afternoon, where 3-5 patients are seen by a GP, and the full medical and social history of the patient is recorded. In the year 2005, the project dealt with 335 patients

between the ages of <40 and 61>. 73% of these patients were male and 27% were female.

Family support and isolation
19% of the patients attending the practice reported that they have no family support or contact. Patterns of migration for Irish-born people differ from other groups in that men and women migrated alone rather than in families. Only 11% were owner occupiers whilst 18% were hostel dwellers. 21% of these patients had moved in the year 2004-05. 8% of the patients reported ‘no next of kin’. The need to move around England for work has meant that many have never set down roots and have no supportive relationships in time of need.

Housing
Homelessness among the single Irish is a severe problem. A survey of housing in London showed that 36% of residents in short stay hostels were Irish but only 4 per cent of those securing permanent accommodation from hostels were Irish. More than 30 per cent of homeless people encountered on the street were Irish (Bondaway Nightshelter, 1990).

Employment
High proportions of Irish men who migrated to Britain in the 1950s and 1960s were unskilled workers and often sought employment in the building industry, where work could be unpredictable and conditions unhealthy (Greenslade, 1994). In the Irish Adults Primary Care Project Report, 53% of the patients were unable to work due to sickness, 27% un-employed but able to work, and 10% were employed. When working 85% the nature of the work that they were employed in was manual. 81% of these patients are reliant on state benefits. Some of these patients have not paid insurance contributions and end up without pensions in their old age or when ill. Unemployment can contribute to mental health problems, especially depression. When Irish people get older, they are more likely to be physically unwell due to the conditions they have worked in during the past. This coupled with unemployment and the isolation felt from having limited support networks can have a severe effect on mental health and well being (Health Education Authority, 1997).

Suicide
Within this same report 55% were diagnosed as having depression and 19% were suicidal. Research has shown that out of all the ethnic groups in Britain, the Irish have the highest rates of suicide (Balarajan, R, 1995). Suicide in older people is a complex issue involving a range of factors; physical, psychological, social and cultural. Untreated depression is a significant factor for many older people who take their own lives (CSIP, 2006). Suicide amongst the older Irish community is therefore a serious issue and needs not to be overlooked. Additionally, although stereotyping must be avoided, it is important to recognise the known relationship between alcohol consumption, depression and suicide and to consider these link where Irish people are concerned.

Alcohol and Substance Misuse
Related to these mental health problems is the misuse of alcohol. The progress report by the Irish community Alcohol Service (Arlington Care Association, 1996) highlights the need for support for this user group. Due to racial stereotyping, alcohol users may find it even more difficult to get access to mainstream services (Kowarzik, 1997).

IWIC and Focus Futures, Part of Midland Heart: St Eugene's Court have, through engaging with older Irish service users, suggested that their is evidence that statutory mental health services are not providing equality of access, experience, and outcomes to older Irish service users who present alcohol dependency and/or challenging behaviour, and may have underlying mental health issues.
The Alcohol and Substance Abuse Project in the Irish Welfare and Information centre have provided the following statistics; they currently have 115 people accessing their services. They report that 18% of their clients who have been accessing support for alcohol and substance abuse have mental health issues. Of this group only 24% have been able to access in-patient services either general or detox services, 14% were seen by a GP specifically to deal with mental health issues, and 9% managed to see a psychiatrist.

Alcohol misuse by some Irish migrants may be a response to being homesick or to discrimination (Walls, P 1996). When this problem is combined with poverty, unemployment or homelessness it can inflict huge mental distress on an Irish person's well being. It may also be a culturally acceptable way of dealing with the symptoms of mental illness.

The director of the National Youth Council made this claim.

> *"Community and Voluntary Sector Organisations have also reported a serious lack in service provision for Irish Service Users who self medicate with alcohol or other substances. Front line workers in these organisations report a 'ping-pong' scenario when accessing services for this client group. When accessing GP services, clients and staff often report that the alcohol/substance issue is usually prioritised in diagnosis whilst the mental health issue is neglected. The service user is then referred to alcohol/substance misuse services, as the client is withdrawing from the preferred substance the mental health issue becomes more prevalent and as there is no Mental Health intervention, at this stage, the service user will either, revert to self-medication, or be referred to mental health services. The waiting time to access such services places the service user at high risk of experiencing a relapse in their substance abuse thus when the appointment arrives for the Mental Health Services, the client is often sent back to the alcohol/substance abuse services*."

Delivering Race Equality (DRE) in Mental Health Care and the 'Older Irish Adults Project':

The Community Engagement Programme is part of one of the key deliverables of the DRE's 5 year action plan which has been designed to deliver on 3 key aims:

- equality of access
- equality of experience
- equality of outcomes

(Department of Health, 2005)

The 'Older Irish Adults Project' has these aims in mind and is committed to Delivering Race Equality in mental health care for BME communities, within Birmingham statutory and non-statutory mental health services.

- Commitment to improving services, experiences and service outcomes for the older Irish adult community remains a priority and a crucial goal for this project.
- The research will identify how services can be more culturally appropriate and specific to the community's needs and how both the statutory and community and voluntary sector can help make this happen effectively.
- The research will enable those groups in Birmingham, i.e. volunteers, social services and primary care, who work with older Irish service users, to have a greater knowledge and understanding of the issues facing them with regards to mental health, thus fulfilling the 'better information' building block of the DRE Paper.
- We also aim to inform how such groups can develop staff teams and, engage with statutory and non-statutory mental health services, to adapt and provide a more holistic approach in their services also fulfilling the other two building blocks of the DRE; 'better community engagement' and 'More appropriate and responsive services'.
- The research is driven by an overall aim to engage with local older Irish adults in Birmingham. By conducting a qualitative piece of research we will capture their stories, experiences, histories which have for a long time not been heard.

Our specific aims and objectives for this research:

- *To ascertain the views of Irish elders, community groups, and appropriate agencies, as to how mental health services in Birmingham can be improved to meet the needs of older Irish adults, i.e. commissioning of services, planning, engagement, participation, ownership, and influencing how services are delivered.*

- *To identify the needs of, and the barriers encountered by, Older Irish service users, community groups, and appropriate agencies when engaging with statutory and non-statutory mental health services in Birmingham.*

- *To find out if statutory mental health services in Birmingham have difficulty looking past alcohol dependency and/or challenging behaviour, and at possible underlying indicators of depression, schizophrenia, and personality disorders etc?, and to ascertain what difficulties they encounter in engaging with Older Irish service users with alcohol dependency and/or challenging behaviour, and how this impacts on their diagnosis.*

- *If GP and mental health services in Birmingham are having difficulty diagnosing Older Irish service users, how are they to become involved in the commissioning process and design & delivery of services appropriate to their needs.*

Methods

The Research team

The recruitment of the three researchers, Catherine Horn, Mike Bracher and Helene Markey, to the project was undertaken drawing on networks and contacts of The Irish Welfare and Information Centre, ICAP and Focus Futures: St Eugene's Court. Each had a prior interest in research and/or issues affecting the Irish community in Birmingham.

Support and Training

All three researchers attended a six day workshop programme provided by the University of Central Lancashire. These workshops focussed on community research methodologies and provided the research team with a very useful and insightful background to matters around mental health amongst BME communities. This programme of learning gave us the suitable training and skills to plan the research, carry out the study, and analyse and discuss the results effectively. Catherine has received a University Certificate in Research and Mental Health. The group met regularly with their support worker to discuss the project and all matters arising. Each member of the team played and equal and important role into the planning of the research, the preliminary studies and the early data collection. Later some members were chosen to support the report writing and data analysis whilst others had more input into the field work. All of this was monitored by the lead researcher and the supervision of the support worker.

The role of the steering group

Support was given to the researchers through a steering group which consisted of community groups, appropriate agencies and individuals which had connections with our organisation and the research community in question. The steering group was set up to assist and guide the direction of the research so that it would fit with local priorities. Members supported the research right throughout and provided their comments on the interview schedule, the findings, recommendations that were achievable, realistic and precise and also helped pick up on ethical issues. The steering group met up on average once every 2 months.

Data Collection technique

The obtainment of participants for the sample group was in part purposive and due to availability. Potential participants were identified on the basis being Irish (1st, 2nd or third generation) with issues around substance misuse and/or challenging behaviour difficulties. These participants had been self identified, or identified by frontline services. Letters of introduction (appendix a) were mailed to support workers, managers, outreach workers belonging to these frontline services. Posters (Appendix b), designed to capture potential participants, were sent out to organisations in the community and put up in churches and social clubs with a high Irish population. As a result of the letters we were able to identify a number of participants who fit the sample criteria. We were able to interview 27 of those identified. We found this technique to be the most suitable so that any feelings of anxiety, regarding confidentiality and trust, could be put at ease by the members of staff which the respondents already trusted. There were a very large number of identified participants who we could not interview which reduced the sample size significantly. Reasons for not taking part included ill health, cancelled interviews due to respondents being intoxicated,

not being able to attend for personal reasons, access problems to chosen interview venue, appointments forgotten and change of mind due to concerns felt around confidentiality. Arranging interviews was extremely time consuming and difficult. For the purpose of future research, more time needs to be spent arranging, planning and managing the fieldwork so that a larger sample can be achieved.

Research Tools

Interview Procedures

All the interviews were conducted in a Face-to-face way and took place at an agreed location; either the interviewees home (with 2 people present at the interview), St Eugene's Court or in a designated room within the premises of the various residential settings. The interviews lasted on average one hour. An interview schedule (appendix c) was designed and used to provide structure to the interview all participants were assured of confidentiality. All participants gave their consent to be interviewed and dictaphones were used to record the interview with the participants permission (See appendix d). The interviews that were recorded were listened to repeatedly, transcribed and themes identified. In three cases the participant's support worker conducted the interview in order to gain a more valid and truthful response.

We decided a face-to-face, semi structured interview was the most appropriate method to use. We anticipated that interviewees would react differently to the questions and wanted to provide the respondent with the opportunity to voice their concerns and their individual stories. With a semi structured interview schedule we were able to allow this to happen and cover the set themes.

Once all the interviews had been transcribed and data collected the themes emerged and results became clearer. These were presented to the steering group for their comments.

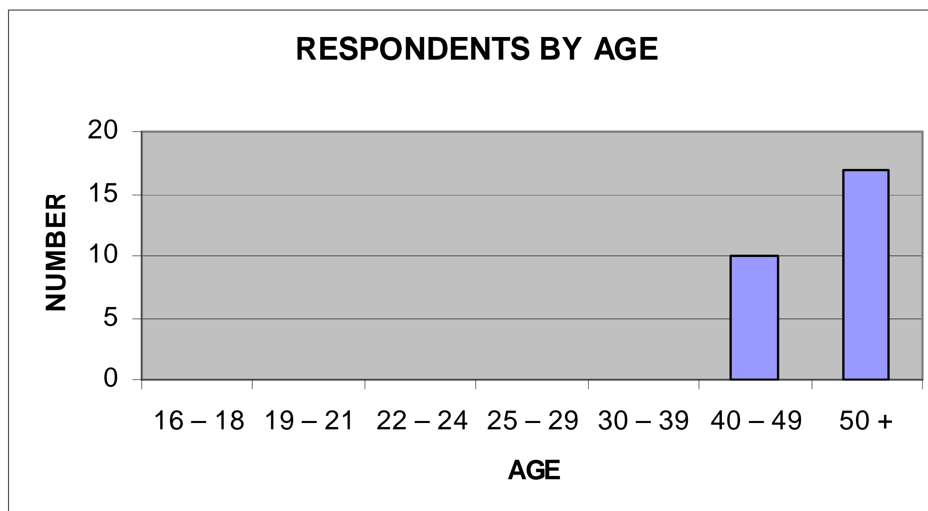
Findings

<u>Core Data</u>

A total of 27 respondents were interviewed. Details are as follows:

1. Age last birthday.

Age group	Number of respondents
16 – 18	0
19 – 21	0
22 – 24	0
25 – 29	0
30 – 39	0
40 – 49	10
50 +	17

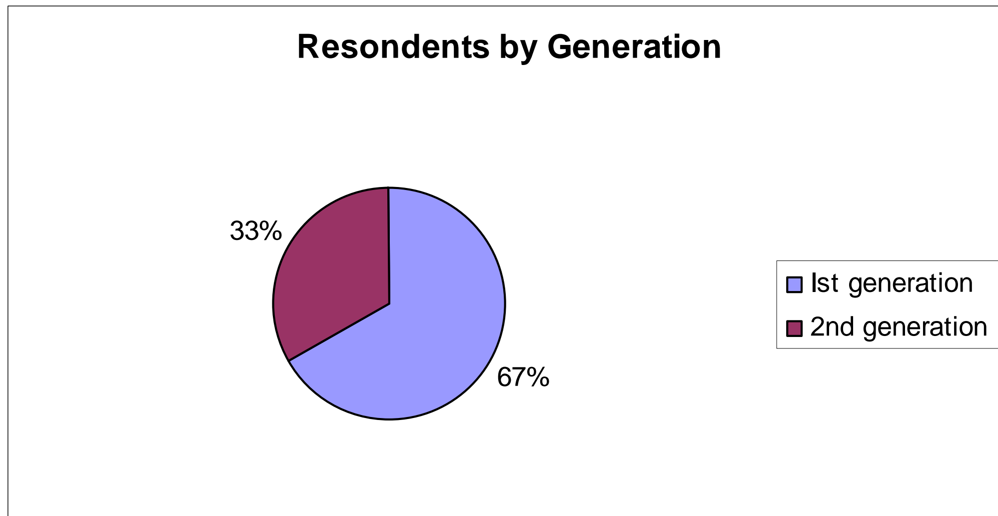


2. Gender

Males	24	(89%)
Females	3	(11%)
Transgendered	0	

3. Ethnicity

All 27 respondents were of Irish descent.
78% classed themselves as “white Irish”
22% marked the “other” category and classed themselves as “Irish”
All the respondents were either 1st or 2nd generation Irish.



4. Length of residence in UK

All 67% 1st generation Irish, born in Ireland, had lived in the UK for 11 years or more. The remaining 33% were 2nd generation Irish and all born within the UK

5. Citizenship

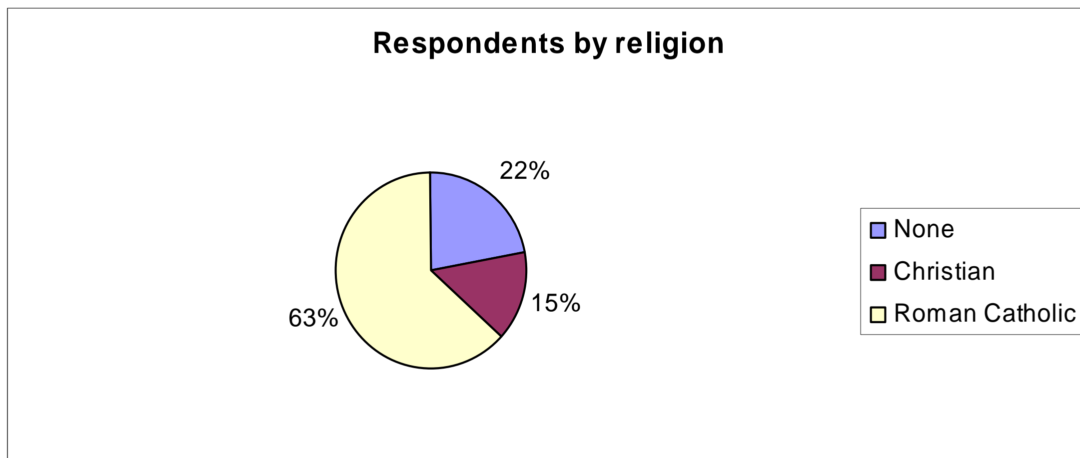
British citizens	100%
Refugee	0%
Asylum Seeker	0%
Other	0%

6. Languages

The language spoken and written by all respondents was English.

7. Religion

Category	
None	6
Christian	4
Buddhist	0
Hindu	0
Jewish	0
Muslim	0
Sikh	0
Other (Roman Catholic)	17



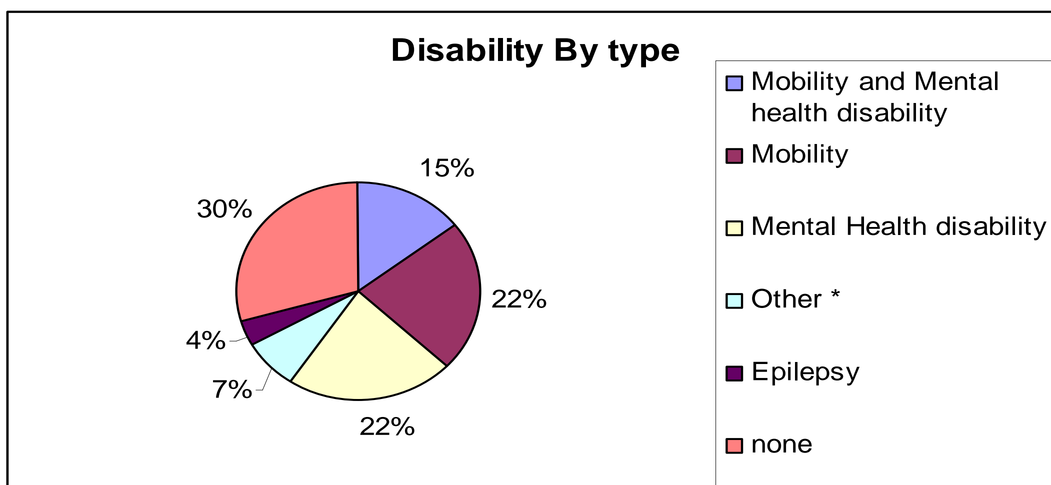
8. Sexuality

Lesbian or gay woman	0
Homosexual or gay man	0
Heterosexual	100%
Bisexual	0
Not wish to answer	0

9. Disability

None	30%
Yes	70%

* Respondents marked yes for having a disability but did not state what kind.



Results

The research process discussed above produced a number of emergent themes regarding a variety of experiences surrounding older Irish adults with alcohol dependency and/or challenging behaviour, and access to statutory and non-statutory mental health provision within Birmingham. In what follows, it is our aim to present and discuss these themes under three broad organising categories: **1) Knowledge and awareness in the 'Older Irish Adult Community', 2) Services – the strengths and weaknesses; and 3) Factors contributing to mental health problems in the Irish Community**. Within each category sub headings will be used to illustrate further key findings and issues. These categories are not distinct from each other and some overlapping does occur but for the benefit of presenting the data they help indicate and highlight some of the important issues which have arisen from this research.

1) Knowledge and awareness in the 'Older Irish Adult Community'

Knowledge and awareness of issues surrounding Mental Health:

The knowledge and awareness of different mental health conditions was poor amongst the sample group. A large proportion of the respondents used terms which might be considered derogatory to define the notion of mental health. They also were unclear about the difference between health and illness

> *"Mental health means when you don't have your head and you're in 'cuckkoo' land"*

> *"The term mental health means to me when people go off their rocker and don't know what they're doing*"

Also a large number of the respondents did not recognise or denied that they had a mental illness but still said they had a history of depression, anxiety or misery.

> *"I don't suffer from any mental health problems." The same respondent said: "I can't sleep at night because of things that worry me and make me anxious and angry."*

> *"I'm ok really, I don't go to see anyone because I don't need to, when I'm depressed I just deal with it, it's just life I'm not mentally ill or anything like that."*

A smaller number of participants were very honest about their mental health problems and were also aware that mental illnesses vary from one person to the next.

> *"Mental health can effect people in different ways for different reasons, it depends what's happened to them really. It was about 6 years ago when my marriage split up and I turned to drink."*

> *"Mental health problems can just happen, its hard to pin point what causes them because they vary so much. It was about 4 years ago when I went to see a doctor about getting psychiatric help and I've been in and out of hospital since."*

This smaller section of the sample was able to suggest that there is a **stigma** towards mental health in the Irish community due to a way of thinking about such issues.

Upbringing, religion, a lack of knowledge in the community and feelings of being proud were common suggestions from the participants to explain this stigma.

> *"I think the Irish might think there's a stigma towards mental health, they also find it difficult asking for help in case they're not accepted………I think if they new where to get help, that would help."*

> *"Irish people feel embarrassed about that sort of thing……that's what I find. It comes from the way they were brought up, it was all hidden back in Ireland and I don't suppose it's changed much here."*

> *"The Irish are very proud, it's hard for us to admit to these things because of how we've been taught to just sweep things under the carpet especially given the effect religion had on our lives, that holds you back."*

There was a smaller section of the sample that had been diagnosed with various mental illnesses but due to the severity of these illnesses they had no insight into their own mental ill health.

Knowledge and awareness of services available:
A majority of the respondents stated that there were not enough mental health services or places to get support for the Irish community.

> *"There needs to be more services for the community and more activities for people to know about."*

> *"I think there needs to be more day centres especially if you've got mental health problems."*

> *"They've got St Eugene's but there needs to be more places where they can get support, make friends and find people to talk to about their problems."*

Most respondents believed that the normal way to get proper help for mental illnesses is initially through their GP. They did not think that alternative places existed to go and get help with mental illnesses.

> *"I suppose people would go to see their doctor if they have a mental health problem, that's where you go if your ill."*

> *"You'd go to a hospital or see your GP if you're mentally ill, where else are you supposed to go?"*

A large number of respondents, those already getting help, however stated that their key workers, support workers or a member of staff would be their first point of contact if they needed to get help.

> *"I never went to see a doctor it was the help of my support worker that got me through, I don't know where I'd be today if it wasn't for her."*

"The first person I go to for help is my key worker, she's brilliant, and I trust her and can tell her anything."

Most respondents had heard of the Irish welfare and Information Centre and the drop in centre at St Eugene's court but for some respondents their knowledge was inaccurate of the services provided here.

"The Irish welfare information centre is good for helping people, I know people that go and get support from them, but I'm not sure exactly what support they get."

"St Eugene's court is good for socialising and meeting people but I didn't know they had a doctor there."

A very small number of respondents were unable to really say what help is available for the Irish who have mental health problems. They had a lack of knowledge and understanding of mental health, services available and were unable to identify with ways to improve their health.

"I think it's difficult to get better, I don't really go out much and I don't go down towards Digbeth so I don't really know what support is down there."

"I don't want any support, I'm just waiting to go to the grave now, I don't want to bother anyone."

"It's hard for me to get around so I don't really find out what new things are about, I just got to my doctor for medication and that's it, I don't really talk to anyone."

It was a common thought that the Irish community needed help to prevent boredom and isolation and that there are not enough of these services available.

"So many Irish men are lonely and don't have any friends and family, they need things to help them keep busy otherwise they just get stuck in a rut."

"It's quite boring here, I don't really have any friends……….If I had something to do that might help."

In terms of accessing alternative treatments such as art therapy, psychotherapy and cognitive therapy, only 2 respondents had accessed such mental health services. The other respondents did not mention them. Their experiences of such alternative therapies were positive.

"I go to art therapy and that really helps me, it brings everything out of you and helps you get better."

2) Services – the strengths and weaknesses

Common barriers in accessing services:
Reluctance to acknowledging their own mental health problems and seeking help

> *"I don't have any mental health problems so I don't want my treatment to be improved or go and get counselling or see a shrink or anything like that."*

> *"I don't want to be nuisance and bother people, I'm not sure if it would help anyway."*

Feeling embarrassed, ashamed or distrustful

> *"It's difficult to admit to people that you have a mental health problem even if you know you have one."*

> *"Some Irish people feel embarrassed about talking about themselves so they won't go and get help."*

> *"I don't talk to anyone except my support worker, she's the only one I trust."*

Not knowing where to seek advice

> *"I didn't even know there was help out there until a friend told me in the hostel, there's probably so many people that need help but don't know where to get it. When you're in a hostel, a bed sit or on your own somewhere you lose touch with things like that. That's what happened to me, I suffered for years."*

Characteristics of successful services in the Irish community:
There were a small number of respondents who felt that seeing a psychiatrist had benefited them. Although it had been a long process and they had encountered some of the above barriers, they eventually found good pathways to care.

> *"Psychiatrists should listen to patients more and get them into therapy not just give them tablets, I've moved on now, got a different psychiatrist and I'm in a good home with people who care and I go to psychotherapy once a week."*

> *"The best support I've received was the psychiatric care. Things got worse before they got better and it took me a while to get the help I needed. I didn't want help at first, I didn't think there was anything wrong with me, the Irish don't like to admit there are things wrong with you, in the end I got remanded, put under section 37. I feel better today, I've got things going on and my life is moving forward.*"

Several people recovering from severe alcohol related illnesses had emphasised that this process was more to do with constant care and support from an individual such as a support worker in which they trusted. The constant motivation and friendship given to these individuals improved mental well being and encouraged them to quit drinking.

> *"I've never seen a psychiatrist and I don't want to either. The best support I've been*

given was from a primary alcohol care nurse. She's been there for me all the way, I thought if I don't get help from her that I would have relapse again. It was as combination of self-motivation and her support. They helped me with practical things to develop myself and help me believe in myself again."

The successful services in the Irish community that were mentioned included the 'Drop in' Centre at St Eugene's Court, the Irish welfare and some surgeries.

"St Eugene's is good for helping people build up their confidence. If I stayed at home my state of mind would get worse. It's also good because I can be around other Irish people. that's very important when you get older you need to be around people you can trust."

"They help me with all my forms at the Irish welfare and the staff are lovely too."

"My doctor has been very good to me and he put me in touch with the Irish welfare. I have my own key worker now and she's very good."

Some respondents were pleased with the treatment from their GP on a physical level but not with mental health issues.

"My doctor is very good, but most doctors are good at writing prescriptions, I wouldn't say I go to him when I'm feeling depressed. I would speak to one of the members of staff here." (refers to supported accommodation)

Dissatisfaction with primary care and mental health services by Irish people:
Some respondents said that they wanted and really needed to receive psychiatric care but were unable to get referred or actively go and seek the right help. A large number of the respondents were dissatisfied with statutory services and pointed out that a major barrier was trust.

"Mental health services are no good because you can't get the help when you want it. I've been trying to get the help and support from xxxxxx (secondary services) but I can't because I'm an alcoholic. It makes me drink more when I can't get support."

"I need to get help, I need to know what's going on in my head and find out what I'm all about. Yeah I drink but I was abused by my father, I don't know what to do though."

"I wouldn't go to the doctor and talk about my life, they just write prescriptions, they haven't got time for you."

"Doctors are good for some things but a lot of the guys I meet have had tough lives and real trust issues. I doubt they'd ever get mental health treatment because they're not going to trust doctors."

Services that need strengthening and improving for the Irish community:
There is evidence to support that trust is major obstacle in the older Irish community and that one to one support is beneficial because relationships can be built up.

"You need to build relationships up with people before you can start talking to them about their lives, the Irish don't like admitting their problems, they're hard nuts to crack."

"I only trust my key worker, I don't like talking about these things to people."

There is a need for more community based services and alternative therapies. Some respondents who had experienced them spoke highly of them whilst others provided indication that they needed alternative treatment, again trust was another barrier.

"I didn't want tablets, I just wanted therapy. I've got it now and it's really helped."

"I don't like going out much but it would help if someone came to visit me and talked to me at home."

"I don't know what you can do really, the Irish are very proud. They won't talk to their doctors or friends. If you start promoting mental health services, people won't come, you need to offer something else first and then introduce the mental health side of things more slowly once you've got them to come along and they know and trust you."

The research points to a need for more integrated services that deal with older Irish adults who have alcohol dependency problems and underling mental health problems.

There was significant evidence that services for older Irish adults struggling with alcohol dependency and depression need improving and adapting to meet those individuals self-medicating and who have not accessed statutory mental health services.

"You need a distraction from alcohol as well, if there are centres and places we could go to keep us busy, it might help my alcohol problems anyway, I'd probably not relapse as often and it would improve my confidence."

"I didn't know that the Irish welfare could help you if you're an alcoholic, I thought that they just helped with benefits and forms, that kind of thing."

"I get out, walk around, see people and keep myself busy, if I didn't I'd be like the other guys in the hostel who just sit and get more depressed."

Alcohol dependent service users had a much better understanding of their mental health concerns and were keen to seek help; this group stressed their willingness to counter their mental health problems.

"I'd like to strive to get back to being mentally ok and being capable of doing things again but when you're an alcoholic it's very hard to do that. I'm trying to stop drinking and I know I've got some major issues which I can't really talk to you about because it makes me feel bad. I'm going into detox soon though."

"I know I've got a problem up there otherwise I wouldn't be carrying on like this and

I have to have a drink to calm down. It would be nice to get help."

Some responses suggested that doctors and GPs were not referring them to see psychiatrists because of alcohol dependency. Respondents felt that from their experience that GPs did not acknowledge their signs of depression or milder forms of mental health problems.

"My doctor only talks to me about my alcohol problem, he never wants to deal with the depression. I know I need help but there's nothing I can do, I can't see a psychiatrist."

"My doctor's very good but he only advises me on how to cut down drinking, I know alcohol's a depressant but I didn't choose to be an alcoholic, things just happened in my life that caused it. The mental things were always there."

3) Factors contributing to Mental Health problems in the Irish community

The results illustrate that there is a need for a holistic approach to care in the older Irish adult community. It was a common theme throughout the interviews that there are a number of factors that cause mental ill health. Emigration, unemployment, manual working conditions, discrimination, housing, general health and isolation were very common issues that ran through out.

Emigration, Isolation and Manual Labour

"I've met a lot of sad people in the hostels. I'm not sure why they end up there, maybe because they don't have family. I stopped seeing my family years ago when I came to England looking for work in 1959. I left my family back home. My children are all grown up now and I don't see them."

"I came over here in the 50's to raise money for my family. I got a job on the buses then in 55 I got called up for the army and was there for 3 years. When I came back I started working in various jobs, all manual, there was so much work going around back then but none of it was secure so you moved around a lot."

"People don't understand about Ireland and what it was like there, there was no work and so many things going on that affected peoples mental health…... For me, coming here was difficult because of the constant work, moving from town to town to find work. I was working in the pipe lines, the conditions were rough with small pay and long hours. There were a lot of Irish people doing the same thing. We used to go to the pubs to relax and get rid of the monotony and have a break."

"Those who come over from Ireland aren't in touch with their own culture, they lose their identity. It's different altogether here, Ireland's very lively and people are laid back. It's very tense living here and I find the lifestyle and the general community makes it difficult."

Unemployment and boredom

Unemployment affected a large proportion of the sample group. Although most had retired or were incapable of working at the time of the interview, it was very common that unemployment, at some point, had affected their well being. We also noted that being unemployed, as well as not being financially secure, had similar consequences as to not having any leisure pursuits.

> *"I'm not able to work because of my drinking, but if I had something to do with my time it would help, it does get boring between these four walls."*

> *"For starters I can't work, I used to enjoy going to work, gardening, fishing but I've no garden to go to, I used to have a big allotment, which I worked for years until last year but then it was too much for me and too far from home, I couldn't always get down to it so I packed it up. Since being here (Hostel) I've done nothing. I'd love access to a garden."*

> *"I'd work with animals that would be good, if there were more projects like that near by more Irish would get involved it would give them something to do and get them out of the hostel. Most of them are living in rooms, they're on their own like myself and don't work. It would create more friends when you work with people. It would help form a better support network."*

Housing, isolation, autonomy and social environment

> *"In terms of every day life my support worker and my friend stop me from being isolated to some degree but the one friend I have got can cause more problems for me (in the hostel) because he drinks a lot too."*

> *I've no contact with nobody, if my carer is here I have a chat with her. There's also another guy from over the road, he's an another alcoholic. I see him but he's an alcoholic and he makes too much noise when he drinks. When he's soba he's as good as gold but when he's drunk he's annoying."*

> *"I've not enjoyed these places hostels etc. I would rather be living independently, the staff I find quite distant. I don't disrespect them, I get on with all of them but there is a distance between us. I understand that they're busy and it's not just me they have to look after."*

> *"I'm not happy here (supported housing scheme) at all, I've got a roof over my head but I do feel like a prisoner because I don't do much. When you go to St Eugene's you feel like you're back home in away, there's the banter there and everything. The atmosphere is good, the staff are good listeners and considerate. The Irish could do with more meeting places like that and I think it would improve peoples mental health."*

> "*In an ideal world I'd like to have a cottage and be living independently. I've been moving around for years, bed sits, the streets, hostels you name but what I'd really like is to have my own place and look after myself. I'm not capable yet but when I get better and go on a detox I'm hoping I can get some control back in my life."*

Discrimination, racism and Irish stereotypes

We wanted to uncover the extent to which discrimination was felt. A number of respondents directly referred to discrimination and direct racism as a thing of the past and something that they weren't a victim of. At the same time there was general agreement across the sample that Irish stereotypes were still common. They existed in the general public and amongst some statutory health services.

"I get on with everybody, I've never had any trouble for being Irish, occasionally I'll get called 'paddy' or something but I'm not that bothered, it doesn't really happen anymore."

"Racism is a thing of the past, I don't have any problem these days, perhaps our parents suffered from it more……Perhaps my doctor thinks I'm just a drunk Irish?"

"People think the Irish are alcoholics and are out to cause trouble that's not the case, it's just that they've not got things to do, day centres etc. That's why doctors aren't very helpful and you can't get treatment. People don't understand Irish people."

"I never really felt it that much; a few times people would say go back to where you came from."

Interviews with Service Providers

In addition to the 27 interviews with older Irish adults, we conducted 3 interviews with GPs who have experience in dealing with the Irish community.

We asked the service providers if they felt there was a link between mental health problems and alcohol/substance misuse. GP2 said that

> *"Patients tend to isolate themselves which leaves them very few ways of being able to help them, instead of asking for help they bury their problems by drinking alcohol."*

GP1 also stated that in addition to the alcohol/substance misuse problems:

> *"The Irish patients that I see also suffer from depression, arthritis and heart disease. They suffer from an array of problems causing serious distress. I think a lot of it has to do with their cultural background but it is sometimes very difficult to work out if there is an underlying mental health problem which caused the patient to turn to alcohol. There is definitely a link however."*

Both GPs 1 and 2 said that before places like St. Eugene's Court and staff on the Irish Welfare's Team, when patients went to try and get help from clinic's, doctors or surgeries they were only diagnosed as alcoholics and therefore didn't receive much help. All GPs pointed out that the "chicken and egg" attitude plays a major part in dual diagnosis. Some GPs will deal with the patients problems separately or at other times they will deal with them as related illnesses. When dealing with the patients problems some doctors only see the alcoholism and tend to miss the underlying problems but it was noted by GP3:

> *"the alcohol consumed by each patient is a major part of their mental health problems and its not always the other way round".*

GP1 also thinks that the Irish patient's problems mostly relate back to their cultural heritage and past experiences.

The following points were also raised:

1. There is a tendency for Irish elders to distrust their doctors and resist opening up to them due to past experiences. GP1 "some have trust problems, so when they first arrive we give them a cup of tea and have a chat so it feels more relaxed."
   GP2 " by taking time to engage with them we can help reduce the alcohol intake and then work out the underlying mental health problems."
2. Holding back their feelings has a link to self medication because feelings, anxieties and problems are not dealt with.
3. A lot of their Irish patients suffer from isolation from not being able to work. Some of their patients aren't educated because they've worked in manual jobs all their lives and consequently can't read or write.
4. Not being able to receive the medication they need because some doctors only see the alcohol problem and not the underlying mental health problems.

5. More services are needed that can deal with other aspects such as help with visiting places if the patient finds it hard to get around, patient support and official work such as filling in forms.
6. There are not enough resources available for patients where they are needed, this is not just with the Irish but all ethnic minorities and this makes it difficult for them to make adequate referrals. There is a great need for services in the community to be developed so that older Irish people can get more help.
7. A lot of patients have become institutionalized and that's what causes their behavioural problems because they don't know how to act outside of the institution.

GP2 said that “more communication is needed between the statutory services and places like ICAP (Immigrant Counselling and Psychotherapy) and the Irish Welfare” This would help miss communication between service users and service providers and would aid their healing process. Surgeries need to have more information about the services that are available in the community. They also need to be made more aware of the specific issues that are faced within the Irish community.

Discussion

Although mental health services are slowly responding to cultural differences, it is clear from the responses of the participants in this research that services still need to improve to meet the needs of the Irish community. The older Irish adult community as a group have needs that are consistent with other BME groups. At the same time there is a massive cultural difference that needs to be incorporated into the way services are provided for this community. It is easy to forget that a white English-speaking group is culturally different to the majority community.

Many Irish-born people experience culture shock, alienation and racism on their arrival to Britain, and this persists for some throughout their stay despite being white and English speaking. Living in Britain can be just as difficult as it is for Irish people as it is for people from visible minorities. Common experiences, shared among all minority groups, such as a lack of identity, feelings of alienation, along with strong relative cultural and social needs will increase the likelihood of mental distress; yet whilst most ethnic monitoring programmes do not contain a separate category for Irish people, their distinct Irish culture is denied and it is presumed that mainstream services can provide adequate care.

Alcohol is a sensitive subject in the Irish community because of the persistent tendency to stereotype Irish people as drunken alcoholics. Although there is a high level of total abstinence from alcohol in the Irish community, there is a problem with alcohol misuse in sections of the community. Alcohol related disorders along with mental health difficulties are widespread amongst Irish elders and the research has shown how this has affected their lives and experiences of mental health services in Birmingham. There remains reluctance from mental health services to deal with both problems with a more integrated approach. Consequently, many Irish patients do not have access to services that could provide them with the adequate care they need. There is frequent reluctance from mental health services to treat people with alcohol related problems, in that it is difficult to medicate patients who are consuming alcohol, due to the complications of combining alcohol with medicine. There is also evidence that professionals focus on the alcohol and fail to recognise underlying mental health problems or the role of alcohol in coping with social stress. We feel that this is a major concern especially when many Irish patients might use alcohol to self-medicate to help their mental health problems.

While there is evidence of the need for culturally sensitive mental health and alcohol services, what was apparent from the interviews was the need for this service to be incorporated into a homely, friendly, neighbourly Irish environment. Being able to talk to other Irish people, to understand their shared experiences and reminisce about the good times and the bad, have the potential to minimise the risk of mental illness. Contact with other Irish people not only reduces isolation and provides social support, but increases the likelihood that professional help is accessed early and that treatment is adhered to, thus increasing the opportunity for recovery for these individuals.

It is also questionable to what extent stigma around mental illness is a problem inherent in the Irish community. Given the mistrust and negative experiences of mental health services, uncovered in the report, it is arguable that perhaps insensitivity and racism account more for low or late access than stigma does.

There is a responsibility amongst mental health services to be responsive to the diverse and specific needs of minority groups. There is a need to ascertain what works in the community practically in order to gain their confidence, meet their specific needs and for statutory bodies to provide the resources for this to take place. Statutory bodies can, by working with the Community and the Charity and Voluntary Sector, improve the experiences, outcomes and access to services amongst BME communities.

Reflection

At the heart of this project was the essence to engage with the community. We felt that this was accomplished well and that this report reflects the concerns of the older Irish adult community. We feel that we have reached out to the community, listened to their stories and heard their concerns.

This project has been a valuable experience for the research team and that within the team we worked to the best of our abilities. We feel that it has given us the opportunity to learn and develop a variety of skills including data analysis, report writing, communication, cooperation, team work and research skills. In particular we have all benefited from the mental health and research workshops, the chance to network and build up contacts through the various BME events and the DRE conference.

The lead researcher, who undertook the field work, felt she had learnt how to communicate and empathise with vulnerable people whilst maintaining a professional approach to those she was interviewing. She has made the following point:

> *"I have personally found this project very challenging. It has been a challenge which I have both enjoyed and learnt a lot from. In particular I had not anticipated such deep conversations to occur within the interviews. Sometimes these were very distressing. I found this aspect of the project most difficult because it meant that I had to remain focussed in a professional manner but also provide an ear for those being interviewed. In my opinion a large number of the respondents just wanted to chat, many of them showed signs of isolation and this interview, to some extent, gave them something to do and gave them an outlet to explore their feelings and things they didn't understand. I particularly learnt to empathise very well throughout this process. The most difficult part of this research was leaving the respondents and knowing that they still had severe problems that were not being tackled. I also felt that sometimes I was taking their problems away with me especially when they wanted answers which I could not provide. I would strongly recommend that debriefing sessions should be provided for interviewers who are engaged in these projects in the future."* Catherine Horn

Helene Markey found the research project both insightful and challenging. She has provided the following statement:

> *"From the research I have gained a more personal insight into my own heritage, I have gained more knowledge in to the older Irish population, the services provided for them and what problems they tend to face. The biggest barrier for me was that my college timetable clashed with a lot of the work that was scheduled to do, and I therefore found it difficult to do some work that was needed of me. Overall my involvement in to this project has been enjoyable as I've been able to learn about a lot of things new to me."* Helene Markey

At the beginning of the project we set out to discover what the mental health needs of the older Irish adult community were. We wanted to discover how services could be improved and what the barriers were for those presenting themselves with alcohol dependency and/or challenging behaviour. There is a need to advance the research further into those Irish elders who have behavioural difficulties as they did not form a representative part of the sample. Further investigation into this area could be conducted by interviewing the

police, those on the front line of accident and emergency services and those professionals who have direct contact with those patients at crisis point.

We were also unable to collect substantial information form older Irish females. We found it very difficult to collect data from this fraction of the population for several reasons. Firstly our sampling procedures meant that we had to rely on the availability of such potential participants and we found there to be significantly fewer females that could be identified by frontline services. Secondly it is has been suggested by members of staff working in these frontline, who also have a knowledge of the Irish community, that Irish women have a much higher tendency to conceal their inner emotions and are further less likely to seek help from both statutory and non-statutory bodies. There is currently very little information available on the needs of Irish women and we recommend that further research to be conducted within this area. We suggest a more informal approach, for this type of study in order to maximise participatory numbers.

Recommendations

1) Better Information

There is a need for more useful and appropriate information to be made available, for it to be utilised with maximum effect to promote change and to improve pathways to care for older Irish persons.

- There is a need for a ‘better information’ strategy. Appropriate information needs to get to the Irish community, including those who are isolated and not accessing the Irish Community and Voluntary Sector Organisations. We recommend publications and events, which seek to explain the term ‘mental health’ and to inform the Irish community of the services available to them. It is also apparent that the Irish community are not aware of their part in the BME agenda, and it is recommended that work needs to be completed to build up their knowledge and awareness of this so that they can access services aimed at the BME population. Investment should be sought so that events can be held in places where the Irish gather and publications could be placed, for example, in pubs, clubs, churches and supermarkets. This would insure that the information is available to the community in the places they access. Regular promotional events and literature will promote a positive outlook towards mental health reducing stigmas and increasing community awareness of the services available to them. We think that community leaders and especially faith based organisations have a responsibility and a vital role here to reduce this stigma and to get this information out to those who are most in need. Such newsletters and events would be culturally appropriate and noticeably ‘Irish’ and would use more user-friendly terminology.

- Statutory services such as G.P’s need to have readily available information of the services in the CVS so that Irish patients can gain support in the community. This will support their general needs whilst promoting recovery. Leading organisations within the community have a role to play in actively promoting their services, their knowledge and experience of dealing with older Irish adults who present themselves with alcohol dependency and mental health problems to the statutory organisations.

- We also suggest using Irish community organisations/members to help advise and deliver Irish specific cultural competence training to mental health professionals, this will also engage the community in making vital changes to the services they receive.

- We would further encourage G.P’s, surgeries and statutory health services to work in partnership with the CVS to help identify underlying causes of mental health problems. This would improve service users pathways into care and ensure preventative measures rather than crisis intervention.

2) Appropriate and responsive services within the CVS, statutory health services and local authority.

- There is an overwhelming need for more community based services such as St Eugene’s court, and Irish Welfare and Information Centre. These both have proven

track records in engaging their client groups and helping their service users access services whereby there would have been mistrust and a reluctance to engage effectively, previous to intervention. Such services would need to be culturally appropriate and would provide professional mental health care and would be done through a venue that promotes integration, activities, education, fun and general well-being. Such a service would employ staff that are culturally sensitive, and would ensure that their staff are adequately trained and competent enough to support individuals with a history of alcohol abuse and mental health issues in the Irish Community. We recommend a holistic ethos/whole system approach within these services that would consider the cultural, physical and mental health needs and the specific life experiences of Irish people. There would need to be an element of friendship, trust and professionalism within the services as the evidence suggest that the pathway to social inclusion needs to be a local one particularly if you are old and frail. We recommend that PCTs and MHTs and local authority, to commission services from Irish community organisations to maximise the potential for community based services.

- The evidence suggests that mental health problems need to be dealt with along side substance misuse problems especially amongst those who self medicate. We recommend further investment into an integrated service which deals with dual diagnosis. Respondents have spoken positively about receiving support from the community and outreach workers. We recommend that this sector should be expanded so that older Irish people have access to these services. Although we are aware of programs such as, the COMPASS program (BSMHT) which addresses combined psychosis and alcohol/substance abuse, there is a need for an integrated outreach service dealing with mild to moderate mental health and substance misuse. Service users have reported they have often felt depressed or anxious before they used alcohol. Their depression is often overlooked as a symptom of their alcohol abuse and not as a form of self medication. It is recommended that services like those mentioned above will be more appropriate and responsive to their need.

3) Community engagement

- Involve the community into higher level planning and get more Irish community representatives on PCT, MHT trust boards and Local Strategic Partnerships. The CVS should train, educate and build the capacity of service users and Irish community members to enable them to sit on such panels. Statutory organisations should support this.

- The CVS has a role to play in actively engaging their service users in developing their skills to participate in schemes at all appropriate levels. The benefits to the community will be tangible as the members of that community will be involved in the decision making processes and its impacts. Trained service users would be able to relate to the communities needs and be able to actively engage with those who need their support.

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