



**IRISH WELFARE &
INFORMATION CENTRE**

Helping to Build a Vibrant Irish Community



**BIRMINGHAM
City University**



Irish Mental Health in Birmingham:

What is appropriate and culturally competent primary care?

A Partnership Project between:

- Birmingham Irish Welfare and Information Centre
- The Centre for Community Mental Health,
Birmingham City University
- Balsall Heath Health Centre, Birmingham
- The Meriden Programme, Birmingham and Solihull Mental
Health NHS Trust
- Immigrant Counselling and Psychotherapy (ICAP), Birmingham
- Federation of Irish Societies



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A GP practice at Balsall Heath Health Centre

The Meriden Programme, Birmingham and Solihull Mental Health Trust

Immigrant Counselling and Psychotherapy (ICAP) Birmingham

Federation of Irish Societies

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Irish mental health in Birmingham: what is appropriate & culturally-competent primary care?

Chapter 1: Introduction

This research was undertaken as a partnership between Birmingham Irish Welfare and Information Centre, Birmingham City University, Birmingham and Solihull Mental Health Trust, Balsall Heath Health Centre, Immigrant Counselling and Psychotherapy and the Federation of Irish Societies. This was the first time that these organisations have all worked together to investigate Irish people's health.

The project was initially developed through Irish community groups in Birmingham. A grant of £30,000 was secured from Mr Bryan Stoton, who was Chair of the then Birmingham Health Authority. Representation leading to a formal bid came from Mr Barney Griffin, Chair of the Sub-Committee on Health and Social Services in the Birmingham Irish Community Forum and the User-led Birmingham Irish Mental Health Forum, assisted by Fr Frank Ryan OMI of the Irish Welfare Centre. It was recognised that despite Birmingham having a long tradition of migration and a large population of Irish migrants, including second and third generation people, there had been no Birmingham-based research into issues regarding mental health needs. In particular there had been no research into outcomes for Irish people using the "hard-end" of psychiatric services, such as psychiatric hospital in-patients and home-treatment services.

Submission of a research proposal was conducted by Professor Marcellino Smyth (Birmingham City University) who had previous research experience with regard to the demographics of Irish populations in the city. The sustained argument of the Birmingham Irish Mental Health Forum was that, given strong evidence of health inequality of the Irish population elsewhere in the UK, the Irish population in England's second city merited similar attention. Evaluation of need was seen as a stage in an overall strategy of improving mental health provision for this group from both statutory and voluntary services.

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The project underwent further development and was eventually re-designed to provide a focus on primary care and cultural competence. The intention was to examine the experiences of those Irish people using primary care services with a view to identifying factors that might help them avoid a hospital stay. Cultural competence was deemed relevant because it reflects a continuous process of learning, performing and reflecting. It requires self awareness, knowledge and skill, socially-embedded expertise and organisational commitment. Competence in this context has three elements: individual, professional and organisational. Culturally competent practice and service provision require a conscious commitment to a continuous process of learning, performing and reflecting through which individuals and organisations strive to meet the healthcare needs of people in a diverse society. Irish people form part of that diversity but little attention has been paid to determining the nature of culturally-competent care for members of this minority group.

The project set out to explore three factors:

- i) the views and experiences of Irish people who used mental health services in Birmingham;
- ii) the views and experiences of mental health practitioners who provided treatment and care for Irish people;
- iii) the range of primary care mental health services, statutory and voluntary, in Birmingham;

Theoretical basis of the project

The complex nature of the subject matter meant that no single approach was likely to provide sufficient data to meet the aim of the project. Consequently the design was based on triangulation, using multiple social research methods and sources of data (Denzin 1989).

Several other factors also had to be considered. First, previous research about the health of Irish people had relied heavily on the quantitative paradigm and survey methodology, the application of which included structured interviews (Abbotts *et al.* 1999, Stillwell *et al.* 2004) questionnaires (Abbotts *et al.* 2004, McConville *et al.* 2002, Christopher 2000, Walsh and McGrath 2000), patient records (Commander *et al.* 2003) and systematic reviews (Aspinall 2002).

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Whilst these studies yielded valuable data, what was absent from the research were the perspectives of Irish people, of how they felt about their mental health issues. Studies that reported the views of Irish people themselves, as opposed to those of the professionals, were less common.

Second, there appeared to be little or no research about mental health practice in relation to Irish people in either the UK or Ireland. Cowman *et al.*'s (2001) study used a qualitative research design with multiple methods to examine the role and function of psychiatric nurses in clinical practice in Ireland but this study was not related to meeting the needs of members of minority ethnic groups. When the research began, no research could be found on how psychiatric nurses in the UK recognised Irish patients, identified their cultural needs or adapted their practice. Consequently, there did not appear to be any definitive statements about the nature of culturally-competent mental health care practice in relation to Irish people despite the fact that transcultural psychiatry is well established as a field that has generated a not inconsiderable literature. In addition, there did not appear to be any research from Ireland on mental health practice in relation to ethnicity despite the fact that the country was then experiencing a rise in immigration generally and an increase in asylum applications. It seemed that this research might be the first to address these issues and it was, therefore, appropriate to use an exploratory, qualitative approach that drew on different data sources.

Methodological triangulation was based on the application of a qualitative, phenomenological approach (Husserl 1999, Heron 1981, Hammersley and Atkinson 1995) and a quantitative approach, using a postal survey. Data triangulation was based on the collection of data from multiples sources that included mental health service users and practitioners and staff in voluntary organisations.

Ethical review and permissions

A favourable opinion was obtained from East Birmingham Local Research Ethics Committee and West Cork Mental Health Services.

Sponsorship was provided by Birmingham City University.

Approvals and permissions were obtained from the appropriate NHS Research and Development Departments in Birmingham and their appropriate equivalents in Ireland.

The project was launched in January 2007.

Project design, methods and sampling

Aim 1: To explore the views and experiences of Irish people who used mental health service users in Birmingham;

Method of data collection: Irish people with mental health problems were invited to take part in either small focus groups or semi-structured interviews. Where possible, permission was obtained to tape record every data collection event but in circumstances in which participants refused, or were unhappy about this, detailed notes were made to record the content.

Data analysis: All recordings were transcribed verbatim. They and field notes were analysed to identify themes based on Giorgi (1985).

Sample: Participants were all self-selected. Multiple strategies were used to recruit people from across the city with a view to gathering a wide range of views and experiences (table 1.1). Two groups of participants were recruited

- Group 1: twenty-seven people born in Ireland;
- Group 2: thirteen people born in England but who had one, or both parents born in Ireland.

Table 1.1 Multiple strategies used to recruit Irish people with mental health problems

Radio Features in newspapers and newsletters Mail-shots containing posters and leaflets to GP surgeries, parish priests, mental health clinics and voluntary organisations Local public libraries Oral presentations to Irish organisations such as the Irish Heritage Group, Survivors' Group and day centres CD recordings of information about the project Birmingham and Solihull Mental Health Trust intranet Oral presentations to mental health support groups and community psychiatric nursing teams.

Aim 2: To explore the views and experiences of mental health practitioners who provided treatment and care for Irish people;

Methods of data collection: Mental health practitioners and other key personnel were invited to take part in focus groups or individual interviews to discuss their experiences of working with Irish clients and issues relating to practice. Practitioners were recruited using multiple strategies (table 1.2).

Where possible, permission was obtained to tape record every data collection event but in circumstances in which participants refused, or were unhappy about this, detailed notes were made to record the content.

Table 1.2 Multiple strategies used to recruit practitioners working with clients who had mental ill health

Oral presentations to CPN teams and other staff groups Birmingham and Solihull Mental Health Trust intranet Posters and leaflets Oral presentation to mental health support groups.
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Data were collected about mental health service provision, in the Republic of Ireland and Northern Ireland, through focus groups and in-depth semi-structured interviews with staff with a view to clarifying the nature of culturally-competent mental health services for Irish people in Ireland.

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Data analysis: All recordings were transcribed verbatim. They and field notes were analysed to identify themes based on Giorgi (1985).

Aim 3: To identify the range of primary care mental health services in Birmingham;
A postal questionnaire was sent to 273 organisations that provided community-based services for people with mental health problems. These organisations were identified through the various data bases used by project team members, Birmingham City Council directory of voluntary organisations, word of mouth and internet searches.

Data analysis: Survey data were analysed using Access 2000.

Consent

Information about the project was circulated through multiple channels. Written consent was obtained from each participant whenever possible.

Chapter 2: Executive summary

This project was undertaken as a partnership between Birmingham Irish Welfare and Information Centre, Birmingham City University, Birmingham and Solihull Mental Health Trust, a GP practice at Balsall Heath Health Centre, Immigrant Counselling and Psychotherapy and the Federation of Irish Societies. This is the first time that these organisations have all worked together to investigate Irish people's health. Funding for the project was provided by the former Birmingham Health Authority.

The project set out to explore three factors:

- iv) the views and experiences of Irish people who used mental health services in Birmingham;
- v) the views and experiences of mental health practitioners who provided treatment and care for Irish people;
- vi) the range of primary care mental health services, statutory and voluntary, in Birmingham.

Information was collected through a mixture of semi-structured, in-depth interviews with 28 Irish people who were born in Ireland, 13 who were born in England and 41 mental health nurses and other staff in the NHS and voluntary organisations. A postal questionnaire was sent to all the services in Birmingham in order to identify the range and nature of services available to Irish people who have mental health difficulties.

Key findings and recommendations

i) Delivering race equality

In Birmingham, statutory and voluntary organisations provide a wide range of services for people with mental health problems but it does not follow that these are designed or delivered with Irish people in mind.

There seems to be a lack of engagement between service providers and Irish people who have mental health problems. Service providers seem to have limited information about Irish people and their culture.

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It is, therefore, recommended that

- i) Advertising should target mental health service providers and commissioners to promote awareness of Irish welfare organisations and the services they offer.
- ii) Attention is paid to the development and maintenance of a resource that provides details of the principal agencies that provide help for Irish people, particularly those with mental health problems.
- iii) Inter-agency networking and cooperation, in which statutory and voluntary organisations work together, should be encouraged. This cooperation requires sustained commitment from all parties, and include, where necessary, designated staff who cannot be withdrawn to cover shortages in other parts of the service.
- iv) The promotion of race equality and ethnic monitoring should include the Irish, alongside other minority ethnic groups, as a basis for developing a knowledge base that informs organisational policies, procedures and practice.

ii) The health of Irish people

Many Irish face multiple health problems regardless of whether they were born in Ireland or in England; mental and physical health problems are interrelated. Irish people are atypical in that, among most minority ethnic groups, the health of members of the second generation shows an improvement when compared with their parents. Individually, those who look after and support people with mental health problems do their best to provide good care for all patients, but their professional preparation does not equip them to address the cultural dimensions of looking after Irish people. Whilst individuals are aware of Irish people's needs and Irish members of staff use their own ethnicity to facilitate therapeutic relationships, too much depends on individual good will. There is no evidence of organisational commitment to change.

It is, therefore, recommended that:

- i) Current emphasis on cultural competence within the preparation and continuing professional development of practitioners should be further developed to include a focus on white minorities such as the Irish. This is an essential part of developing a workforce that is fit for future practice.
- ii) Organisations that provide services for people with mental health problems should expand their commitment to clients by recognising the inequalities that Irish people experience and supporting staff in bringing about change. This commitment should be made evident through policies, procedures and practice.
- iii) Attention is paid to tackling the negative stereotyping of Irish people. In particular, attention should be paid to
 - a) avoiding the view that Irish people are homogenous;
 - b) tackling the prevailing stereotypes about alcohol.
- iv) Staff development about diversity in mental health care should be expanded to include the health care needs of Irish people. Service provision would be retained at the current points of delivery, but with raised awareness and support.
- v) Assessment of Irish clients should include specific questions that reflect health patterns and trends among Irish people.
- vi) Liaison with Irish welfare organisations should become part of established practice when working with Irish clients.
- vii) Irish members of staff should not be pressurised into acting as interpreters or advocates for Irish clients. Members of staff who are happy to take on these roles, should, regardless of the ethnic groups concerned, receive organisational support.
- viii) Irish welfare organisations could do more to make Irish people aware of the services they have to offer.

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iii) Born in Ireland: Irish culture and health

Recognition and understandings of the cultural differences between Ireland and England is an important step in providing culturally-competent mental health care. Inherent in this step is the need to avoid stereotypical thinking; Ireland is not a homogenous, static society but one in which a great deal of change is taking place. There are now multiple Irelands with differing cultural values and beliefs.

Nevertheless, caring for older adults does require some understanding of traditional Irish society and the lives of those who migrated to England to find work. Sending money home, working in manual jobs, living in rented accommodation became, for many migrants, a permanent way of life. Factors such as exposure to anti-Irish racism and, for some, the legacy of trauma and abuse that caused them to leave Ireland all have a bearing on their mental health.

Added to this, is a cultural value placed on privacy and not talking about private matters outside the home. Older Irish people tend not to seek help even about health problems. The role of linkworkers is highly beneficial in enabling them to access and use mainstream health services thus promoting social inclusion. The skills of mental health practitioners and service providers are important in establishing therapeutic relationships in which older Irish clients feel able to tell their stories.

Finally, Irish migrants appear to share many of the experiences of other minority ethnic groups and further work is needed to document the ways in which being Irish in a city such as Birmingham has changed over time. This could have important implications for future health planning and for the Birmingham Irish community as a whole. It might also allow for the development of some comparative studies that examine Irish experiences alongside that of other minority groups, a factor that receives very limited attention from researchers*.

*The project team wishes to thank Dr Louise Ryan, Middlesex University for this point

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It is, therefore, recommended that

- i) Professional education and staff development should aim to present a balanced view of Ireland that takes account of the
 - a) the ways in which Irish cultures differ from those in England;
 - b) changes that have occurred in both the Republic of Ireland and Northern Ireland.
- ii) Consideration be given to supporting and further developing the linkworker role to facilitate in-reach that:
 - a) Enables Irish clients to access, negotiate and integrate into mainstream services as a strategy for improving health and promoting social integration.
 - b) Supports or liaises with local mental health and Irish welfare organisations.
- iii) Attention is focused on the specific ways in which practitioners can use their expertise to work therapeutically with Irish clients, particularly those with histories of trauma.
- v) Further work be undertaken to document Irish people's experiences of coming to England and living as members of a minority group, in different decades, with a view to identifying changes in health needs and promoting more comparative research.

vii) Born in England: the hybrid generation

The children of Irish migrants occupy a unique position with regard to Irish and English societies. Their identity appears to be characterised by hostility from those born in Ireland, fluidity and selectivity; they can choose whether to accentuate their Irish or English dimensions in any situation. Many of the issues that they face are similar to those experienced in other minority ethnic groups but these have not been sufficiently documented in relation to Irish people. These issues include cultural brokerage on behalf of their parents. Practitioners and service providers need to be aware of the issues and experiences of the children of Irish migrants and how these may impinge on their mental health.

Irish mental health in Birmingham: what is appropriate & culturally-competent primary care? Linkworking can be seen as a form of cultural brokerage that, in relation to other minority ethnic groups, is well established. However, whilst linkworkers do excellent work with older Irish people, little attempt has been made to document their activities or the contributions that they make. It is, therefore, recommended that

- i) The children of Irish migrants should be regarded as a separate group.
- ii) More research is needed to explore the idea that the children of Irish migrants are symptom carriers of the trauma experienced by their parents.
- iii) Irish welfare organisations should emphasise their inclusive approach, welcoming the children of Irish migrants.
- iv) Linkworkers' activities should be documented as a basis for comparison with similar activities in other minority ethnic groups.

Conclusion

This report highlights the complex nature of the health needs of Irish people in Birmingham. In particular it has demonstrated the importance of recognising the Irish as a separate, minority ethnic group and some of distinctive features of Irish culture.

The report raises a number of issues for mental health practice. The project team hope that practitioners and service providers will take account of the recommendations provided so that Irish people can receive the culturally-competent care they need to improve their quality of life.

Chapter 3: Findings

Introduction

This chapter presents an account of the findings of each section of the project:

- i) current service provision for Irish people in Birmingham;
- ii) the Irish Elders project;
- iii) the views of mental health service users who were born in Ireland;
- iv) the views of mental health service users who were born in England;
- v) the views of primary care mental health practitioners and service providers;
- vi) the views of mental health practitioners and service providers in Ireland.

All data were anonymised using codes (table 3.1). Each participant was allotted a unique code regardless of whether they took part in an interview, a focus group or simply completed the questionnaire. The only exception was a very large focus group of over twenty people in which it was often difficult to determine individual contributions; this group was, therefore, given a single code followed by a + sign.

Table 3.1: Data codes

Questionnaire responses	QR + number allocated to each individual respondent	QR12 = questionnaire respondent 12
Mental health service users	SU + number allocated to each individual respondent	SU35 = service user 35
Mental health practitioners and service providers	SP + number allocated to each individual respondent	SP20 = service provider/practitioner 20
Practitioners in Ireland	PIE + number allocated to each individual respondent	PIE 10 = practitioner in Ireland 10

i) Current service provision for Irish people in Birmingham

A postal questionnaire was sent to 273 organisations, in Birmingham, that provided community-based services for people with mental health problems.

Forty-four responses were received, a response rate of 16.1%: twenty-four statutory and twenty voluntary. Two questionnaires from statutory organisations were returned

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blank and two organisations, one statutory and one voluntary, sent duplicate responses which were amalgamated leaving a total of forty usable responses: twenty-one statutory and nineteen voluntary.

a) Staffing

Statutory organisations included various services within the Mental Health Trust, each of which was treated as a separate response, and a GP practice. Nineteen statutory respondents stated that their organisation employed mental health practitioners (MHPs) and thirteen employed social care professionals (SCPs) as paid staff alongside a smaller number of volunteers and other staff.

Voluntary organisations represented a wide range of activities and services that included housing, advocacy and befriending. Almost all employed paid staff but just under half also relied on volunteers. Five organisations employed SCPs and three had MHPs.

b) Range and availability of services

Statutory organisations provided a wide range of help and support with the most frequent being counselling (86%), support for carers (76%) and therapy (71%) (table 3.2). In contrast, very few statutory organisations provided debt counselling (14%), laundry facilities (14%) or legal advice (5%). Organisations varied in the number of services provided. At one end of the spectrum some were able to cover nineteen or twenty services whereas others concentrated on one or two. 86% of statutory organisations were open during the daytime and 57% provided evening services. 14% covered weekends and 29% were open during bank holidays.

57% of statutory organisations were advertised in GPs' surgeries; other popular venues were community centres (48%), out patients' departments (29%), local public libraries (14%), hospital wards, the Mental Health Trust's intranet (9.5% each), and shops (5%).

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One organisation advertised in all five places and all respondents used more than one venue. Individual organisations also advertised at day centres, mental health awareness events, organisational literature or relied, to some extent, on word of mouth.

Voluntary organisations also provided many different services. The most frequent were social events (68%), advocacy (58%), benefit advice (47%) and support groups (47%) (table 3.2). Very few voluntary organisations provided therapy (5%). In addition to the list tabled in the questionnaire, individual voluntary organisations provided other services such as liaison with statutory services, pastoral support, and employment training. The number of services provided by an organisation varied: one provided a range of twenty-one different services whereas others focused on only one or two. 94.7% of voluntary organisations were open during the daytime and 36.8% were available in the evenings. 15.7% covered weekends and a similar number were open during bank holidays. 73.6% of voluntary services advertised in GPs' surgeries; other venues were community centres (63.1%), out patients' departments (52.6%), local libraries (47.3%) and shops (15.7%). Two organisations advertised in all five places and every service used at least two. In addition, voluntary organisations advertised via mailing lists (15.7%), yellow pages, leaflets, the press/media, websites (10.5% each), the job centre, the local PCT, hospital wards, outreach and the community mental health team (5.2% each).

Table 3.2 Services provided by statutory and voluntary organisations

Statutory organisations provided the following			Voluntary organisations provided the following		
Service	Numbers	% (n=21)	Service	Numbers	% (n=19)
Counselling	18	86	Social events	13	68
Support for carers	16	76	Advocacy	11	58

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Doctors/nurses	15	71	Benefit advice	9	47
Therapy	15	71	Support groups	9	47
Support groups	14	67	Help with drug dependence	8	42
Benefit advice	14	67	Help with alcohol dependence	8	40
Housing advice	12	57	Housing advice	7	37
Social events	12	57	Befriending	7	37
Advocacy	12	57	Shower facilities	7	37
Interpreters	12	57	Food	6	32
Help with drug dependence	12	57	Help with literacy problems	6	32
Help with alcohol dependence	10	48	Doctors/nurses	6	32
Help with literacy problems	9	43	Support for carers	6	32
Financial help	7	33	Laundry facilities	6	32
Resettlement	7	33	Financial advice	5	25
Food	7	33	Resettlement	5	26
Befriending	7	33	Clothing	5	26
Shower facilities	6	29	Chiropody	5	26
Chiropody	6	29	Legal advice	4	21
Clothing	5	24	Holidays	4	21
Furniture	4	19	Furniture	3	16
Dentist	4	19	Counselling	3	16
Holidays	4	19	Debt counselling	2	11
Debt counselling	3	14	Interpreters	2	11
Laundry facilities	3	14	Dentist	1	5
Legal advice	1	5	Therapy	1	5

c) Clients

Statutory organisations were intended for anyone with mental health problems (86%) although most served some form of specialist need (81%). Clients could belong to any background; 62% of respondents stated that clients included Irish people with enduring mental illness and 43% added Irish carers. For 90% of clients the usual route into services was via an individual's GP. In addition, 71% were referred by Community Psychiatric Nurses, 52% by social workers and 47.6% by therapists. Other sources of referral included the police, carers and the clients themselves (table 3.3).

Table 3.3 How clients accessed services

Statutory organisations			Voluntary organisations		
Service	Numbers	% (n=21)	Service	Numbers	% (n=19)
GP/consultant referral	19	90%	Self referral	18	95
CPN referral	15	71.00%	Social workers	14	74
Social workers	11	52.30%	Carer brings client	12	63
Therapist referral	10	47.60%	GP referral	11	58
Self referral	10	47.60%	CPN referral	10	53
Police	8	38%	Therapist referral	10	53
Carer brings client	7	33.40%	Police	4	21

Voluntary organisations were intended for everyone but 15.7% specialised predominantly in helping people with mental health problems and a further 16% concentrated on the needs of Irish people. 47% of voluntary organisations provided services for Irish clients with enduring mental illness and 21% did so for Irish carers. 21% had services that were accessed by Irish carers. Respondents stated that 94.7% clients accessed their services by self-referring. 73.6% were referred by social workers and 63% were brought by carers. Others routes into the services included referrals from health professionals or the police (table 3.3).

d) Issues in service provision for Irish clients

Statutory organisations collected data about their clients via ethnic monitoring, client satisfaction surveys and or consultations with Irish people (table 3.4). Information about Irish people was shared through staff meetings (33.3%) staff development seminars (29%) and in-house newsletters (14%).

Respondents added comments about attending one-off training events (14%), in-house handbooks and databases about minority ethnic groups (9.5% each). One respondent was not aware that the Mental Health Trust provided any training about Irish people and a second stated that *referrals have identified a generation of Irish people who used*

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to access services more often QR42, the implication being that they now went elsewhere.

Respondents could not identify any barriers that might specifically affect Irish people who wished to access services. Respondents suggested that whatever barriers there were might arise because of the nature of a service, for example, as referral only (1 response) or difficulties that might apply to any client, for instance, because of the stigma associated with mental illness (1 response) or transport problems (1 response). However, one respondent stated that there was *a lack of awareness and understanding of what exactly is or isn't available to meet Irish people's needs QR21* and another suggested that there might be *a reluctance to accept that illness is psychological in origin QR26*. 29% respondents stated that their organisation had taken action to address possible barriers but each respondent in this category had taken only one.

Respondents identified a small number of factors that inhibited their organisation from working with others to meet the needs of Irish people. These included resource issues, stereotypes about Irish people and lack of awareness about their cultural needs but each was mentioned only once.

Table 3.4 Organisations collected the following information about Irish people

Statutory organisations			Voluntary organisations		
Service	Number s	% (n=21)	Service	Number s	% (n=19)
Ethnic monitoring data	16	76	Ethnic monitoring data	15	79
Census data	11	52	Satisfaction surveys	8	42
Data from social workers	8	38	Census data	4	21
Satisfaction surveys	6	29	Consultation with Irish people	4	21
Carer groups	6	29	Public consultation	3	16
Consultation with Irish people	2	10	Data from social workers	2	11
Public consultation	1	5	Risk assessment	1	5

Voluntary organisations collected similar data about their clients drawing on ethnic monitoring data and client satisfaction surveys. In contrast to statutory organisations, 21% had consulted directly with Irish people (table 3.4). Voluntary organisations shared information about Irish people mainly through staff meetings (47%), staff development seminars (26%), training events (21%) and in-house newsletters (15.7%). Additional individual opportunities arose through conferences, joint working with Irish organisations, open days and other events.

Respondents' volunteered very little about factors that might inhibit Irish people from using their services. 16% suggested that such barriers might be linked to some aspect of the service, for example, stereotyping or lack of advertising. 37% made statements to the effect that Irish clients might be deterred from seeking help because of factors such as fear, pride, lack of confidence or low self-esteem. 47% of voluntary organisations had taken some steps to address possible barriers to their services. Individual examples included promoting services to the Irish Centre, education, perseverance and training.

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15.7% of respondents identified a small number of factors that inhibited or prevented their organisation from working with others to meet the needs of Irish people. These factors were a reluctance to work across agencies, lack of staff time to set up networks and lack of space. Two respondents stated that their organisation had tried to set up links with Irish organisations to address inhibitory factors and a third added that any initiative to tackle this issue would be welcome.

e) Information needs of service providers

Statutory organisations provided a number of statements about the information that would be useful to them in meeting the needs of Irish people. These statements were divided into three categories. Practice issues (29%) raised concerns about the relationship between somatic and psychological problems among Irish people, the need to combat discrimination and improve access to services. Cultural issues (29%) focused on the need to understand Irish culture and the specific needs of Irish clients. In-house training and the contact details of Irish welfare organisations were requested. Service issues (14%) included the need to network with Irish organisations, identify appropriate venues to advertise information about services and develop research.

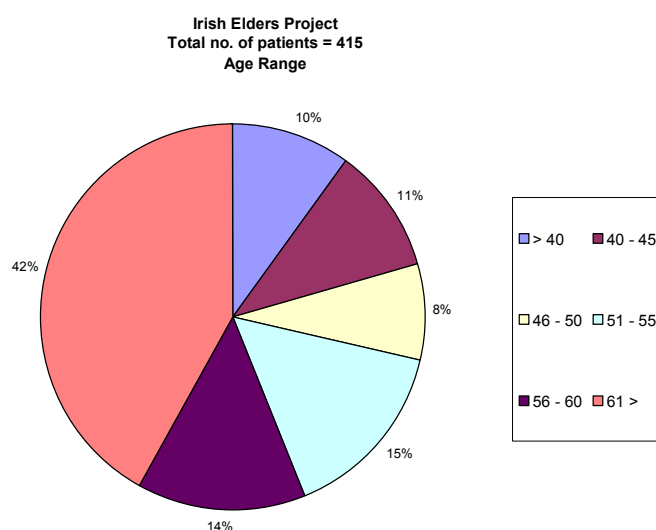
Voluntary organisations also provided similar types of statements but with more emphasis on cultural (42%) and service (32%) issues. Cultural issues were concerned with training and the likelihood of any possible differences in the manifestations of mental illness in Irish people. Like the respondents from statutory organisations, those in this group wanted the contact details of Irish welfare organisations. Service issues (32%) focused on access to dual diagnosis services, the need for forums that facilitated direct contact with Irish welfare organisations and inter-agency working. There was only one comment about practice issues and this was on the subject of how best to respond to specific needs.

ii) The Irish Elders Project

This project was developed by Birmingham Irish Welfare and Information Centre and Balsall Heath Health Centre with the intention of addressing the health needs of older, Irish people who were born in Ireland. Although not part of the original project the findings are presented here as an example of an initiative that might otherwise go unreported. Even more importantly, the findings illustrate the level of health need within the Irish population in Birmingham which reflects previous research undertaken in various parts of the UK.

Linkworkers actively encouraged older Irish adults to attend the clinic which was held, at the Health Centre, every Friday. Data for 2007 showed that 427 individuals were invited to attend during the course of the year resulting in an attendance rate of 98%.

Figure 3.1 Irish Elders' project: age groups



40% of attendees were aged 61 or over and 73% were male; 89% had lived in Britain for at least five years and represented every part of both Northern Ireland and the

Republic of Ireland (fig. 3.1). Over 90% were raised within traditional Irish culture which was predominantly Catholic. 19% were either married or cohabiting but the remaining majority were single, widowed or divorced. 75% had a next of kin, usually a blood relative, in the West Midlands, although 19% had no contact with their families and 2% had no next of kin anywhere. 93% were literate; 11% had police records.

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The majority of attendees, 65%, had been registered with the Health Centre for less than a year before attending the clinic, 51% were new patients and 4% had not been in contact with the Health Centre during the previous year. Every individual had, at some point, been in contact with other agencies but only 11% received any type of care.

Attendees' accommodation varied but only 10% owned their own homes (fig. 3.2). 62% had lived in their present accommodation for more than five years. The standard of accommodation was not recorded but photographic evidence collected by the Birmingham Irish Welfare and Information Centre revealed sub-standard housing, examples of which are included here (fig. 3.2, illus. 3.1, 3.2).

Figure 3.2 Irish Elders' project: accommodation

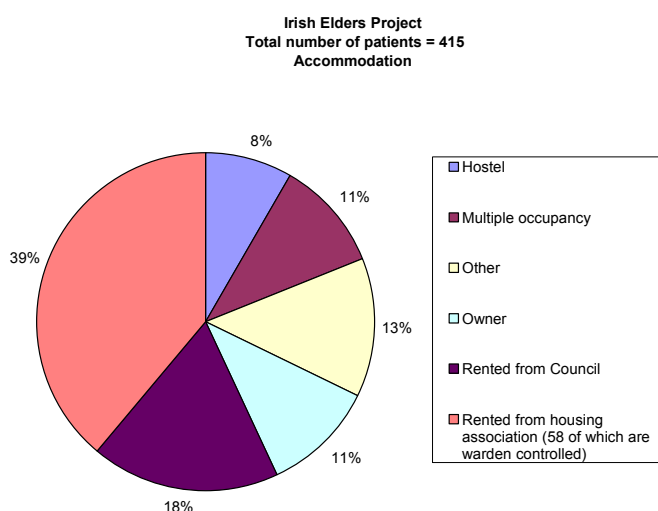


Illustration 1:

Example of sub-standard housing in which older Irish people were found.

Photograph courtesy of Birmingham Irish Welfare and Information Centre



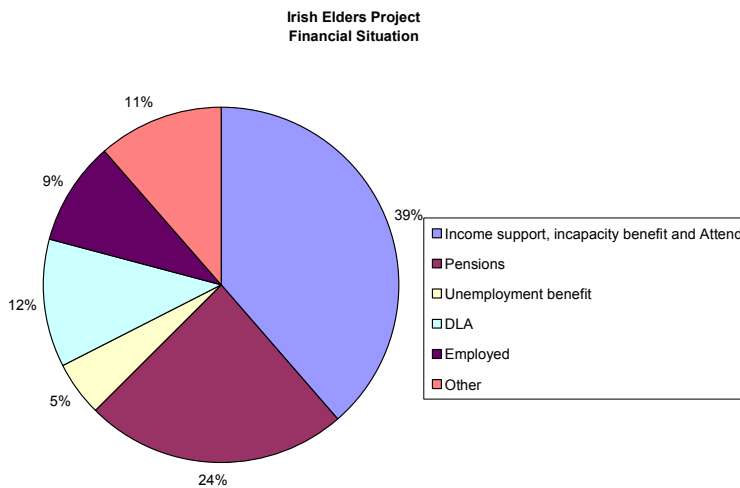


Illustration 2:

Example of sub-standard housing in which older Irish people were found.

Photograph courtesy of Birmingham Irish Welfare and Information Centre

Figure 3.3 Irish Elders' project: financial situations



52% were unable to work because of poor health, 9% were unemployed and 29% were retired leaving only 10% in work. 85% of those who were employed or who had previously been

employed worked in manual occupations. With the exception of those in employment, all attendees were living on state benefits and 42% were entitled to more than they were receiving (fig 3.3).

Medical assessment and examination revealed a wide range of health problems. The most common diagnoses were depression (57%) with 20% of patients reporting suicidal feelings, arthritis (42%), breathing (25%), urinary (23%) and gastric problems (22%) (table 3.5). 69% had raised levels of helicobacter pylori. 35% were overweight.

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Breathing and gastric problems may have been linked to tobacco as 61% smoked and alcohol. Every attendee drank alcohol and 18% listed going to the pub as leisure activity. Just under half, (48%) felt that their drinking was a problem. The incidence of arthritis may reflect large numbers employed in manual occupations especially those who worked in the construction industry before the introduction of modern safety regulations that were introduced in 1994 (Health and Safety Executive 1996).

Table 3.5 Irish Elder's project: the most common medical diagnoses in 2007

Outcome	Numbers	% (n=415)
Depression*	235	57
Arthritis	174	42
Cardiovascular disorders (ischaemic heart disease, cerebrovascular accident, hypertension, heart murmur, angina)	121	30
Shortness of breath	102	25
Urinary problems (haematuria, frequency, nocturia, incontinence, infection)	100	24
Indigestion	90	22
Chronic obstructive airways disease, asthma	80	19
Skin diseases (scabies, lesions)	23	5
Palpitations	23	5
Diabetes	22	5
Weight loss	20	5
Hearing problems	10	2
Hernias	8	2
Cancer: Prostate	8	2
Colon	5	1
Lung	5	1
Rectal bleeding	7	2
Prostatism	6	1
Oedema	6	1
Child sexual abuse	5	1
Constipation	5	1
Insomnia	4	1
Melaena	4	1
Parkinsons disease	3	1
Genital problems	3	1
Epilepsy	3	1
Schizophrenia	3	1
Bronchitis	2	1

* 46 (20%) out of 235 were suicidal

iii) The views and experiences of mental health service users who were born in Ireland

Twenty-eight Irish-born people agreed to take part. Eighteen were men but one changed his mind a few days before the interview; all except one was over forty years of age. Twelve lived alone; of these, one was divorced, two were widowers and one was separated from his partner. Two men lived with partners but the remaining men did not provide any information about their circumstances.

Ten participants were women, nine of whom were over forty years of age. Five lived alone; of these, two were divorced, two were widowed and one had never married. Two other women lived with partners. A further two were members of a religious order and one did not provide any information about her circumstances.

Nineteen themes were identified from the data. These were grouped into eight major themes each of which is discussed below.

i) Coming to England

Twenty participants, thirteen men and seven women, talked about coming to England. They came to England from many different parts of both the Republic of Ireland and Northern Ireland. Two men and one woman were brought to England as children (SU13, SU5, SU19). The remainder came as teenagers and had lived in England for between 28 and 50 years. Reasons for coming to England were mainly about work (SU12, SU18, SU9, SU34, SU39, SU31, SU25, SU33, SU35) 'to make a fortune' (SU25) as a natural progression in a working life that began very early. One man recalled that 'we went to school but not a lot because when you were that height you were needed on the land. If I counted how long I went to school I'd say about two and a half years' (SU25). By the age of twelve this man was earning a living picking potatoes in Scotland and never went back to Ireland.

Earning a living was important but part of coming to a wealthier country such as England was the need to contribute to the support of family back home: 'My parents needed the money and I'd send it home every week, if I had enough, and they'd be grateful' (SU34). Families were large with maybe eight, ten or even nineteen children and parents depended on money sent home by older children who had left home (SU34, SU25, SU21, SU41).

For some of the young people (SU25, SU34, SU39,), leaving home was associated with a sense of adventure, 'all those dreams you know. I thought I could make it'

(SU25) and travelling without any plans: *'I wouldn't be here at all without my sister she was travelling with a pushchair and the big case and she couldn't manage. I only planned to come only for a day or two. I was supposed to go back several times but never did'* (SU35). For one of the nuns the adventure lay in wanting *'the English mission'* (SU24), the chance to go somewhere different. After life in the countryside or a small town, England offered a liberating experience: *'I love the English. I love the way they're so liberated but, in another way, very conservative. I love the fact that this society welcomes everybody and that we've gone to the stage of equality and diversity for everyone, it's wonderful'* (SU42). For other Irish people, (SU23, SU42, SU41, SU27, SU16), coming to England offered a way out of traumatic situations that included sexual abuse in childhood (SU41, SU23, SU27), parental suicide (SU16) bereavement (SU42) and physical abuse (SU27, SU20).

ii) Living and working England

Seventeen participants, twelve men and five women, talked about the type of work they did. The older men had worked mainly in a variety of unskilled occupations: five had worked in construction all their lives (SU39, SU31, SU25, SU35, SU41). These men, plus one other, also took jobs in factories and anywhere else they could find work, for instance, emptying dustbins (SU32, SU16, SU39, SU31, SU25, SU35, SU41); none of the jobs seemed to last very long and the men moved around the country quite a lot. For example, *'you went around with your mates. We'd head into Southend for the weekend and you wouldn't get beaten up. We lived in digs in Birmingham and would go back to the same place because you could always sleep on the floor until you got yourself fixed up. Young lads then you know'* (SU25). Two men went into the army (SU19, SU16). Another had been a junior school teacher for about six years and then switched to factory work (SU32). A much younger man was working part time in an office and had been a student (SU42). Two of the women had worked in unskilled occupations, cleaning or packing goods in factories (SU34, SU23). Two were members of a religious order and one was unemployed (SU5, SU24, SU36).

Short-term jobs, living in digs and moving regularly meant that some of the older men had never married or settled down either because they *'never thought of it'* (SU16) or because they were *'too wild, running around you know, never settled. This is the first time I've really settled'* (SU25, SU16, SU35). At home their mothers had done everything for them but in England they had to learn to be independent. One man whose wife had divorced him after forty-seven years had never learned to cope on his own. He had put his wage packet on the table every week and his wife had sorted out

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all the bills. He had never paid a bill, did not know how to deal with official letters and missed appointments because he could not organise his time (SU12).

In some instances, family members helped in both providing support and work. For example, SU41 came to England to work for his brother's building firm where he eventually became a foreman. Those who came to England as children or with family members found their relatives' support helpful (SU31, SU5, SU34); for instance, SU5 reported that she *'couldn't cope without my family'*. However, in later life, such relationships seemed to offer little. SU37 had *'contact with brother and sister, I don't see much of them really. We're in contact all the time but I don't really see a lot of them but they can't come running backwards and forwards to see me'*. Similarly, SU16 had *'got brothers and sisters but they're, there's only one younger than me, the others are older and you can't take anything off them'*.

Maintaining links with relatives back home was even more problematic. Six participants reported that, whilst their parents and close family members were alive, they tried to keep up contact and visit them whenever they could (SU32, SU34, SU18, SU20, SU33, SU38). Inevitably, over the years, these visits home became associated with funerals (SU33, SU32, SU34). Five people said that they felt unwelcome when they went home; they didn't fit in any more for various reasons (SU5, SU34, SU41, SU42, SU23). SU5 recalled her visits back to Northern Ireland in the school holidays: *'my cousins would be, 'well don't ask anyone the time, talking like that', because we'd lost our accents..... my family were embarrassed, my cousins who were the same age, were embarrassed of us'*. SU34 also felt that *'some people mightn't want you, you know, you get the feeling, you know'* especially if you were gay (SU41, SU42).

The sense of distance from home was hard to bear because, even after more than forty years, *'you do get homesick sometimes. I miss Ireland'*. Irish culture and social mores differed: *'I thought I was completely prepared for life here and I was taken by surprise actually. It took me quite some time to adjust. I think I really missed the Irish sarcasm and sense of humour. British people's attitude to money: Irish people, I find, are so embarrassed about money. In Ireland, if you bought your friend that's your friend buying you coffee but here your friend might say, 'Oh you owe me £1.50 for that'. I used to be shocked and quite offended at just how easy it was for them. I thought it was much closer than it actually is'* between the two cultures (SU42).

Despite the homesickness, going back to Ireland was not an option when participants had children and grandchildren in England; there was no base, no home to go back to

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(SU9, SU18, SU21, SU25): *'my father is buried here, the girls are settled here. Why would I take myself away from all that?'* (SU9). Coupled with this was a sense of regret. Coming to England *'all seemed exciting but it was a big letdown'* and *'do I regret it? I regret it? Yes, of course I do, you know, that I didn't settle down there in the first place...I mean I'm very close to all the lads but it would've been nice to be there and be part of it all'* (SU18).

iii) Negative feelings about the self

Six men and three women, all of whom had mental health problems, expressed very negative feelings about themselves. Another woman was very tearful throughout the interview, especially when talking about her husband's poor state of health (SU34). For two of the people in this group negative feelings were linked to bereavement. SU18 had loved his wife very dearly throughout their forty years together but caring for her during her last illness had worn him out. SU9 had just learned of the death of friend with whom she went to school. This friendship had marked her final link with Ireland *'but that's the connection now finished'*.

The other participants had different, much darker stories that impacted on how they felt about themselves and which were associated with feelings of shame. SU21 had never been to school because it was too far away from his home and winter conditions made travel impossible. Consequently, he had never learned to read and write and had employed a wide and elaborate range of strategies to hide this fact. He was a widower but his wife had never known about this and he was too ashamed to reveal his secret to his England-born, England-educated adult children (SU21). SU20 had been considered a very bright child and was sent to a junior seminary, a boarding school that prepared boys for training to become priests.

He was very badly bullied by other children and beaten by the teachers. Each holiday he refused to return and his father beat until he agreed to go back to the school: to have a son studying to become a priest brought prestige that would be forfeited if he gave up. When he reached the age of fifteen, SU20 was too big for his father to beat him and so he was able to leave the school but by then he had lost his ability to learn.

Another man had seen his father hang himself when he was a small boy, after which he had spent some time in a children's home that he hated. He had drifted through many different jobs in England and now lived alone in very poor circumstances and with minimal possessions. He expressed very negative feelings, shame and embarrassment about himself and didn't want anyone to know about either himself or his living conditions: *'I don't want to communicate with people. I'm embarrassed about*

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my appearance and also the situation I'm living in, even though a lot of people don't know about it, but I know about it'(SU16). Two other men felt that they could never be accepted in their home towns in Ireland as gay men (SU42). Neither had felt able to tell their parents about their sexual orientation. Such revelations in a small town would mean that *'they'd all be talking about you'* (SU41) and not in a kind way which *'just inspired such fear'* (SU42).

One of these men had been repeatedly abused sexually by a teacher, who he had never reported, once again out of fear of rejection (SU41). Both men had tried to fit in, to conform to what their families and local society expected of them but, in the long term, this strategy undermined their development so that, as one of them stated, *'I have no idea who I really am'* (SU42).

Two of the women had been sexually abused, by family members, from early childhood, experiences that had led to feelings of shame and dirtiness (SU23, SU27). In one case these feelings were compounded by years of physical abuse by nuns who ran the children's home in which she was later placed. As she described it, her childhood was one of continuous ill-treatment: *'When I was with my parents I endured rape, when I was with the nuns I endured beatings. I often had to stand out in the snow, peeling potatoes for the nuns' dinner and we had to lay out the nuns that had died. There were the bullies, the girls they were committing sexual acts with us younger girls'*. As a result she said she developed a belief that she was *'not fit for human society, so I always had an inferiority complex, I couldn't join in, couldn't communicate. I lied all the time, all the time. I would go to the pub and drink all day long and then I would come back here at night and I'd drink a bottle at night'* (SU27). The root of this behaviour, she said, was that *'I hate who I am'* (SU27).

iv) Health

In talking about their health participants highlighted the inter-relatedness of mental and physical problems. It was clear many men and women suffered multiple health problems and consequently, focusing on psychological issues such as depression would not have revealed the context in which it might be experienced.

Of the seventeen men who took part, twelve stated that they had multiple health problems. Seven reported that they experienced physical and mental ill health; four reported experiencing only mental health problems and three others said that they had only physical health difficulties. Three said that that they did not have any health problems at all (SU30, SU26, SU12).

With regard to physical health, four men had arthritis and another said he had problems with his hips (SU33). Four men had long-term chest conditions such as chronic obstructive pulmonary disease (SU39, SU32, SU41, SU31). Two had heart conditions (SU16, SU39). Other physical health problems included two men with shingles (SU25, SU19), two with back problems (SU25, SU39, and two with diabetes, one of whom was insulin dependent (SU31, SU35). Individual men also reported deafness, stomach problems, skin problems, varicose veins, osteoporosis, weight gain and thrombosis (SU31, SU31, SU39, SU42).

Seven men reported experiences of depression which in two instances were associated with having had to retire because of poor physical health (SU39, SU33); another linked his depression to the death of a close family member (SU31); three men reported suicidal feelings (SU20, SU13, SU16). Six men reported heavy drinking, in one instance up to twenty-two pints a night. This group included all three of those reporting suicidal feelings as well as two others who suffered from depression (SU20, SU13, SU16, SU32, SU41, SU35). Other mental health difficulties reported included panic attacks experienced by three men (SU18, SU21, SU41); one of whom also suffered from agoraphobia and acute episodes of anxiety (SU41). Three men reported that they experienced other mental health difficulties relating to specific events in their lives that, in one instance, involved having been sexual abused during childhood (SU32, SU42 SU41).

Nine of the women talked about their health; the other woman did not report any health problems (SU28). Six women experienced multiple health problems (SU23, SU24, SU27, SU34, SU37, SU38); five of these experienced physical and mental ill health (SU38, SU37, SU34, SU27, SU23). Two women had mental health problems but did not suffer from physical illness (SU5, SU9); two had physical health problems only (SU24, SU 36). Two women had been treated for cancer (SU23, SU 36) and two others had cataracts (SU34, SU38). Individual women also reported a range of physical health problems: gastroenteritis, vertigo, chest infections, bladder problems, hypertension, osteoarthritis, hearing loss, hay fever, asthma and menopausal symptoms (SU23, SU27, SU34, SU37, SU38).

Five women suffered from depression that, in two instances, was untreated (SU23, SU27, SU34, SU37, SU38); two other women in this group reported a history of sexual abuse in childhood (SU23, SU27). Two women had enduring mental health problems that began during or just following pregnancy (SU5, SU9). One woman suffered from

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agoraphobia and obsessive compulsive disorder (SU23). Only one woman reported a previous problem with alcohol abuse (SU27).

iv) What helped and why

Participants were asked what they did when they were '*feeling rough*', '*feeling down*' or depressed and who or what was most helpful to them. Sixteen identified sources or activities that they found helpful (SU16, SU13, SU37, SU41, SU42, SU23, SU5, SU21, SU39, SU31, SU33, SU20, SU27, SU18, SU38, SU22); ten participants used more than one of them (SU13, SU37, SU41, SU42, SU23, SU5, SU39, SU27, SU18, SU38). For seven participants, doctors were a major source of help (SU16, SU13, SU37, SU41, SU42, SU23, SU5). Having a good GP with whom the participant could relax, '*have a bit of a laugh with*' (SU16) and who knew the individual well enough to know when something was wrong was considered very important (SU13, SU37, SU16). SU5 and SU41 also valued having good relationships with psychiatrists.

However, having a good relationship with a doctor did not necessarily mean that individuals disclosed any mental health problems. SU16, for example, did not talk to his GP, or anyone else, about his depression. Similarly, SU41 felt that he had a good relationship with his psychiatrist but had not disclosed to her anything about the sexual abuse he had experienced. Reasons for non-disclosure included an inability to relate to the therapists or the organisation in which they were employed (SU41, SU42). However, one of the women stated that she did not like to take her problems to the GP. She didn't '*really fancy talking about (it) to him (GP). He's got a lot of other clients besides me. I'd sooner leave it*' (SU34).

Nevertheless, some participants did appreciate psychiatrists and the services they could provide (SU41, SU42, SU23, SU5). For SU42, medication could be helpful (SU42, SU23): antidepressants '*actually afforded me a period of time without peaks and troughs of emotion....almost like a bit of a buffer to help, it helped me to forget the trauma*'. Residential psychiatric care, that included medicine, nursing and other therapies, was very helpful in making SU5 '*take a long hard look at myself ...learn to open up, I'd been conditioned as a child not to talk about feelings, not to talk about thoughts or anything, fears or anything, and it had a massive impact on my life*'.

The voluntary sector was seen as providing three major sources of community-based help for ten participants (SU13, SU21, SU39, SU31, SU33, SU20, SU41, SU42, SU13, SU5). The first of these was the Irish Welfare and Information Centre. The linkworkers were praised for the practical help and support staff provided in filling out forms,

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obtaining passports, helping people move to sheltered accommodation and sorting out benefits (SU21, SU39, SU31, SU33): *'they've helped me out. My wife was very ill, they helped me sort out all the paperwork and came back just to make sure I was alright'* (SU18) and I *'had the shock of my life, (when the money arrived), couldn't believe it'* (SU31). In addition, one man valued the day centre at St Eugene's court where he was able to buy an inexpensive lunch and gain support to avoid drinking alcohol (SU13).

The second source of help in the voluntary sector was Immigrant Counselling and Psychotherapy (ICAP). Two men used this service and found the counsellors very supportive (SU41, SU42). What attracted both was, first, that *'it's an organisation that's built around Irish people. My therapist comes from Ireland and can understand the narrow mindedness that I experienced and that influenced my thinking around being homosexual'* (SU42). Thus participants did not have to waste energy setting the scene in order to explain what had happened to them.

In addition, there was a feeling that, even if they were not actually using the service right then, the door was never closed in terms of further help: *'there's no time limit in the back of your mind'* (SU42) and *'I can phone up (therapist's name), I can go back to ICAP'* (SU41).

The final source of help in the voluntary sector came from other community-based organisations that, for example, provided assistance in applying for benefits or practical support in terms of accompanying clients when they went to the GP and helping them explain their mental health difficulties (SU13). Other examples of this type of help included an organisation that provided anxiety management courses (SU41, SU5).

Five participants stated that they gained support from family and friends (SU23, SU5, SU42, SU27, SU37), for instance, in understanding complicated written information or filling out forms (SU23). They might also offer a welcome respite or escape from difficult situations (SU42). For one woman, relatives offered a chance to make amends. In her view she had visited some of the abuse she had endured, during her childhood, on her own children but being with her grandchildren was *'like being given a second chance. I went wrong first you know'* (SU27).

Finally, six individuals described their own personal strategies that they had devised to help themselves (SU39, SU18, SU38, SU39, SU33, SU27, SU23). All members of this group suffered from mental health problems but only one was receiving any formal help (SU23). These strategies included learning to read and write (SU23), gardening (SU39, SU18), writing about their lives (SU27) and cleaning (SU23).

v) *What didn't help and why*

Eleven participants talked about experiences that they had found particularly unhelpful when trying to address their mental health difficulties (SU32, SU41, SU23, SU5, SU13, SU37, SU41, SU42, SU9, SU20, SU34). Three women and two men stated that they found admission to hospital unhelpful (SU5, SU9, SU41, SU20, SU23). They felt that staff did not listen to them, that *'they just don't really seem to care'* (SU23). There was no emphasis on recovery and one woman had witnessed staff physically abuse another client (SU5). Two men and one woman complained that mental health professionals did not take them seriously (SU32, SU41, SU23). For example, when SU32 attempted to explain to a psychiatrist the event that had first triggered his depression, *'they laughed at me and they told me to stop smoking'*. The other two participants also felt that they were not taken seriously when they asked for help with their mental health difficulties: *'you see if you're Irish and alcoholic' they don't take you seriously* (SU41).

This failure to take Irish clients seriously linked with the ways in which Irish people were stereotyped, particularly with regard to alcohol (SU32, SU5, SU23). Two of the women illustrated this point very clearly (SU5, SU23). Both were adamant that they had never drunk alcohol at any time in their lives but mental health professionals persisted in thinking that this could not possibly be true. The women argued that these professionals did not have *'not a lot of understanding of your background and what Irish people are like. All they know is all the drink and that's all really. That's the first question we get asked; I don't drink'* (SU23).

Three participants found therapy unhelpful either because *'the people that were running (the place), I didn't get on with them'* (SU41) or because they couldn't get on with the counsellor. The lack of support in between appointments was also seen as unhelpful because it meant that there was no one to call when a crisis arose (SU23). Added to this was a lack of continuity in care and services. Seeing a new psychiatrist every three months did not help SU23 because *'you never actually see them (the consultant). Each time you see a psychiatrist for about three months, the same one, and then he's gone or she's gone, so you never progress. So you still have the problem there all the time'* (SU23). A similar criticism was levelled at Childline in that callers had to speak to a different person every time they rang and although the organisation maintained some records, *'you kind of have to start from scratch each time; that put me off calling'* (SU42).

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Diagnostic labels created confusion for some participants. Both SU13 and SU5 had been given specific diagnoses; specific that is to the practitioners responsible. However, when these individuals were transferred to other practitioners, these specific diagnoses did not seem to travel well and were discounted. A man and a woman found medication unhelpful (SU13, SU37). SU13 was discharged from hospital with medication that he did not understand. He went to the park with a bottle of cider where he swallowed all his tablets, following which he was admitted to hospital.

Two of the women found day centres very unhelpful (SU23, SU5). Those they had attended were *'very dirty and the people there aren't interested in learning anything; all they did was sit around and drink tea and have a cigarette. I'm not against anyone doing that but, you know, it's nice to learn something'* (SU23). The underlying message was that *'oh you're mentally ill and this is all you're worth'* (SU5). For these two women, what was needed most in the mental health services was *'a bit more care; they don't care about you a lot, you're just another number'* (SU23, SU5).

Additional sources of complaint included the length of time between referral and the start of treatment (SU5, SU41), not knowing where to go for help (SU42), being turned down for a disabled driver's car sticker (SU9) and being criticised by the GP for wasting his time (SU34).

vi) Alcohol

In considering what helped and what did not, drinking alcohol occupied a position between two extremes. Some, but not all, participants liked to drink but this did not automatically mean that they habitually drank to excess or that they were alcoholics. For three people alcohol provided a way of coping with distress. SU32, who reported being laughed at when he tried to explain his mental health difficulties, regretted ever going to see a psychiatrist because he felt he was under surveillance all the time. He preferred to drink alcohol, eight or nine pints a night, rather than consider professional mental health support. SU27 and SU41 provided similar accounts of using alcohol to deal with trauma although both had given up drinking. The problem for these two was that the *'alcohol took over (and I) suffered from severe anxiety, depression, can't go outside, can't go to shops sometimes, think people are talking about me'* (SU41).

At the opposite extreme were two men who drank prodigiously from an early age (SU39, SU35). It was a habit they had acquired when they first arrived in England. They had lived in rented rooms which meant that you couldn't go *'home and just sit in the room. There was company in the pub'* (SU39). Going to the pub after work was part

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of the way of life. SU39 had reduced his intake to around two pints at any one time, found a partner and settled down. Not everyone was so lucky. The other man had lost his chance to marry when the woman he was courting broke off their relationship because *'I was too fond of the drink'* (SU35).

vii) Attitudes to Irish people in England

Fourteen participants talked about British attitudes towards them, as Irish people. This was not a subject easily discussed and participants tended, at first, to either deny experiencing any anti-Irish sentiments or to argue that these were only ever directed at other people, never towards themselves. Eight began by stating that they themselves had not experienced any discrimination (SU13, SU9, SU24, SU34, SU33, SU41, SU42, SU12). One young man who had come to England quite recently firmly denied any problems adding that *'I'm quite happy to sign as white Irish'* (SU42). Two men who had arrived in 1956 and 1960 respectively made similar comments. In their view *'the factories were full of Irish, (they) were well liked in this town. We were in the building trade, on the gas. The Murphys and the Gallaghers (the main building firms) were well thought of, good employers, things were well organised'* (SU25). The Irish got on well with the Birmingham people.

SU13 was adamant that being Irish had not disadvantaged him in any way within the mental health services and another man felt that everyone had *'always treated me right'* (SU33). SU42 was able to draw comparisons, as a service user, between Ireland and England and, in his opinion, *'my experience of healthcare, actually it's much more positive here in the UK and I think that it's a wonderful, wonderful system. I have this stomach condition. I take a tablet every day and in my later years of living in Ireland I got a medical card so the prescription alone for three months was nearly 100 Euros. So, coming to the UK and having three months of medicine for about six pounds or seven pounds was wonderful'* (SU42).

However, in considering these views, it is useful to note that both SU13 and SU42 had lost their Irish accents. Moreover, as the interviews progressed, different experiences began to emerge. Whilst insisting that they themselves had not experienced discrimination, participants were aware that it could happen (SU9, SU34, SU42, SU13, SU25, SU41). Even SU42, who expressed the most positive views about life in England, acknowledged that when his mother lived in London there were *'signs in the windows saying No Blacks, No Irish, No Dogs'* (SU42), something confirmed by SU20 who had directly experienced this *'now I came here first - No Dogs, No Irish, and No Blacks. You couldn't get a job as an Irish person'* (SU20).

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Six participants, including two who had initially stated that they had no direct experience of discrimination, revealed a rather different picture (SU5, SU32, SU27, SU16, SU9, SU41). Most of the discriminatory behaviour described was verbal and directed towards individuals. Following the 1974 pub bombings, SU32 felt that the atmosphere at work changed. Comments were made, remarks were passed although nothing was said directly to him; it was impossible to pin anything down. Years later, in the 1980s, SU5 found much the same thing when she and her sisters first went to school in England. She recalled the school canteen where *'if we said to someone, 'pass the water jug', they'd say, 'pass the water jug' (in an Irish accent), and they'd be like, 'what did you say?' and they'd laugh and then we went without water because we didn't want to say it again'* (SU5). Discrimination could also operate in others ways; for example, a woman recalled a senior colleague who *'hated the Irish'* and who got her sacked from her nurse training (SU9). Only two participants recalled events that involved outright bullying and physical violence by the police, prison officers (SU27, SU16) and staff in detoxification units (SU16).

Stereotyping was seen as a form of prejudice. SU23 and SU5, both of whom had never drunk alcohol, reported that some mental health practitioners refused to accept that they were telling the truth. This caused feelings of frustration and undermined therapeutic relationships but refusal to accept that clients were telling the truth was only half the problem. Even those who admitted having a problem with alcohol found themselves dismissed as just another, hopeless, Irish alcoholic.

viii) The Church

Eight participants expressed views about the Catholic Church as a source of help; only two were in any way positive. SU19 was the only participant who had continued to be an active member of the Church. One young woman with severe mental health difficulties that had necessitated a stay in hospital felt that her local priest had provided very good support; she had felt able to telephone him whenever she needed to. However, he had now left the parish and she was finding it very difficult to build a relationship with the new priest (SU5). She found certain aspects of Catholicism helpful but *'it's so conflicting and so contradictory'*. She and her sister took *'take from it what we want and use it for our own strengths and for myself (there has) been a lot of guilt and trying to forgive myself. I've been to confession and had absolution... It does help'* (SU5).

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Other participants had either drifted away from the Church and never considered it as a source of help (SU16, SU31) or had felt oppressed by it in some way even if they continued to believe in its teachings. Two men and one woman had experienced considerable abuse: sexual, physical or both. SU20 had been physically abused at a junior seminary by both staff and other boys. He described the school as being like a prison to which *'you went in at night so that you couldn't see'* that it was surrounded by high walls. From the start there was bullying by the other boys and beatings from the teachers: *'I think I cried nearly every night'* until he was eventually able to leave.

For SU41 his uncertain sexual identity and sexual abuse by a monk at school placed him in conflict with traditional Catholic values. Looking back he thought he should have reported it but at that time either nothing would have been done or he himself would have been blamed. Consequently, he had parted company with Catholicism.

In contrast, a woman who had suffered years of severe physical and emotional abuse from nuns still believed in Christ. She was beaten repeatedly and *'when I say beaten I don't mean a couple of slaps, I mean you were literally thrashed'*. The nuns made the children do all the work *'and we used to have to go on our hands and knees and pick up all the weeds ..in the stone and gravel..... waxing wooden floors, polishing wooden floors; it was all done on our hands and knees.... you know we had prayers 24/7 .. we weren't praying three times a day, we were praying all day and night'* (SU27). However, whilst she was in hospital and before she was sent to the home, she had a vision of a man she believed to be Jesus in the night sky: *'it was like a door opened ...he came out, long hair, long robe and he walked from there not very far away and then knocked and then this other door opened and I saw candlelight inside there. That figure made me believe in God ...I believe that there is a God and I believe it's a good God'* (SU27).

iv) The views of mental health service users who were born in England

A total of thirteen English-born people volunteered to take part. Twelve were second-generation Irish, that is to say that each had at least one parent born in either the Republic of Ireland or Northern Ireland. The remaining person had an Irish grandparent. To preserve her anonymity, because she was the only third-generation participant, her data were added to that of the other participants in this category. Seven participants were men, all over thirty years of age. Four lived alone and had never married. One man lived with his wife and another with a friend. The other man did not provide any information about his circumstances. Six participants were women all over thirty years of age. Four lived alone; of these, three were divorced. One woman lived with her son and the other did not provide any information about her circumstances.

Twelve participants gave information about their occupations. The majority were or had been employed in white collar or skilled occupations. Some had been employed in more than one type of job. Seventeen themes were initially identified. These were grouped into nine major themes, each of which is discussed below.

i) Parental origins

Ten participants, five men and five women, talked about their parent's origins and their decision to move to England to find work. Five participants had two parents who were born in Ireland (SU3, SU15, SU10, SU2, SU1); two had one Irish-born and one English parent (SU17, SU40) and one had an Irish-born mother and an English-born father of Irish parentage (SU14). The remaining participant had an Irish grandmother (SU4). Three participants' fathers came to England from Northern Ireland (SU10, SU17, SU40) but all the other Irish-born parents originated in different parts of the Republic of Ireland. Two participants stated that their parents did not share the same religion; one was Catholic and the other Protestant.

ii) Family life and relationships

Seven participants talked about growing up with their parents. Each of these accounts reflected difficulties in relationships between parents and their children. In three instances, verbal and physical abuse or violence was a part of family life (SU14, SU17, SU40). For example, one woman who had an English mother and a father from Northern Ireland, felt that '*there was no way she was prepared for the heavy drinking and he also became quite violent, and was violent, all the way through our childhood*' (SU17). As small children, she and her brother learned to fear the television news because her father would start accusing her mother over events in Northern Ireland, as though she had personally perpetrated or was responsible for them. Her mother would respond and an argument would start: '*he'd come home from work, reluctantly, and*

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paralytic and the news would be on every night and our experience, in fact we both remember this very clearly, was the news. Either the first item was Vietnam in which case we were relieved or it was Northern Ireland in which case we were in for trouble'. Her parents would argue and 'it was very difficult for children to listen to because it's two halves of you warring in front of your eyes, incredibly frightening' (SU17).

In another example, physical violence was directed at a child who had been raped but had not told her parents or any other adult because the man had threatened to stab her if she did so. She didn't know how much time passed after the rape but it was probably several weeks. She recalled lying in bed asleep one night when her father came in and grabbed her by the hair and pulled her, by her hair, down the stairs. He was very angry and the policewoman, who was there, had to intervene and told him to stop what he was doing (SU40).

For at least one man, violence at home was linked to mental illness. SU15's Irish mother was mentally ill, as was his brother. As a child he had been deeply embarrassed by her behaviour; *'she'd go round shouting her mouth round the streets and stuff, she accused a taxi driver of raping her (and) I was embarrassed'* (SU15). She had tried to stab his father; his brother had smashed windows. His father was an alcoholic and little help. SU15 had learned to be responsible from a very early age, to do what he could to look after the home but he had found it very difficult.

Two other men felt that their parents had not treated them well, although no mention was made of violence. One recalled a very unstable family life that resulted in him, and his siblings, being taken into care for a while. His older sister had, in his opinion, virtually raised him and she was the only contact he now had with his family (SU10). The other man felt great bitterness towards his parents, *'that awful lot'* (SU14). He had been born in England but grew up in Ireland which was still, in his opinion, home. They had brought him to England when he was fourteen and made him lie about his age so that he could get a job. He missed Ireland and the opportunities he felt he would have had there. For two of the women, their own mental health problems seemed to be linked to difficulties in relationships with their parents (SU6, SU1). One felt that she had been rejected by her family when she became ill (SU6). The other, commenting on her relationship with her mother, felt that *'it's strained our relationship. I'll always be my Mom's daughter and I'll always be a child to my Mom but I want to be'* someone better (SU1).

iii) Health

Like the participants who were born in Ireland, those born in England experienced mental and physical problems that could not easily be separated. All thirteen made statements about their health. Five men reported that they had multiple health problems (SU10, SU11, SU14, SU15, SU29). Three had experienced a mixture of mental and physical ill health conditions (SU11, SU14, SU29). With regard to physical health, two men suffered from arthritis. Both had worked on building sites until ill health forced them to give up work (SU14, SU29). One man had a history of heart disease and another was confined to a wheelchair following the amputation of one of his legs (SU29, SU11). Three men had multiple mental health difficulties (SU10, SU14, SU15). Two stated that they had only mental health problems (SU2, SU7).

In speaking about their mental health two men described themselves as having suffered *nervous breakdowns** (SU14, SU15). One of these men also had a *schizophrenic disorder** (SU15). Three men suffered from depression and anxiety (SU14, SU29, SU15). In one instance this was linked to constant fear of a heart attack; this man had already had one such attack and his father had died as a result of one (SU29). The other two men had histories of alcohol abuse and one was also agoraphobic (SU14). The severity of the anxiety was seriously disabling. One of the men described how he had lost his job. He *'just walked away; I couldn't even tell anyone what was wrong, you know'* (SU14). Whenever he felt anxious *'I can't go out at all and if it hits me when I'm out I just try and get home as quick as I can; I couldn't even catch a bus. It just happens in a split second and it gradually gets worse and worse and I shake and the only thing that seems to get rid of it is when I do eventually fall asleep. I'm normally alright when I wake up but the shaking is still there for a little while'* (SU14).

A less acute form of anxiety was described by two men as a persistent lack of confidence (SU15, SU2). For SU15 this was linked to going out. He couldn't cope with crowds and felt that people were talking about him. The other man attributed his lack of confidence to the behaviour of his parents who *'used to make me feel so uptight about a lot of things'* and failed to accept his relationship with another man (SU2).

Two men did not provide any information about their specific mental health problems (SU2, SU11). One man had been diagnosed with short-term memory loss and another had moderate learning difficulties (SU7, SU15).

* = participants' own terminology

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At the time of interview, five men were receiving some sort of help, from statutory mental health services, in managing their difficulties (SU7, SU10, SU14, SU15, SU29). Another was not receiving any help at that time but had done so in the past (SU2).

In contrast, all the women experienced mental health problems and were either currently receiving help from statutory mental health services (SU1, SU3, SU17, SU40, SU3) or had done so in the past (SU6). Four also reported physical health conditions that included chronic fatigue syndrome, an under-active thyroid gland, emphysema and throat problems (SU3, SU6, SU17, SU40).

Two women suffered from depression (SU6, SU3) that, in one instance, started after the birth of her second child (SU3). Another described herself as *bi-polar** and reported attempting suicide once (SU4). A fourth said that she had suffered a *nervous breakdown** (SU17). The other two women did not give any details about their mental health problems (SU1, SU40) although one added that she thought she '*must have had it since I was a young girl because when I was eight I got raped*' (SU40).

iv) What helped and why

Participants were asked where they went for help when *things were difficult* or when they *felt down**. Twelve identified positive sources and experiences (SU3, SU15, SU10, SU40, SU1, SU14, SU29, SU2, SU6, SU11, SU17, SU 4); seven participants used more than one of them (SU3, SU15, SU40, SU1, SU14, SU2, SU6). Having a good relationship with a doctor was very important for seven participants (SU3, SU15, SU17, SU10, SU40, SU1, SU14). For these individuals, a GP who is '*sympathetic to my issues*' (SU3) and who treated clients with respect made all the difference when they were feeling unwell: '*we discuss the thing collaboratively and he's a very warm and open person and I can sense that he struggles with his lack of what he can offer. He recognises that I am the expert in my own experience*' (SU17). Other doctors could also be a source of help. For SU10 a particular psychiatrist was '*the only bloke who put me right at ease*' and advocated on his behalf so that the service this man received at his local health centre improved. Such relaxed relationships did not prevent practitioners from firmly pointing out to clients that some of their actions or behaviour were unacceptable. For example, SU10 recalled that his psychiatrist had, on several occasions, told him bluntly what he thought. It was not complimentary but SU10 had accepted it because of the relationship between them. One of the women recalled a similar experience with a psychiatrist who had seemed more of a friend than a doctor but who had, nevertheless, talked her out of her plans to murder her first husband.

* = participants' own terminology

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However, feeling at ease with a doctor did not mean that participants would disclose their problems. One man, who felt he had been severely ill-treated by his family, did not tell anyone about this because *'I don't like to talk about that an awful lot but I suppose I should because I never really spoke to doctors, I never really told them what could be troubling me or reasons why I could be cracking up or anything, I couldn't because it was too personal, just something that I'm trying to forget, don't want to drag it all up again'* and in any case, as he explained, *'there's people worse off'* (SU14). He also wondered whether some of his symptoms might be caused by his medication but had never raised this with the doctors.

Despite the avoidance of revealing personal stories, participants did appreciate their doctors. Their ability to provide a diagnosis could open doors to other, much-needed help (SU6) and, for four people, the medication they provided could relieve unwelcome symptoms (SU15, SU14, SU40, SU3). Even if the medication did not appear to help it still offered the hope of improvement even if, deep down, participants thought this might not happen: *'they're not working yet but the fact that I've got them gives me a bit of hope'* (SU14).

Finally, one woman recalled obtaining medical help from an expected source. A psychiatrist had invited her to take part in a research project which led him to diagnose her underactive thyroid for which she then received treatment which helped to improve her health generally (SU3).

Other sources of assistance included a local pharmacist who *'knows when I'm poorly and there's been times when he's dropped my medications round because I'm not able to go in and collect them'* (SU1). Non-medical staff at the local health centre or hospital could also help when it came to learning to manage day-to-day difficulties (SU6, SU11). One woman reported that her CPN provided a lot of support and felt secure knowing that she could contact him if necessary, even if she did not actually do so: *'he comes and sees me every month now. I've got his mobile, anything's wrong I've got to phone him, but I've only ever phoned him twice in twelve years'* (SU40).

Three participants, one woman and three men, had accessed the community-based support available at the Irish Welfare and Information Centre. One had received help with claiming benefits (SU29, SU15) and the other two had enjoyed visits and lunch in the day centre (SU2, SU40). The linkworkers had also been able to find suitable accommodation for SU15's mother. He *'felt guilty looking after my Dad and not my Mum but I couldn't cope with Mum'* (SU15). SU14 knew about the welfare service but

had not used it because *'I'm always thinking about charity. I'd become some kind of charity case when I don't want to be'* (SU14). SU1 thought the Centre was too far away from where she lived and she felt unable to travel there.

SU3 had recently discovered the Irish Welfare and Information Centre but had not used the services. She and another woman were attending ICAP regularly (SU3, SU4). SU3 was impressed by how quickly she was able to begin therapy. It was *'intrusive but I feel after eleven years of going on anti-depressants. I need to resolve some things'* (SU3). The other woman had gone on the recommendation of a friend of a friend but *'I didn't know it was there to be honest'* (SU4). Her experience at ICAP led her to *'recommend (it) highly'* (SU4). One woman described the help and support she received from her local parish church. The priest made her feel welcome, that she was as good as everyone else and had even arranged for financial support for so that she and her son could go on the parish holiday, their only break in the year (SU1).

Two women and one man stated that they had found help and support in attending various clubs or sheltered workshops (SU6, SU2, SU40). Family and friends could also be very supportive (SU17, SU1) but, whoever people chose to approach, what was most important was that *'time after time people pick out the beacon, the person, who sat with them and stayed with them, very often didn't say anything very much, but abided with them while they went through it. That's it, that's what they needed, that's what they wanted, that's what they usually didn't get very much of'* (SU17).

v) *What didn't help and why*

Ten participants recounted experiences that they had found particularly unhelpful, unpleasant or both. Four made statements about the negative attitudes of doctors such as the GP who refused one woman's request to see a psychiatrist because for someone in *'your professional position to have that on your medical record, that you've had psychiatric care and referral, is bad news'* (SU17). One of the men had also been refused a request for help: *'I wanted to go to a clinic for the alcohol thing and she wouldn't put me down, she wouldn't put me in there. She said it cost too much and something about it not being done anymore'* (SU14). Lack of continuity could also be a problem (SU15, SU1, SU40) because *'you never get the same consultant two of three times and if you do you've got 10 or fifteen minutes. You can't go through what's going on in your head in 15 minutes. You're thinking, here we go again'* (SU1). Consequently, service users had to start from the beginning each time, a situation made more difficult because, in their opinion, psychiatrists did not seem to read their notes. This

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added to their sense of frustration: *'you're thinking you've got two files, you may not want to read two files but guess what it's your homework'* (SU1).

Alongside relational issues were concerns about medication. SU3 had been prescribed Seroxat but *'now I wish I hadn't. I didn't feel right on it, coming off it was dreadful and I became very high on it as well so sometimes I wish I could have gone to secondary (care) because I realise I was bit high on it. It was nasty to a point where I was acting irresponsibly'* (SU3). Another woman complained that a similar drug, Prozac, had caused stomach problems and abnormal bleeding (SU40).

Alterations in medication *'sent me mad, couldn't sleep'* (SU15) until the prescription was changed back again. Discharging clients without explaining their medicine regimen caused misunderstanding and confusion: *'she sent me out different tablets, I forget what they were now, and a prescription for tablets and a prescription for vitamin tablets, I mean I didn't know why they were sending me vitamin tablets. Nothing was explained to me, just a script in an envelope'* (SU14). SU17 recalled that, whilst she was in hospital, she was blamed for not responding to medication. She was given *'all sorts of cocktails and they kept changing it and it wasn't working and they actually decided I was 'treatment-resistant' as if I got up one morning and decided to be awkward'* (SU17).

The attitudes of other mental health professionals and services generally were also criticised. The NHS was so over-stretched that, when SU4 had been admitted to hospital following an overdose, *'the way they treated me I was like a prisoner, the doors were locked behind me. I wasn't allowed to go home, they told me I had to stay in'* (SU4).

Two participants took issue with the whole idea of being labelled as having a mental health problem. One of them felt that *'with the mental health problem I feel that it's something I should be able to cope with and I shouldn't have a mental health problem'* (SU7). SU6 and SU17 were uneasy also about labelling, arguing that these could be very destructive. They cited examples of what mental health professionals wrote in their notes and which could not be erased, although corrections could be added later on. In their view, mental health professionals had power that could be misused: *'can be frightening, if it gets into the wrong hands, is the power there and a lot of the rigidity about, 'You need to take this medication', or, 'You need to do what we tell you'. I'm not going down that road again, you know? I'd rather perish in my own sweet ways'* (SU17). There was a lot of rhetoric about how the service had to change and become more accessible but the professionals only made it so between 8am and 6pm.

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Professionals had to make more effort to accommodate the fact that *'you ask anybody with mental health, they sleep all day and are up all night. Your body for some strange reason reverts its clock'* (SU1).

Four participants described difficulties with some form of therapy (SU17, SU3, SU10, SU14). One woman had found psychotherapy intellectually fascinating but of little use in addressing her emotional problems (SU17). Another complained about waiting times. She had undergone a two-hour assessment and then waited eleven months only to be offered a student therapist.

In her view this was not good enough and she had made her own arrangements by going to ICAP (SU3). Two men described walking out of a therapeutic setting. In one instance this was because he simply did not like the residential detoxification unit to which he had been sent (SU10). The other man had been referred for counselling after his discharge from hospital. He felt that the therapist had offended him and so left as quickly as he could (SU14). Criticism was also directed towards social services (SU14, SU1). Both of these complaints reflected a perception that the severity of the participants' conditions was not appreciated by assessment panels. Rejection of applications for benefits and withdrawal of existing ones caused considerable stress and frustration because, in the end, they *'either they believe what the GP says or they don't'* (SU1).

vi) Alcohol

Six participants talked about drinking alcohol. Two of the men had histories of alcohol abuse which had caused many problems in their lives. Both had worked in the construction industry and drinking was *'part of being Irish and that you drank at work'* (SU14), a sentiment echoed by one of the women: *'dad drank even harder because of working on the road. (It was) part of the culture here'* (SU17). This man felt that he had managed to get the drinking under control. He still liked to drink but *'I'd be afraid to drink too much now with all the painkillers and anti-depressants'* (SU14) but it was not clear whether the other had done the same. A third man said that he too had given up drinking alcohol (SU29). One woman and one man described their fathers drinking as *'alcoholic'* (SU15) or men who *'drank heavily'* (SU17), behaviour that, in both instances, was associated with violence. SU17 commented that, in her experience, Irish women did not drink; it was only the men who did so. However, heavy drinking could also be seen, not so much as a gender issue but as an expression of homesickness. SU3 called for greater appreciation of this saying that there was a need for *'an*

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understanding perhaps of the first generation and how they adapted to Birmingham life and drank all their life because, they missed home so badly' (SU3).

vii) Identity and belonging

Ten participants expressed their views about how they saw themselves: English, Irish or something else. Only two participants were clear about their identities. SU11 described himself as English. SU14 regarded himself as Irish because he *'grew up there and it's my home and I still go there when I can. I was brought back (to England) when I was very young and I was homesick and I missed it for an awful long time'* a situation that perhaps was reinforced by working on building sites because these afforded little or no social contact with English people (SU14).

For the other participants, the question of identity prompted discussion about what it meant to be Irish and Irish culture. One woman argued that this meant distinguishing between the popular tourists' images of Ireland and the reality. Real Irishness was much more hard headed: *'I don't think they ever were, particularly into the kind of tradition that people see on picture postcards. There's absolutely nothing sentimental about them'* (SU17). For SU3, being Irish meant a sense of belonging: *'if you mention to the person, you're Irish, it means instant family, there's a bond. It makes a huge difference'* (SU3). Irish people were seen as *'very, very proud. Asking for money is not the done thing. I used to see people come to my Dad (saying) "Joe have you got a fiver?" And it might be his last five pounds (but he would) never tell anybody and never ask for it back'* (SU1). Pride meant that they would not ask for handouts and receiving benefits was a source of embarrassment (SU1, SU14).

Pride did not only apply to money. Maintaining a public face on behalf of the family was also important; certain things were never discussed outside the home. The older generation were brought up to ensure that any problems were always *'kept in the family; it was always done at home. And it was never brought out. If you'd got a problem at home very few people outside the family and your house would know'* (SU1). Consequently, many things were never discussed (SU6) and so parents often did not tell their children about their own backgrounds, the kind of family lives they had lived or what had happened to them when they were young (SU17).

Being born and brought up in England automatically created a sense of conflict between an English and an Irish self (SU29). The possibility of a place at Cambridge University had crystallised this conflict for one participant who came to realise that she couldn't *'culturally or socially be in this place without either cutting off from home or to*

try to pass' as English (SU17) so she turned it down. Participants' sense of identity depended to a large extent on circumstances (SU7, SU4, SU3). For example, some *'things have made me feel more Irish. If I'm on the bus or in the pub or whatever and I hear somebody with anti-Irish sentiments talking I'm more aware of my Irishness'* and *'on application forms I always call myself Anglo-Irish'* (SU4) but when this woman went to the St Patrick's Day parade she felt *'like an outsider looking in'* (SU4). SU3 felt a similar ambivalence adding that *'when we're with people from Ireland we talk about Irish things if you like and then you adapt to the culture'* (SU3). Identity was fluid so *'I can be Irish when I want'* (SU4). However, this ability to be selective about identity, particularly the English part of oneself, could attract hostility especially from Irish people who, having been born in Ireland, considered themselves to be more or purer Irish. These Ireland-born Irish referred to the England-born Irish as *'plastic Paddy .. if we talk about our heritage'* (SU3). This was seen as deeply unfair because *'I look at people from other cultures whose parents are perhaps Indian, Caribbean and they're not called 'plastic Caribbeans' or 'plastic Asians'* (SU3). Hostility could also come from members of other minority groups who refused to recognise the separate ethnicity of the Irish (SU6, SU3).

For England-born participants, identity was also complicated by other factors that affected both their links with Ireland and their sense of belonging. Most participants had visited Ireland as children. This could be quite exciting because *'for weeks, (you'd be) dying to go and then you'd meet your school friends on the bunk beds and sing whatever it was they were singing and I found all that incredibly exciting, couldn't wait to get there'* (SU17). SU15's mother had taken him to Ireland for a year when he was in primary school. She would *'go to these friends and talk Gaelic and you know I'd sit there and not know what was going on'* (SU15). He had loved his time in Ireland and did not want to come back to England where, because he had missed so much schooling, he was put back a year. He reflected that his mother seemed to be well whilst they were in Ireland: *'No, she wasn't bad then at all. I think it was after she had my brother that she got bad again'* (SU15).

In adult life, participants had to make their own links with Ireland (SU1, SU14, SU3, SU17). Four had managed to do this. SU17 had some of the strongest family ties. She travelled to her father's home town about twice a year and was very involved in family commitments there. She had a place in the community, a place that she described as *'the place in the world that I would say was home'* (SU17). Being part of such a small place meant that *'they all know your business and they all talk about you but, still, you*

Irish mental health in Birmingham: what is appropriate & culturally-competent primary care? *belong*' (SU17). Despite this apparent integration she did not wish to live there permanently because *'I'm not of there and I'm not sure I belong there either'* (SU17).

SU3 also visited whenever she could and felt that she was Irish whenever she was there. Visiting Ireland as adults meant that participants noticed a lot of changes that challenged their childhood memories (SU2, SU3, SU17). Ireland was now a multicultural society. It now contained many different cultures and these were evident in many places, not just in Dublin (SU3). It was also wealthier. The money was welcome: *'you can't blame people for enjoying having some wealth and grabbing it with both hands'* (SU17). The problem was that so much was being discarded' (SU17). She had expected better: *'I thought Ireland had more depth and more perception and more reflective stock, that it wouldn't just grab it to the exclusion of everything else'* (SU17).

Links with Ireland took on a different complexion if parents decided to return, leaving their adult children in England. SU1's parents had returned to Ireland when they retired. It had taken her father a long time to settle down but now they were both happy there and she tried to visit regularly because, for her, Ireland was home: *'I live here but Ireland is home'* (SU1).

viii) Attitudes to Irish people in England

Six participants commented on the extent to which they felt that being Irish affected their care or any other aspects of their lives. In their view the Irish were not regarded as a separate, ethnic minority. Other minority groups such as the Muslims seemed to get more attention and, in one example, even objected to support being given to an Irish organisation so *'I do feel the Irish have really been badly let down'* (SU4, SU6).

The problem was that *'people don't know we're Irish'* because our *'skin's white, people wouldn't recognise whether we were from Ireland or not'* and there was no accent to draw attention to any difference (SU3). People could be racist, for example, in telling anti-Irish jokes, without realising that they were in the presence of Irish people or recognising that they were causing offence (SU3).

There was little current and direct experience of anti-Irish attitudes. SU11 was aware that some people *'put on the Irish'* but had not experienced this himself. However, this changed when the 1970s were mentioned. One man had been working in a factory at the time of the Birmingham pub bombings and his accent meant that he became a target for bullies: *'people'd hit you and even people that weren't in this, you know, coloured people and Asian people and I was fourteen and they were all sixteen or*

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upwards. So, I defended myself once or twice and after a while they left me alone, but there was always that stigma' (SU14). As a result he got a job on a building site where the presence of a lot of other Irish people protected him. Nowadays, he could sense if someone *'is thinking you're a second class human being because you're Irish'* and he avoided them (SU14). Both he and SU2 felt that black, Pakistani and other South-Asian people had to put up with far more prejudice. SU2 felt that there had been *'racism after the bombings but life's not fair is it (and) I don't think the Irish are an oppressed minority any more or anything like that, I think they're generally accepted and generally fit in well'* (SU2).

SU3 felt things had improved since the 1970s. She had been in junior school at the time of the bombings and had not felt that her Irish background was a problem. However, she and the other children of Irish parents *'were always told not to talk about being Irish'* (SU3). This did not stop them feeling proud of their Irish heritage of scrawling the IRA's initials on the bus shelter (SU3). Nowadays it was far more acceptable to be Irish and it was members of other cultures who were made to feel unwelcome (SU3).

ix) The Church

Six participants expressed views about the Catholic Church. Two women held positive views about the Church having both received help from their local priests when they had been mentally unwell. Both felt that going to Mass was very important. Even though they did not feel up to going every week, they appreciated the support and encouragement they were given by their local priests (SU3, SU1). SU3 recalled coming home one day, whilst she was getting divorced and finding a pint of orange juice and a prayer on the doorstep. They had been left by a nun who, she felt, really understood *'what I was going through and I just thought that was really lovely. That sort of thing encouraged me to go. I don't go very often but I go more than I used to'* (SU3). She drew comparisons between the people in charge at her local church nowadays and the parish priest of her childhood who *'was not a very nice man. I'd seen him beat children'* (SU3).

Two of the men were indifferent to the Church. They had been baptised as Catholics and had gone to Mass as children. However, in adult life they had drifted away (SU15, SU2). A third man had also drifted away and did not go to Mass because he found it too long. Nevertheless, he still believed in God. *'I've got a fair few points why I shouldn't believe in God but I just do'*. He still found it helpful to *'visit the church and light a candle and say a prayer'* (SU14).

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The remaining two women were rather more ambivalent, arguing that the church had done a lot of harm to Irish people and to women in particular '*how it made women feel, and how it made me feel as a woman growing up in it, and the churches attitude to sin and self-esteem*' (SU17, SU6). She added that the priest to whom SU17 had expressed these views agreed with her unreservedly and said that the Church was trying to address these issues. She now attended Mass when she felt like it. SU6 did not attend church at all but felt that there was much to be done by the institution to heal the damage done to Irish people.

v) *The views of primary care mental health practitioners and community-based service providers*

A total of forty-one people agreed to take part in the project: Fourteen worked in statutory services. Ten of these individuals were employed as mental health professionals; four worked in general practice. One mental health professional proved impossible to contact and was deemed to have changed her mind.

Of the remaining thirteen, seven were born in Ireland, two had Irish parents and the remaining four had other ethnic identities. Twenty-five participants worked in voluntary organisations. It was not possible to gather data about their backgrounds. Data were gathered through a mixture of twelve individual interviews and three focus groups. One group was composed of three mental health professionals. The other two were made up of two and twenty-two people respectively. Fourteen themes emerged from the data. These were grouped into eight major themes each of which is discussed below.

i) Issues in statutory health service provision for Irish people

Eight individuals made statements about health service provision for Irish people with mental health problems. One community mental health professional estimated that between 30% and 40% of the people that he saw were of *'Irish heritage. I don't carry a caseload but I see people as and when they present with mental health issues. In a week, I'd say see fifteen or twenty. I'm thinking five, six, maybe seven would be Irish'* (SP9). Another professional added that he thought there was *'a real genuine need' because Irish-born people tended not to seek out mental health support or, indeed help with the physical conditions either so this is why the Irish are a special category where you have actually got to look for them'* and check their health on a regular basis (SP15). Identifying early signs and symptoms of serious health problems made them cheaper and easier to treat so *'you do something about protection for them well ahead and in a way you are saving a lot of work for the future and a lot of money'* (SP9).

Attitudes to health and this reluctance to consult a doctor were rooted in Irish culture in which sickness was simply an accepted part of life and not something to take to a doctor: *'I think that's going back people in Ireland, I know when I was a child you didn't call the doctor, you didn't go unless you were really ill. It was automatic that you would get colds and flu and cuts. They were a normal part of living'* (SP11). People simply got on with things and used home remedies for their ailments. Professionals, therefore, needed to reach out to Irish-born people and ensure that services were accessible. However, even when this was successful, Irish-born people might not reveal very much about themselves because they did not like to bother the doctor: *'not many (tell their*

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stories) because I think they're embarrassed and of those people who do, which is very few, they don't tell you the whole story and from time to time they actually tell me that the other details are not very nice and won't tell' (SP15).

In contrast, the second generation seemed more prepared to seek out and accept help (SP9). South Asians behaved quite differently: *'for everything they are here like a shot, that's the first generation. Second generation are much better, they would try to look after themselves, look on the internet etc. and then they'll come' (SP9).* It seemed that the principles of good practice for working with members of minority groups were not applied to Irish people. For example, *'if you were to talk to a South Asian woman - the language and dialect, the religious and family connotations that are attached to that - somehow it's not transferred to Irish people'* or members of other, white minorities (SP7).

Professionals had little knowledge about the needs or culture of Irish people and, consequently, *'didn't realise half the problems that they'd encountered or experienced. In Birmingham we've got good services for a whole range of ethnic minority communities but, on the whole, they're (the Irish) not particularly recognised as an ethnic group'* (SP9). Lack of understanding of Irish people and their background could make it difficult to treat them (SP4). Despite this, the Irish did not feature in diversity education: *'throughout my training and all the work that I've done, when you talk about minority communities, Irish people don't figure in that'* although motivated professionals would make an effort (SP9).

The Irish did not feature in any of the planning regarding diversity in the NHS (SP3, SP9). This meant that not only were they disadvantaged but also that other white minorities might be similarly disadvantaged (SP7). The influx of white migrants into the UK afforded Irish people the chance to renegotiate their social position but changes also had to be made in the Irish community itself in which many people were uninformed about health issues (SP4).

ii) Issues in voluntary service provision for Irish people

Eight individuals and the large focus group made statements about voluntary services for Irish people. These concerned two organisations based in Birmingham. Immigrant Counselling and Psychotherapy provided counselling for Irish people although members of other ethnicities also used the service. Clients were predominantly from the Republic of Ireland: *'we've got very limited facilities in terms of the waiting areas but*

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there's a sense of people making themselves quite at home which suggest to me that there is an active transference to the organisation' (SP17, SP18).

The Irish Welfare and Information Centre had thirty two members of staff who provided a wide range of services that included primary care, outreach to older adults, pastoral care, housing support, tracing birth certificates, helping people to give up alcohol, obtaining Irish passports and a recently appointed opportunities coordinator (SP13). These services were important because *'these people are here and if we don't help them'* no one else will do so (SP12). Their needs were multifaceted; ill health, poor housing, poverty, isolation all had to be addressed (SP12). Outreach, visiting people wherever they lived was an essential part of the work but there were risks. All the linkworkers had an alarm and a mobile; risks assessments had to be undertaken and where necessary, workers visited in pairs (SP14+). Whilst care had to be taken to avoid dependency since the Centre was not geared for long-term support, clients deeply appreciated the services provided: *'you should read the comments book. It's from reading that that you realise what a valued service it is'* (SP13, SP14+).

Despite this success, practitioners and service providers in both statutory and voluntary services, even very experienced individuals, seemed to know little about the Centre. SP16 had *'been linking in with Irish welfare to find out what's available'* and SP2 remarked that the Centre was good at helping people who wanted to reconnect with relatives back home but little other information was volunteered.

iii) Mental health and other problems

Nine individuals and the large focus group talked about mental health and related issues. In their view mental ill health was never discussed among the older generation of Irish people. Sometimes people disappeared, went away or lived in the back room of the house to which no one was allowed access and no one talked about them (SP5). Mental illness carried considerable stigma but there was *'this very strong sense that you just looked after your own and so you had to manage it within the family'* (SP7). This sense of stigma was reinforced whenever the project leader visited Irish community organisations to give short talks about the project in order to recruit participants. Afterwards, older people would whisper in her ear about their relatives who had developed mental health problems and how things had turned out for them.

There were various perceptions of the causes of mental health problems among Irish people. Some individuals had experienced considerable trauma in during childhood. This was frequently perpetrated by family members. Often they had told no one about

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this but, on reaching later life felt that they needed to deal with their suppressed feelings (SP9).

There was a great deal of loneliness and depression amongst Ireland-born people, especially men, who had been on their own for a long time (SP14+). The principal reason for coming to England had been to find work but, for many men, the type of work they did created a lot of stress because of the way in which it was organised. To get a job in the construction industry men had to get up very early and then go to a collection point which was normally a pub. This was where the contractors selected men for work, where they picked them up and dropped them off each day and *'it was always living in fear that they may not be picked for the job , if they got picked for the job, what were they going to be paid for the job?'* (SP16). The constant stress took its toll. Many did not settle down or marry but continued to live in rented rooms. They felt too ashamed to go home because *'they feel that they're a very long way from here and don't want to say they've failed. They're ashamed'* (SP11). Over the years *'being cut off from the family back home and maybe siblings here that they've not been able to keep in touch with over the years'* and not forming sustained friendships, all contributed to their loneliness and depression (SP9). When they looked back at the Ireland they left and which did not exist any more, they felt anger and loss (SP1). In later life, when they could no longer work, their main purpose in life was gone (SP15).

Allied to the loneliness and depression was the cultural background from which they originated; an authoritarian society in which they were made to feel that they counted for very little: *'they were ruled in their homes by their own parents'* who made them feel worthless or in institutions that did the same. Then they came to England where they were treated very badly. They need to know that what happened to them was not their fault (SP11). However, it was necessary to strike a balance and not see every Ireland-born person as having a terrible past: *'it's the victim thing that concerns me, the bleeding heart bothers me'* because it provides another way of stereotyping people (SP1). It also created a foundation for blaming Ireland-born people for their children's misfortunes. Thus, when they became mentally ill, the *'second generation would be reflecting a lot of the blame back on their parents in that their parents weren't broad minded enough'* (SP16). In other words such blame may not necessarily be justified.

The incidence of physical health problems was also commented upon, for example arthritis and back problems were attributed to poor working conditions. When working on building sites men *'wore discarded Sunday suits. There were no such things as working gear'* (SP9). Poor physical health was also linked to alcohol (SP15). Men who

were dropped off at the pub at the end of a working day, and who had nothing else to do, or to go back to, except a *'bed sit which was a lonely place'*, went to the pub *'which ended with them drinking and excessive drinking causes a problem which they wouldn't have been aware of'* (SP16). Going into the pub for a drink provided company in a warm, friendly environment; it was only later on that the physical effects on their livers and other organs became apparent (SP16, SP15). Alcohol abuse was said to be more likely to occur among members of the first and second generations of Irish people than among the third generation which seemed to be moving on to other substances (SP4).

One of the problems with alcohol abuse was that individuals tended to be referred for detoxification first before their mental health problems were addressed. Rather than refer clients by saying that they were alcoholic and depressed, it was better to say that they were depressed and that this was causing them to drink heavily because *'I haven't met any alcoholic who actually likes to drink. They are reduced to drinking because there is nothing else on offer. One analysis of the reasons why they took up drinking is that they're very distressed, (with) problems and you wonder how they survived. So the main problem in my view is not alcohol, it's the depression, the trauma, it's the psychological upset'* (SP15). It was imperative to stop the assumption that nothing could be done about mental ill health because an individual had a drink problem. What was needed was on-call psychiatrist or GP who could be accessed quickly to perform on-the-spot assessments that enabled people access the help that they urgently needed (SP14+).

iv) Alcohol

Six individuals and the large focus group made statements about alcohol consumption. Drinking alcohol was an accepted part of Irish culture that, for many men who came to England, was reinforced by the association between work and the pub (SP4, SP1). So if somebody said they drank *'that was normal, that was what people did. Maybe Sunday dinnertime after Mass, you'd go down the pub and then be home for three. I think there was a general perception that men drank hard'* (SP7).

However, alcohol also served other purposes in that it helped people to cope with loneliness and many other difficulties (SP15, SP9). It helped to block out negative feelings and experiences and release tension. Other people might regard the amount of alcohol consumed as a problem but, from a practitioner's perspective it could be seen as a readily available coping mechanism, albeit one *'that's not particularly healthy'* (SP9). Moreover, when listening to individuals' life stories *'sometimes I think, if you've got no friends, you've got nothing to do with your time, lots of issues playing in the back of your mind, then it's very, very difficult to face those issues sober'* (SP9).

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Thus the focus for the practitioner should be on what the alcohol consumption means for each person rather than on detoxification.

It was also essential for staff to understand that their ideas about drinking alcohol could be part of a stereotype of Irish people. Not everyone had a problem with alcohol or even drank (SP14+, SP5, SP7, SP6) but *'there is still that underlying idea that all Irish people are drunks'* (SP12). This attitude was so ingrained that one participant had encountered Irish people who were pioneers but had been referred for detoxification on the assumption that alcohol was the root cause of whatever was wrong with them (SP5).

v) *Caring for Irish people*

Twelve individuals and the large focus group made statements about their experiences of working with Irish people using health services. Staff development was needed to help practitioners develop an understanding of the society from Irish people have originated and which may influence how they behave, irrespective of whether they were born in Ireland or in England (SP6). What is or was considered normal behaviour in Ireland could be viewed quite differently in England and vice versa (SP6). Moreover, Ireland was not homogenous. People who originated from the Republic of Ireland were culturally different to those of Northern Ireland but this was not the only cultural division and *'I think there is a huge problem about identifying the different types, the different groups of Irish people'* SP17, SP18).

The stigma associated with mental illness, the cultural value placed on privacy, not talking about family problems and past experience of anti-Irish attitudes in England meant that *'Irish people are very secretive and are untrusting of authority figures. They don't feel respected; when they do get that (respect) they will open up more on mental issues or personal issues'* (SP11, SP12, SP16). This meant that Irish people could be very reluctant to seek or accept help. They were *'such private people all the time, not really that willing to accept help a lot of them because they feel they're putting people out and then it's a pride thing as well'* (SP12) because they do not want to admit that they have problems (SP16).

Consequently, staff needed to invest some extra time in putting people at ease, building relationships because *'once they discover that doctors and nurses and staff are not all superior beings'* they will begin to relax (SP11). Once they *'feel comfortable and they get to know the staff'* they will begin to open up but staff had to be watchful, look out for signs of this and be ready to respond because if people felt that their first

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efforts had been, as they saw it, snubbed, they might not try again (SP10). Once trust was established *'you'd be amazed at what people will tell you'* (SP10, SP12). Reminiscence therapy could provide a useful therapeutic tool in helping some people tell their stories and reveal other, previously unseen, aspects of themselves (SP2).

Ireland-born members of staff could also help to enhance experiences of care because people would *'hear their accent, one of our own so you can talk to us'* (SP11, SP16). The advantage was that, from the client's perspective, certain experiences and events were already accepted as givens that did not have to be explained: *'I know that some of our clients have expressed a sense of ease about the fact that they know I'm Irish. They don't have to explain everything'* (SP17, SP18). One of the factors that did not then have to be explained was that *'there's something about the experience of displacement; it's just crucial, displacement in terms of being uprooted'* (SP17, SP18).

Membership of a community inevitably conveys a better understanding of behaviour, gender dynamics and many other factors but this was not an argument in support any form of apartheid psychiatry for the Irish or any other minority group. Practitioners who shared the same ethnicity as the client could be too close to the situation, hindering rather than facilitating recovery (SP3). Sometimes it was necessary to challenge clients about their behaviour, what they were either doing or not doing to help themselves (SP14+). It was unrealistic to expect services to bring about social change *'because we are fleeting in people's lives, we're not resourced to do it'* (SP1).

In many ways Irish people just needed the same as everyone else: *'information (and) people with them who can work alongside them'* (SP16, SP14+). Participants argued that the Irish were not alone in having to deal with sadness or feelings that prevent individuals from getting the help they need; like others, they also had to contend with poverty, poor nutrition and other difficulties (SP14+, SP1).

Practitioners should not assume that clients or their families knew how the mental health services worked or what was available to them. They were likely to be very frightened about what was happening, so they needed to be told what was available to help them and to understand that they could recover (SP16). Where possible, family members were included so that they understood the treatment and *'what sorts of options are available and (how) they can be involved'* (SP16). The aim was to facilitate recovery and enable clients to achieve independence if possible whilst recognising that some clients would never achieve this (SP14+).

vi) *Language, literacy and communication*

Five individuals and the large focus group made statements about communication factors in working with Irish people (SP5, SP7, SP9, SP11, SP16, SP14+). These were principally concerned with those who were born in Ireland. Irish accents could be difficult to understand even for those practitioners who worked regularly with Irish people. Practitioners who originated from Ireland or who had Irish parents sometimes found themselves having to interpret what clients were saying (SP16, SP5, SP5). This interpreting role was not simply a matter of repeating, without an accent, whatever the client said.

Interpreting involved understanding the meaning of English words used in a different context: *'a woman who was an in-patient (with) depression. She was agitated, she couldn't sit still, she was wandering around the ward and she was saying things like, 'I've got to go, I've got to get my messages' (and) 'I've got to get a milk pan'. And then, by chance, one of the Home Treatment workers, who's first generation Irish herself, came on the ward. I know they were thinking about (sectioning the woman) and then she said, 'Don't be silly. That woman's talking about she wants to go to the shop,' 'Don't worry about it, we've got plenty of shopping in', she said, 'I've got bread downstairs, I'll get you some'. And she (the woman) was alright and that could've quite easily, I think, have ended up with her being sectioned'* (SP7, SP5).

There was also a need to explain clients' circumstances to colleagues who did not understand the significance of what was said. As an example, SP7 recalled another client from Kerry who *'had worked mainly on the buildings and never married and lived in landlady accommodation (rented room); there was a lot of that in Sparkhill. He was depressed. People didn't quite understand the setting, this landlady-type accommodation, that it was a woman who had two or three lodgers'* (SP7).

Interpreting was also needed for Irish people who did not speak English. Older people, especially those who originated from the west of Ireland, the Gaeltacht, might not speak English to any great extent. They might have a few words of English for everyday needs but nothing more. This could cause difficulties if practitioners did not appreciate a client's lack of understanding and lead to misunderstandings, inappropriate treatment and stereotyping as *thick Paddies* (SP5, SP16).

Reading and writing were also problematic for many older Irish people (SP5, SP11, SP7, SP9). One practitioner explained that *'Mum and Dad can read and write but their writing isn't brilliant at all. I was about six or seven writing the letters and they'd put*

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money in it, they'd always send money back' home (S7). In health care, a lot of information for service users and their families is produced in writing which disadvantages those who cannot read. Practitioners need to bear this in mind when assessing clients: 'it's one of the interview questions I ask. I will just ask (the) question straight about reading and writing: some will say yes' (SP11). Others might not answer straightforwardly so 'it's something that I have to try and suss out quite subtly' (SP9). Lack of literacy did not mean that a client was uneducated. One experienced practitioner with good educational qualifications obtained in Ireland, had learned English after coming to England and still, after many years in the country, found difficulty in writing in English (SP).

vii) Irish culture and the Church

Thirteen individual participants and the large focus group made statements about Irish culture. Irish culture was described as very rich and creative with a strong tradition of literature. There was a unique sense of humour, a genuineness and use of banter based on shared meanings and experiences that did not have to be explained (SP6, SP4). The Irish also had a strong relational capacity and could fit in with others anywhere in the world (SP6). The younger generation was highly educated. In Northern Ireland the Troubles caused young people to stay in school much longer (SP1).

In the Republic of Ireland the standard of living had improved as the economy boomed and young people there now received a much better education than their parents. Young Irish people who came to England now, from all parts of Ireland, were more likely to be taking a gap year and going out on Broad Street: *'they speak a different language'* to the older generation and *'they haven't lost Ireland'* (SP16). This new, prosperous Ireland also brought pressures and higher expectations. Not everyone could cope with these and now *'nowadays every family in Ireland has been affected through suicide'* among young people (SP16).

Older adults who came to England as teenagers came from a very different Ireland, a country that was extremely poor and in which there was *'no way of making a living'* and so the only option was to leave (SP10). Leaving was not so much about starting a new life as sending money home, as fast and as often as possible, to support the family: *'there were about 15 families living in the village and all the husbands of these ladies (worked in England). The husband used to come home from work (in England), plough the land and then be away again until say September time'* (SP10, SP8). Families were large so the older children had often left home before the younger ones were even born and, consequently, siblings might not even have met one another (SP8).

Society was dominated by the Church. When SP8 was growing up she was told *'that from the cradle to the grave you could rely on the Church. When I was growing up the church ruled the government'* (SP8). Evidence of the Church's caring side could still be seen. Parish priests referred clients to the Irish welfare organisations and being an active member of the Church *'does work for some but even if it only worked for one in a 100 that's good'* (SP13). The problem was that, despite good intentions, the Church was no longer able to meet demand. In days gone by *'the churches had so much support in that they had the St Vincent de Paul, the Legion of Mary and other groups and that but then there's so few of those around'*; aging parish priests, a lack of volunteers, *'the SVP is not active, the Legion is dwindling'* reflected a decline (SP14+). Whilst some people continued to *'turn to the Church in times of desperation'* and *'I don't recall ever hearing anything negative about'* it, the Church was losing ground (SP1).

Despite its good work, the Church had a lot to answer (SP1). The Ireland that older people had left in the decades after the Second World War was a very authoritarian society. The principal source of authority was the Church. The priests had great power over every aspect of people's lives, especially in rural areas. The priest could use the pulpit to shame people. He could decide who should have a particular job and who should not. People could be disowned for crossing boundaries set by the Church, such as marrying a non-Catholic. Education was dominated by the Church because the schools were run by religious orders (SP5, SP6). The priest, the teacher and the doctor were held in high esteem. This authoritarianism masked a wide range of physical, emotional and sexual abuse perpetrated against children in schools and other institutions run by religious orders. Recent revelations about this abuse led to a crisis of confidence in the Church, causing people to leave. Leaving was exacerbated by social change: *'people are changing their views on things like contraception, sex before marriage and cohabitating before you get married and abortions'*, people led busy lives and the Church was no longer a priority (SP12).

Authoritarianism was not confined to the Church. At home *'Daddy's word was law'* and mother too was a source of authority (SP6). Obedience was highly valued. Feelings were discouraged and suppressed; signs of affection were not encouraged; things were not talked about, not discussed. Children were to be seen and not heard. Consequently, there was a culture of silence (SP14+) in which people did not develop as emotional beings; they could not articulate their feelings because they never developed an emotional vocabulary and thus relied on external factors to garner self

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esteem (SP6). In old age people from this authoritarian background could appear to lack focus in their lives as if they were waiting for something (SP2).

Pride was another feature of this culture, especially for men who were brought up never to complain (SP4). The image given to them was that of a tough, hard working, hard drinking man whose behaviour was validated by other men who did the same. Money was always about cash. SP7 commented that her father never had a bank account until he retired; he earned and paid all the bills in, cash. Many others like him did the same: they financed the education of their younger brothers and sisters, their nieces and nephews but they had no savings; everything was '*sent home to mother*' (SP8).

Women lived under intense pressure coping with the demands of the Church and society. Domestic violence, heavy drinking and other problems could not be discussed; problems in a marriage could bring shame on the family (SP6). Pregnancy outside marriage was one source of shame. The women would work right to the end of their pregnancies, give birth and be back at work within a few days having given up their children for adoption. Their situations were never acknowledged, never discussed (SP6). Given such experiences, it is perhaps not surprising that mothers tended to favour sons over daughters. Sons were waited on and cosseted whilst their sisters did all the work at home: '*we were told we had to clean their shoes and we had to make sure their clothes were ready and it was our job to do so*' (SP8) and so many men must have found it hard to live independently as adults (SP8).

viii) Attitudes towards Irish people in England

Eight individual participants and the large focus group discussed the negative stereotypes of Irish people in England and the ways in which discrimination could occur. S10 had never experienced any discrimination, although she had heard other Irish people talk about it. Before she came to England she had hardly been away from home and felt that she might not have recognised signs of prejudice when she first arrived in England. The most frequent statements were about the assumption that all Irish people drank heavily (SP5, SP6, SP7, SP9, S12, SP14+). As one Irish practitioner observed, this stereotype was so strong that, when she first came to England, it didn't seem to matter whether she drank or not because the assumption was that she was drunk (SP6). Allied to this stereotype was the, still prevalent, assumption that Irish people were stupid (SP12, SP6, SP14+).

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For two participants the worst period was after the Birmingham pub bombings. There was hostility at school and *'my Mum going up Stratford Road and shops wouldn't serve her. I remember her coming in quite upset. I had to do the shopping and then there was this thing about being careful for ages'* (SP7) and *'it frightened me and that time after the bombings, it really did'* (SP8). SP12 described one of her clients as being so badly affected by the discrimination she had suffered that she was unlikely to accept help from English people. Parallels were drawn with the current situation for Muslims and *'I want to say, just wait thirty years'* (SP8, SP4). Things were better. In the large focus group, one participant described how, when a client had gone missing, the police had put in so much effort *'you'd think it was the Queen'* (SP14+). Nevertheless, anti-Irish feelings were still there, underground, and could surface when least expected, for example, when presenting documents written in Irish (SP10, S5). Thus going to a place where there were other Irish people still helped to give a sense of security (SP10).

vi) The views of primary care mental health practitioners and service providers in Ireland

In the Republic of Ireland fourteen people agreed to take part. They were all based in a single mental health service in a rural area which was very similar to the places from which many service users in this study originated. Ten participants were women and data were gathered through two individual interviews and four small group discussions; one was of five people and the other three each comprised two.

In Northern Ireland data were collected from six organisations including the city Council services, an organisation that provided sheltered employment for people with mental health difficulties, a forum for service users, carers and providers and a voluntary organisation that provided help for those with addiction problems, a trauma counselling service and a residential mental health unit.

Eleven themes were identified. These were grouped into three major themes, each of which is discussed below with reference to both the Republic of Ireland and Northern Ireland

i) Service and practice issues

a) Republic of Ireland

This was a rural area in which the distances between villages and towns and the limited public transport could make it difficult to provide services. There was a lot of travelling involved in both working and social lives. Many properties, up to one third, were empty, and were either second homes or let as holiday accommodation. The population was largely settled with people whose families had lived there for generations. Everybody knew everybody or at least knew of them.

In this setting all participants made statements about *issues in service provision and practice*. The total population was approximately 53,445. The client base was predominantly, that is about 60%, Irish with the remainder made up of *'mainly English, Scottish, some Americans, some Germans, some Swiss'* Polish, other white minorities, hippies and older people who had moved there in retirement (PIE1-5). Amongst this last group were Irish people who had returned home but not always settled successfully; when one of them died or became ill, the other was left socially isolated. All these newcomers, or **blow-ins*, were accepted but only up to a point (PIE1-5).

*A term used throughout Ireland to denote newcomers or strangers

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The mental health service was quite small and the distances people had to travel meant that *'there is an accessibility issue'* for some clients (PIE9). Staffing the service was a persistent problem and international recruitment had been undertaken in several different countries including the Caribbean islands (PIE9). There was an efficient referral system with waiting times of *'two or three weeks, six weeks in some clinics'* (PIE1-5). There was an emphasis on *'engaging the community around mental health'* and *'we have a fully developed community mental health team. There's a focus always about trying to keep people in the community'* (PIE9).

Teams were multi-professional and the rate of admission to hospital, for clients with mental health problems, was the lowest in the country (PIE7&8). Nevertheless, some services seemed to be less developed than others. Although respite care, was available on a limited basis (PIE9) a lot of families struggled to care for relatives at home: *'the community nurses will tell you its very high percentage and struggling terribly, relatives who are at their wits end'* (PIE6).

Living and working in a small community meant that the practitioner was never really off duty (PIE13&14). Clients and practitioners knew and saw each other in a variety of different professional and social settings which facilitated a holistic approach to monitoring people that was also undertaken by the wider social network (PIE1-5). Thus practitioners developed an understanding of how individuals coped with various everyday situations, in some instances over many years, based on their own, direct observations; they did not have to rely solely on the time spent in therapeutic activities. In addition, they could depend on an informal network of friends and acquaintances who would do the same and who would contact the mental health team if they observed unusual behaviour such as leaving church early, or putting out loads of extra rubbish (PIE1-5, PIE13&14). Whilst this social surveillance was a useful source of information it could also serve as a form of oppression (PIE1-5). There was a tendency towards negative labelling, for example, *'he's like his father before him'* that could prevent people from receiving help (PIE10-12).

Living and working in a small community was also an advantage in assessing clients. Practitioners knew, exactly, not only how to phrase questions that would be meaningful to clients but also how to interpret the significance of their answers (PIE13&14, 11&12). Thus they gained a holistic picture of each client's problems, family and circumstances. There were concerns that this locally-embedded expertise might not help in working with clients from other backgrounds: *'you wouldn't get, probably, the depth of information or the quality or the quantity because they would be different to us'* and

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would not share the same language (PIE1-5). Practitioners who were not Irish and who had trained elsewhere, had to work to achieve this level of expertise. They had to adapt their skills to learn how to communicate using the local idiom and body language whilst also coping with hostility and racism from some clients (PIE1-5, PIE 7&8).

Practitioners recognised that older clients could be very afraid of mental illness because, when they were young people, were either kept at home or taken away to an asylum; either way they were probably not seen again (PIE6). Younger people were less likely to be affected by the sense of stigma associated with being mentally unwell (PIE1 (PIE13&14)). Thus, in providing therapeutic interventions, practitioners worked towards enabling clients to understand that modern mental health care was about helping them to articulate, in some way, what had happened to them *'what led them to that point. They begin to unravel it for themselves, what their symptoms might lead to and it becomes a personal journey. There's very little need for hospitals. There's very little need for long term admission. There's no need for long term care and I suppose that's what's changed, that the madness that society wanted to push away has actually been more integrated'* (PIE6). Inherent in this journey was the need to challenge ways of thinking and behaving that had persisted perhaps over generations, for example, that someone was not allowed to speak to particular people or do certain things (PIE11-12). Addressing such issues linked with learning about the nature and severity of their symptoms, how these could be managed in *'right way for you, so you can live and have a decent life; it's that normalising of the experience'* (PIE6).

Clients whose childhoods were marred by physical, sexual or emotional abuse might not have the words to explain verbally either what had happened to them or how they felt about it. They would also be afraid of how the practitioner might react when the story was told and so they tested practitioners to see what they would do. As an example, one man had come for twenty-two sessions before he told his story (PIE10-12). Others needed to use non-verbal channels such as painting or to express themselves physically. For instance, *'one man put tissues around him... (he took tissues out of a box and put them right round his chair and that was it...His story was told'* (PIE6). Others used body language: *'he stood right behind me and by the fourth session he sat and he spent about ten minutes sitting. He didn't need to say anything he just sat there, never told me more. I didn't need to know, it was the fact he thought it was time enough'* (PIE6).

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Events such as these placed tremendous responsibility on practitioners particularly with regard to establishing trust, being non-judgemental and maintaining confidentiality (PIE1-5, PIE6). Achieving recognition as a trustworthy practitioner could take time.

Initially, clients would consider the practitioner in terms of that person's family: social standing, reputation, past events. After several years the focus would shift to the practitioner and how he or she behaved (PIE13&14).

b) Northern Ireland

This was a small city where the sense of belonging to a community, of having social support seemed very important. People felt a sense of pride in their city and were inquisitive about their neighbours, friends and family. Health and life expectancy was described as poor (PIE15). In terms of mental health there was a high incidence of anxiety and depression as a result of people living through and with the aftermath of the Troubles.

Throughout the Troubles the treatment and management of mental ill health was largely based on the use of medication such as tranquillisers, often in high doses, which helped people to cope with high levels of stress (PIE17, PIE18). Talking therapies were not used at that time because of the potential for breaches of confidentiality (PIE15, PIE17). Now that the political situation had changed there were many issues to be addressed. Two of the most pressing seemed to be a lack of expertise in dealing with trauma and a lack of respite care (PIE15, PIE18). The first attempt at mapping what support was available was undertaken in 1999 and led to the development of counselling services to enable people to cope with coming down from these high levels of stress (PIE17). For many service users, withdrawal from prescribed drugs was also an issue which, in itself, was very problematic. There were long waits for appointments in statutory services; the target for new clients was thirteen weeks but services were finding this difficult to achieve (PIE18). There were plans to place mental health professionals in GP clinics from 2008 (PIE18). Not everyone could afford to use voluntary services that required payment (PIE18).

ii) Irish cultural issues

a) Republic of Ireland

There was a strong sense of two Irelands co-existing in the same space. Each had features that could be seen as contributing to a very positive way of life but which, in certain circumstances, might lead in the opposite direction.

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Traditional Irish society was based on collectives, family, church, community in which only those with power could make decisions: parents and priests decided what should happen (PIE10-12). The family provided for all its members and took care of them when they became ill, old or infirm. Religion was an important part of this society and could provide great support for people with mental health problems. Asking the priest to see a client, who had something on their mind, *'in some cases did absolute wonders'* (PIE1-5). Priests continued, in some instances, to contribute to recovery from mental illness through a non-judgmental approach. For example, a woman admitted following an attempt at suicide could not settle until she had seen the priest who told her that if she felt like that again he hoped she would go to him first (PIE10).

However, certain expressions of traditional religious belief could make clients' situations worse. These focused on God as an authority figure who issued punishment for sin. This belief was said to persist even today. For example, wars and other terrible events were thought to occur because the people affected must have done something wrong. The same might apply if someone were black or not a Catholic (PIE10-12). Working with clients could involve challenging such beliefs.

There was a strong collective memory, in this traditional society, that was transmitted through each generation and which gave people pride in who they were. The strength of this collective memory was such that individuals might talk about past events, for example, the Famine, as if they had experienced them. Therapists sometimes had to help clients distinguish between past and present contexts (PIE10-12). This was particularly the case with regard to family reputations. The negative actions of one family member many years ago could taint future generations, seemingly for ever: *'Johnny's father was the same before him and then there was Johnny's grandfather'* (PIE6).

This was a culture in which it was polite to avoid confrontation and making a fuss. People were easily embarrassed. Thus it was not acceptable for a person to speak bluntly or straightforwardly about what was bothering them. For example, if a client did not like something that a particular practitioner had said or done they would not say anything outright to avoid making a fuss. Instead *'it might be like that for six months and (then) they might complain to somebody else about you but they won't complain to yourself. This thing about not wanting to make a fuss (is part of it) but there's also a feeling that you're actually going to make things worse. People are reluctant to ask for things because they might actually make things worse. Everything's been going ok, like this for years and let's just leave it as it is'* (PIE1-5).

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This roundabout way of dealing with things, coupled with the stigma attached to mental ill health, meant that people carried a lot of secrets. Where, when and how these secrets could be told and to whom was a constant issue that required considerable patience: *'it can take ten years to get the secrets'* (PIE1-5). There were places in which secrets could not be told. For example, *'a lot of people won't tell their secret in the home because you see, there, it contaminates their space. It's more likely in the environment of the office that you'd actually get them to say it'* (PIE1-5). For some people, even telling their secrets in the practitioner's office might not be right because there was the possibility of being seen entering the building; they preferred to travel for maybe fifteen or sixteen miles to see a practitioner in another place rather than take such a risk (PIE6).

This traditional society contrasted with that of the Ireland of the younger generation whose members were likely to be much more direct in dealing with issues such as mental ill health. They were far more open about it; their friends still visited them if they were mentally ill and there was no need to hide the fact that someone was unwell (PIE6). Young people no longer had to emigrate to find work but there were concerns that the economic bubble might be about to burst (PIE13&14). House repossessions were increasing and there was talk of a recession (PIE13&14, PIE7&8). Prosperity had brought new problems. Cocaine had followed the Celtic Tiger right across the country whereas previously illegal drugs had been largely confined to the Dublin area. For practitioners who originated outside Ireland, the availability and use of alcohol was alarming (PIE7&8).

b) Northern Ireland

There were no data relating to this issue.

iii) Migrant issues

a) Republic of Ireland

Traditional Irish society was a place that welcomed visitors, including many tourists, from many different parts of the world; many had been settled for anything up to twenty-five years (PIE13&14, PIE1-5). The poverty in Ireland and the lack of job opportunities had, in the past, led many young people to leave: *'you're talking about leaving in their droves, the sadness was in every house'* (PIE6). Even many professionals had gone abroad for at least part of their careers (PIE6). However, such exposure to difference did not seem to lead to integration or an understanding of what it was like to be a migrant.

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Irish society could be very insular even towards Irish people who moved from one village to another; people would be pleasant and polite to outsiders, to whom they referred as *blow-ins*, but that was as far as things would go: *'we'll be very friendly and very welcoming but only so far'* (PIE1-5). From the Irish point of view, whilst meeting and welcoming visitors was the right thing to do, it was by nature a transient activity. Visitors were meant to visit, not to stay. Recent immigration had changed all that; now people came to Ireland to stay and the Irish felt overwhelmed by this because immigration had happened so quickly with no transition period in which they could adjust (PIE13&14, PIE7&8). Practitioners had concerns about their ability to meet the needs of clients from minority groups; achieving the same depth of insight and understanding they reached with local people might not be possible with clients from other backgrounds especially if they experienced or exhibited signs of mental illness in ways that differed from the local population (PIE13&14, PIE1-5, PIE6, PIE7&8). Cultural difference was construed mainly in terms of language and difficulties in communication. Interpreters were available for the more common languages but the costs of booking them could be prohibitive (PIE1-5). Referral rates were reported to be low, allegedly because immigrants were paid only half the standard rate in many jobs and so could not afford health services for which they might have to pay (PIE7&8, PIE6). In addition there was a suggestion that maybe immigrant *'communities deal with issues themselves'* (PIE6).

Practitioners who were outsiders faced many challenges. It could take about a year to become familiar with the local accent, idiom and body language. Patients were often seen at a different stage of their illness when compared with the practitioner's home country and so practice had to be adapted to suit not only a different culture but also the level of need. Even then it could be difficult to clearly identify psycho-social issues that might affect progress particularly when clients were hostile to the idea of being treated or cared for by a foreigner.

b) Northern Ireland

Northern Ireland was receiving migrants from Poland, Portugal, China, Lithuania and many other places although numbers were very low. Service providers had undertaken mapping exercises to identify the level of need with regard to health care. The exercises included gathering information about occupation, languages spoken and level of education. Findings suggested that migrants lacked information about how to access the health service. For instance, in Poland, people would not automatically consult a GP (PIE16).

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This had led to misunderstandings with immigrants being charged for hospital treatment because they were not registered with a GP. There were also examples of hostility towards migrants. For instance, some GPs had told migrants that their patient lists were full (PIE16). However, some progress had been made in tackling these issues, for example through good practice initiatives, although more work was needed (PIE16).

Conclusion

This chapter has presented the findings drawn from data generated through the use of multiple methods of inquiry. These findings raise a number of issues for the care and treatment of Irish people, particularly in mental health services. These issues are discussed in the following chapter.

Chapter 4: Discussion

Introduction

The findings raised a number of key issues that had implications for the treatment and care of Irish people who use health services, particularly those seeking help when they are mentally unwell. This chapter presents a discussion of the implications of these issues which leads into the conclusions and recommendations that form the outcomes of this research and which are the basis of the executive summary set out in chapter 2.

i) Implications for delivering race equality

Survey findings revealed a lack of engagement between service providers and Irish people who have mental health problems. This lack of engagement was evident in a number of ways. First, during the data collection phase, it quickly became apparent that there was no single source of information about organisations that might provide services for Irish people or the nature of the help available. Statutory organisations were fairly easy to identify with the help of project team members from Birmingham and Solihull Mental Health Trust and the database held by Birmingham City University's Centre for Community Mental Health. Identifying voluntary organisations was rather more problematic and the project team had to draw on a variety of sources: the Birmingham Mental Health and Community Resource Directory 2006-7 (MIND 2006), internet searches, personal contacts and word of mouth. The mailing list developed for this project could be used to form the basis of a Birmingham directory of sources of help for Irish people.

Second, whilst organisations collected data about their clients via ethnic monitoring and the 2001 census, neither source was sufficient to develop a clear, reliable picture of the needs of Irish people. The 2001 census was the first in which a white, ethnic minority group, the Irish, was identified as a separate category. The census indicated that at least 600,000 people in the UK regarded themselves as Irish. The 31,467 Irish people in Birmingham made up 3.2% of the city's population and formed the third largest ethnic group (Birmingham City Council 2001). However, these census data cannot be regarded as accurate because some respondents will have found it difficult to decide whether to identify themselves as Irish, English or British because either they, or at least one of their parents, were born in England, Wales or Scotland. In addition, given the Troubles in Northern Ireland, some respondents may have preferred not to draw attention to their Irishness in any way, for fear of reprisals, and so cast themselves as English or British. Consequently, whilst census data may indicate that Irish people form

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a substantial minority within the population, it is not clear exactly how many Irish people are in the UK or in Birmingham.

Similar issues apply with regard to ethnic monitoring. Until recently, Irish people were not included in ethnic monitoring in any systematic way. Recent changes in health policy have tried to address this situation, for example, through the census of mental health clients belonging to minority ethnic groups, which included the Irish, but the fact remains that counting Irish people in England is problematic (Mental Health Act Commission 2005, DOH 2005a). Thus it is possible that lack of engagement between service providers and the Irish simply reflects the historical exclusion of Irish people from official statistics. If this is the case then it is imperative to establish other, reliable sources of information. One solution might be to consult with Irish people but there was little evidence of this and an apparent lack of contact between services and Irish welfare organisations. Only two respondents reported any contact; one had advertised services at the Birmingham Irish Welfare and Information Centre and the other had established a working relationship that had been in place for several years but which was, at times, hampered by staff shortages in the statutory organisation concerned. These two instances aside, request for names and contact details of Irish welfare organisations, together with an outline of the services they provide, indicates that organisations are operating without any advice or input from those with up-to-date experience of working with Irish people. The overall impression is that the distance between the general provision of services and Irish people is very wide indeed. This may, in part, explain the inability of respondents to identify aspects of their services that might inhibit their uptake by Irish people. Instead, respondents hypothesised about the possibility of pride, stigma or lack of confidence; in other words barriers were formed by the clients rather than the services. In this situation it is no surprise that negative stereotypes of Irish people, about which participants complained, continue to persist.

Bringing about change is dependent on the extent to which organisations take seriously their legal duty to collect data and the extent to which Irish people are included. Current evidence from the Health Care Commission suggests that, on a national basis, far more effort is needed to promote race equality for clients and staff in the NHS (Johnson and McGee 2008, Department of Health 2005). Similar work may be required in the voluntary sector. What is important is that organisations find appropriate ways to identify Irish clients and develop an expanding knowledge base about their needs that constantly informs policies, procedures and practice.

Conclusions and recommendations

In Birmingham, statutory and voluntary organisations provide a wide range of services for people with mental health problems but it does not follow that these are designed or delivered with Irish people in mind. Service providers seem to have limited information about Irish people and their culture; engagement between service providers and Irish welfare organisations appears to be limited. It is, therefore, recommended that

- i) Advertising should target mental health service providers and commissioners to promote awareness of Irish welfare organisations and the services they offer.
- ii) Attention is paid to the development and maintenance of a resource that provides details of the principal agencies that provide help for Irish people, particularly those with mental health problems and carer support.
- iii) Inter-agency networking and cooperation, in which statutory and voluntary organisations work together, should be encouraged. This cooperation requires sustained commitment from all parties, and include, where necessary, designated staff who cannot be withdrawn to cover shortages in other parts of the service.
- iv) The promotion of race equality and ethnic monitoring should include the Irish, alongside other minority ethnic groups, as a basis for developing a knowledge base that informs organisational policies, procedures and practice.

ii) The health of Irish people

Findings demonstrated that many Irish people born in Ireland have poor physical and mental health and that their descendants fare no better. Over half of the 415 people who attended the Irish elders clinic were diagnosed with depression and of these, 46 people had suicidal feelings. Eighteen of the participants interviewed had mental health problems, the most common of which was depression.

These findings are supported by several earlier reports which demonstrated high levels of mortality and morbidity that exceeded that of both other immigrant groups and the host population. For example, Bracken *et al.* (1998) asserted that Irish people, particularly men, were twice as likely as white British people to be admitted to hospital with depression and alcohol-related problems. Rates of admission for Irish people continue to be higher than those of the white British.

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Routes into hospital care for Irish people vary but are less likely to be based on GP referral than those for white British clients (Mental Health Act Commission 2005). Leavey (1999) found that Irish people were more likely than their white British counterparts to commit suicide. In his view Irish people found living abroad, particularly in the UK, stressful. This is a not uncommon view. Kelleher and Hillier (1996) argued that migration from Ireland to England was a journey from a society coping with the legacy of oppression to one in which the oppressor predominated. In coming to England, Irish people found that they had to deal face to face with a society that had historically, and very recently, considered them inferior. Thus the legacy of colonialism and the political issues surrounding Northern Ireland militated against the formation of a positive Irish identity in Britain (Aspinall 2002, Walsh and McGrath 2000, O'Meachair 1996).

Karlsen *et al.* (2005), in an exploration of the links between racism and mental illness in members of minority ethnic groups, including 733 Irish people, identified a relationship between disorders such as psychosis and the experience of verbal and physical racist abuse. They estimated that the annual prevalence of psychosis among Irish people to be about 10 per thousand, higher than that for Bangladeshi people but less than Indian, Pakistani or Caribbean people.

In a longitudinal study in the west of Scotland, Abbotts *et al.* (2001a, 2001b, and 1999) found that older adults of Irish Catholic descent were more likely than their white Scottish counterparts to suffer from depression. Stillwell *et al.* (2004) found that Irish girls in Britain were more likely to engage in alcohol abuse than young people from other backgrounds.

Thus the findings of this research are consistent with those of many previous studies. Where this particular research differs is, perhaps, in drawing out the interrelatedness of mental and physical health. Among the first generation, thirteen of the twenty-seven participants experienced mental and physical health problems: seven men and six women. Among the second generation, all six women and five of the seven male participants reported the same situation. Mental health problems, such as acute anxiety, caused distress that was experienced both psychologically as fear and physically as symptoms that incapacitated the individual (SU14). Similarly, physical conditions such as heart disease led to acute anxiety (SU29).

These findings suggest that asking participants about their overall health, rather than focusing only on a particular aspect of it, may contribute to a more holistic understanding of the factors that contribute to the serious difficulties that many Irish

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people experience. This interrelatedness was also evident in examining what participants, both those born in Ireland and those born in England, found most helpful with regard to mental health, what did not help, and why. Overall, a great deal of what members of both groups considered most helpful hinged on relationships with professionals whom they could trust. A good GP, psychiatrist or CPN with whom a relationship could be developed over a long period of time, was essential and highly valued.

For example, SU40 was able to contact her CPN by phone if an emergency arose; she had done so only twice in twelve years but nevertheless she valued being able to make contact if necessary. SU1 and SU13 valued their relationships with their local pharmacists who ensured that they received their medication. Participants welcomed the time given to them and, for some, medication could provide some relief from symptoms. Even when medication did not work, the contact with professionals and what they provided, offered hope and the prospect of change.

Whilst participants valued these relationships they still maintained a distance between themselves and the professionals, rarely trusting enough to tell them their secrets. Some professionals were aware of this, commenting that clients would sometimes reveal snippets of information but then say that the rest is too horrible to talk about. Some of this reluctance can be understood within the context of participants' experiences of unhelpful relationships with other professionals who laughed at them (SU32), treated them as a joke (SU6, SU41), refused help (SU17, SU14) or stereotyped them as an alcoholic, even if they never drank (SU5, SU23, SU32). Such negative attitudes and behaviour towards Irish people reflected, in participants' opinion, both a lack of understanding of '*what Irish people are like*' (SU23) and a more general absence of care. Other criticisms included seeing a different psychiatrist every few months (for example, SU1), being unable to access support between appointments, long waiting periods when referrals were made and day centres that did not encourage clients to make progress (SU23 SU5). Medication and even admission to hospital might be helpful but not if staff could not be bothered to listen to clients, explain what medication had been prescribed or why, when and how it should be taken (SU13, SU14).

Such criticisms have to be considered initially within the context of individual experience. For every participant who found mental health service provision helpful, there was another who had experienced the opposite. Nevertheless, there do seem to be issues about continuity in care and the negative stereotyping of Irish people,

Irish mental health in Birmingham: what is appropriate & culturally-competent primary care? particularly with regard to alcohol. For some participants the overall impression was that all Irish people are drunks and so '*this is all you're worth*' (SU5).

Whilst some participants did have histories of heavy drinking (for example SU27, SU32, SU41) this was, in several instances, associated with either learned behaviour acquired whilst working on building sites or underlying trauma such as sexual or physical abuse. Some professionals acknowledged this, arguing that it was the trauma and ensuing mental health problems that led to drinking alcohol rather than the other way around (SP9, SP15). Despite this, service users felt that professionals focused on the drinking rather than the underlying problems.

Voluntary organisations were also a source of help. Birmingham Irish Welfare and Information Centre's linkworkers were held in high regard, by some of the participants born in Ireland, seven of whom had sought help in dealing with officials and complicated paperwork or securing a move to more appropriate accommodation. The Centre also supported people who were trying to give up alcohol. For some participants, the Centre's help brought real benefits that improved their quality of life although some worried about the possibility that this help meant that they were receiving charity. In contrast, only three participants who were born in England had used the Centre. SU3, for example, was unaware that it existed until she began attending therapy sessions nearby.

Immigrant Counselling and Psychotherapy was also praised by a small number of participants; two were born in Ireland and two in England. The main reason was that practitioners there understood their clients' backgrounds. However, other participants did not know that Immigrant Counselling and Psychotherapy existed.

A final potential source of help was the Catholic Church. Amongst the older adults born in Ireland, only one continued to be an active member although others still believed in God; most had parted company with the Church or drifted away from it. This situation contrasted with experience of one of the younger participants and with those born in England. It suggests that at least some older Irish adults feel alienated from the Catholic Church because of personal experiences of abuse or because they have simply lost interest. Consequently, care must be taken in broaching the subject of the Church as a possible source of help or support.

Implications for practice and service provision

Individually, practitioners were aware of many of the issues surrounding Irish people and health. SP9 for example, saw, on average, five or six Irish clients each week and could comment on the level of need as he experienced it. Those with managerial responsibilities were able to comment on the absence of the Irish in service planning, the ways in which ignorance about Irish culture encouraged stereotyping (SP3, SP7). Members of staff such as SP9 and SP3 also noted that their professional education and in-house training courses failed to address the culture and health of Irish people. Cultural dimensions of care were conceptualised in terms of those of non-western, non-European origins and, consequently, practitioners were better prepared to care for South Asian clients than those whose roots were in white minorities such as the Irish. Recent migration from an expanded Europe has changed the profile of those likely to be accessing mental health services in future. In this context, learning to provide culturally competent care for Irish people is the first step towards meeting the needs of other, newer minorities.

Ireland-born members of staff in both statutory and voluntary organisations noted that their presence could be helpful and comforting to Irish clients who were terrified of what was happening to them (SP11, SP16, SP10). They and England-born staff with Irish parents could interpret and translate, prevent misunderstandings and misdiagnoses. Thus they could use their own Irishness to help and support clients. These activities have been documented in relation to other minority ethnic groups. McGee (2000), in a study of culturally-competent care in acute general hospitals, found that nurses from other cultures were regularly required to interpret and perform other services for patients who shared their cultural background. The nurses were happy to take on these responsibilities, although often they had no choice, and the patients welcomed their presence. However, the nurses also complained about the pressures they experienced from both patients and colleagues. The patients would save up their problems and requests until the nurses were on duty.

Nurses who had not been educated in languages other than English could struggle when asked to interpret complex medical treatment or sensitive information, particularly if they were still students or junior practitioners. Colleagues seemed not to appreciate how stressful the responsibility could be and often assumed that, because the nurses could speak, for example, Urdu or Polish, that they could also speak any other language. This could generate hostility if nurses tried to explain that this was not the case; further hostility could arise if they spent too much time interpreting and failed to complete their other work. Thus the nurses had to cope with high levels of stress and a

lack of support. Similar situations may arise if Irish members of staff are to take on roles in which they have to advocate, interpret or perform any other role that involves using their Irish backgrounds. Moreover, it should not be assumed that they will all wish to do this.

Conclusions and recommendations

Many Irish people face multiple health problems regardless of whether they were born in Ireland or in England; mental and physical health problems are interrelated. Irish people are atypical in that, among most minority ethnic groups, the health of members of the second generation shows an improvement when compared with their parents. Individually, those who look after and support people with mental health problems do their best to provide good care for all clients, but their professional preparation does not equip them to address the cultural dimensions of looking after Irish people. Whilst individuals are aware of Irish people's needs and Irish members of staff use their own ethnicity to facilitate therapeutic relationships, too much depends on individual good will. There is no evidence of organisational commitment to change. It is, therefore, recommended that:

- i) Current emphasis on cultural competence within the preparation and continuing professional development of practitioners should be further developed to include a focus on white minorities such as the Irish. This is an essential part of developing a workforce that is fit for future practice.
- ii) Organisations that provide services for people with mental health problems should expand their commitment to clients by recognising the inequalities that Irish people experience and supporting staff in bringing about change. This commitment should be made evident through policies, procedures and practice.
- iii) Attention is paid to tackling the negative stereotyping of Irish people, particularly with regard to alcohol.
- iv) Staff development about diversity in mental health care should be expanded to include the health care needs of Irish people. Service provision would be retained at its current points of delivery, but with raised awareness and support.
- v) Assessment of Irish clients should include specific questions that reflect health patterns and trends among Irish people.
- vi) Liaison with Irish welfare organisations should become part of established practice when working with Irish clients.
- vii) Irish members of staff should not be pressurised into acting as interpreters or advocates for Irish clients. Members of staff who are happy to take on

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these roles, should, regardless of the ethnic groups concerned, receive organisational support.

- viii) Irish welfare organisations could do more to make Irish people aware of the services they have to offer.

iii) Born in Ireland: Irish culture and health

Findings revealed a great deal about the nature of traditional Irish culture. The importance of understanding this culture is essential to practitioners and service providers working with Irish clients. Learning about the cultural context in which events occurred may facilitate the development of a deeper understanding of the presenting difficulties. This is not to say that learning about Irish culture should be a history lesson but that certain aspects of the past will help to clarify several current issues.

a) Sending money home

The main reason that participants gave for leaving Ireland was to earn money. Ireland was, at that time, a predominantly rural and extremely poor society in which the export of young people was a financial necessity. Going abroad, was not, primarily, about finding a new, more prosperous life but about sending money home to support parents and younger family members, some of whom the emigrants never met. Coming to England did not seem to involve a great deal of planning. In comparison to America or Australia, England was very close and easily accessible; less than a day's travel and thus an attractive destination (Kelleher and Hillier 1996, Clarke 1998, O'Dwyer undated, O'Meachair 1996). Consequently, some individuals seemed to almost drift into England. SU35, for example, travelled with his sister because she needed help with her luggage; he didn't intend to stay but time passed and so did about forty years.

This lack of planning seems to have continued into life in England. Young people who arrived in the 1950s, 1960s and 1970s, especially the men, took unskilled jobs and led transitory lives moving from one job to another in different parts of England. They lived in rented accommodation and never settled anywhere. O'Grady and Pyke (1997) have vividly described this life: the craic in the pub, the company of other men and pride in the physical strength needed to do hard, manual work. This contrasts with the often primitive accommodation, the long emptiness of Sundays in which, after Mass and the paper from home, there was nothing to do until work started the next day. In later life, when there was no work at all, that emptiness and loneliness became a way of life (O'Grady and Pyke 1997).

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An additional factor in this life was the cultural differences between Ireland and England. Even young, fairly recently arrived participants, such as SU42, expressed surprise at the cultural distinctions between English and Irish society. The underlying assumption seemed to be that geographical proximity, a shared language and a long period of colonisation would mean a close similarity between the two countries. Reality appears to have been something of a culture shock in which, like other adult immigrants, participants experienced '*loss of cultural integration and challenges in adapting to a new environment*' that may precipitate mental health problems (Breslau *et al.* 2007 p190).

An integral part of this cultural difference was encounters with anti-Irish sentiments. Historically, British attitudes towards the Irish have been characterised by racism, discrimination and oppression. Irish people were portrayed as animals in the British press and regarded as subhuman (Curtis 1971, Curtis 1984, Keneally 1999, Scally 2004). Until the introduction of legislation about race relations, employers and landlords could advertise vacancies and, at the same time, openly state that Irish people were not welcome, hence the comments by some participants in this study about signs stating that no Irish people could apply for jobs or accommodation. Prejudice and discrimination continue today in more subtle forms that serve to socially exclude Irish people from society in ways that may adversely affect their mental health, a view supported by Breslau *et al.* (2007) who argue that the United Kingdom is one of the five countries in which immigrants are most likely to develop psychotic disorders.

Nevertheless, there was, and still is, an element of ambivalence in this hostility. In the 1950s and 1960s England needed workers to staff factories, building sites and the public services. This created opportunities for foreign workers and, as Hillyard (1993) observed, the Irish were, if not welcomed, then at least tolerated in this context. What caused the situation to change was the impact of the Birmingham pub bombings in 1974 that led to the introduction of the first Prevention of Terrorism legislation later that same year. Subsequent bombings and the extension of anti-terrorist measures '*all played their part in making the Irish living in Britain, or Irish people travelling between Ireland and Britain, a suspect community*'. (Hillyard 1992 pp257-8). The political situation has changed; the Irish no longer occupy the same position as a suspect community and certain elements of Irish culture have become almost fashionable. Nevertheless, anti-Irish sentiments have not gone away, an attitude of orientalism prevails in which Irishness is both idealised and denigrated (Pointon 2007).

In addition to living and working in England, participants had to contend with the consequences of never returning to live at home. It is important to emphasise the distinction between this and the country; links were always about home, parents, family and the farm rather than Ireland. Over the years links with family who stayed at home became more difficult to maintain. Parents and friends died, each representing a lost link with home. Those who remained did not always seem to welcome or want to know about emigrants. Even where participants had maintained good family links with Ireland, these were tinged with regret for the lives they might have had if they had gone home. Homesickness persisted even after many years.

These experiences do not appear to have been documented by many Irish people but they are by no means unique. For example, Anwar's (1979) study of Pakistani immigrants in Britain amply demonstrated the experiences associated with migration. What begins as a move to earn some money, just for a few years, is gradually extended because, for example, finding well-paid work was not as easy as anticipated, more money is needed at home, some individuals are better equipped to cope than others, relationships develop and children are born. Those who do go back can find it difficult to settle down into the lives they once led; they feel aliens in their home societies as well as the ones to which they migrated (Anwar 1979). Thus what this research and discussion suggest is that coming to England was not part of a long-term plan to make a new life. Employment was mainly in manual occupations; wages were sent home to parents, living accommodation was a rented room. There was no opportunity and no incentive to save, buy a house or settle down because there was always the possibility of going home. Similar experiences have been highlighted by other minority ethnic groups but do not appear to have been documented in relation to Irish people.

b) Escaping from Ireland

A second reason for leaving Ireland was the experience of some form of trauma in childhood or early adult life, for example, sexual or physical abuse, bereavement, parental suicide. It must be emphasised that this applied only to a small number of participants but, nevertheless, coming to England offered them a means of escape from intolerable situations. Whilst it is important to note the abuse itself, the context in which it took place is also relevant. Until the 1970s Ireland was, in effect, a patriarchal, authoritarian theocracy controlled by the Catholic Church (McCluskey 2000, Kearns 2004). The Church, rather than the State, was the main provider of social care through the religious orders, whose members enjoyed high social status (McCluskey 2000). Within this society emphasis was placed on conformity and discipline; failure to comply

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carried not only social but spiritual consequences. Added to this was the cultural value placed on privacy which, as participants in this research observed, meant that many things were never discussed outside, and maybe not even inside, the home. This was a context in which those with the power could inflict cruelty on others (Mollon 2000).

In documenting the lives of women, Kearns (1994, 2004) has shown how religious and social systems inflicted cruelty on women. Women were required to obey their husbands with regard to sexual matters. The priests enforced the idea that '*your husband was your lord and master ...obey your husband and that's it!*' (Kearns 2004 pxix). Sexual, physical and emotional abuse meant that many women had more children than they could provide for and were old before their time.

Children were also subjected to what might now be regarded as cruelty; attitudes towards them were very different to those that pertain today. Children were seen as intrinsically evil and in need of discipline from parents, teachers and anyone else responsible for their care (McCluskey 2000). In fairness this attitude was not confined to Ireland; having a close, loving relationship with one's children is a fairly recent idea (Bluglass 2003). However, Irish society has recently had to face up to events that went well beyond acceptable child-rearing. In 1997, a Radio Telefís Éireann programme revealed abuse that had taken place in a children's home over many years. This was the first step in the development of scandal that touched every part of Irish society as it became clear that staff in other institutions had also perpetrated abuse. The impact and the scale of these revelations were so profound that writers such as McCluskey (2000) have equated them with that of the Famine: so terrible that no one could believe it but, at the same time, having to accept that it had happened.

c) Silence, secrets and shame

A persistent theme in participants' accounts was that of the cultural value placed on privacy and not talking about family business outside the home. In traditional Irish society the family was a cultural icon, a model of the Holy Family, an ideal, to which everyone had to aspire (Walter 2001). This cultural value has implications for mental health practice in that clients will not readily divulge what is really troubling them. Participants in this research made plain that they did not tell professionals their secrets; sometimes they did not even tell their own families because they were ashamed. SU21, for example, had not even told his wife that he couldn't read and SU41 never told anyone at home when a monk at school raped him. Bluglass (2003) suggests that holding secrets is a way of coping with traumatic events, as though shutting off a part of the self enables the individual to function with apparent normality, whilst in reality,

individuals who do this are likely to be highly preoccupied with whatever happened to them. This was certainly the case for SU21 whose elaborate strategies for hiding his inability to read required constant vigilance and maintenance.

Contemporary Irish mental health practice seemed to take account of secrets. Practitioners recognised that clients would not easily reveal their secrets; it could take months or even years before such revelations were made. Practitioners seemed to be members of the local culture; their families had, in some instances, been in the locality for generations. They saw their clients over long periods of time and thus had time to build relationships. Clients for their part had time to do the same, to establish when, where and to which practitioner their secrets could be told. Local practitioners could thus be regarded as receivers and keepers of secrets. This suggests that local practitioners, embedded in the culture, are not unlike traditional healers, roles that occur in every society to minister to the sick and distressed. In doing so they are able to incorporate physical, psychological and spiritual dimensions of care in ways that are meaningful to their clients (Helman 2000, Nolan 1989). In traditional Irish culture, there were individuals who were said to have the cure for particular conditions; it is possible that, in modern Ireland, this type of role has been reconfigured as that of a receiver and keeper of secrets (Nolan 1989). This may have implications for mental health practice in Birmingham. Practitioners will need to be aware that clients may not reveal the full story of what has happened to them; that clients need a long time to build up relationships and decide whether they can trust practitioners. Participants' complaints about lack of continuity (for example, SU23, SU1), the entries made in their notes and the possible consequences of this (for example, SU5, SU17) are factors that will militate against the revelation of secrets.

d) Not making a fuss

Allied to the keeping of secrets was that of not wanting to make a fuss about anything by drawing attention to one's misfortunes or difficulties. Practitioners remarked that, in traditional Irish society, people would not consult a doctor unless they were, in their opinion, very ill indeed. Findings presented in this report illustrate that reluctance to seek help. SU34, for example, did not want to bother the doctor even though she was clearly not well. Such attitudes may be laudable up to a point; frequent consulting over minor ailments is not necessary but, as older adults, most participants had multiple, long-term health problems that required treatment and careful management (Department of Health 2005b). Left untreated, long-term conditions such as arthritis, heart disease and depression will, in many instances, cause irreversible damage and poor quality of life. In this context linkworkers proved invaluable in encouraging Irish

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people to see their GP; the ensuing medical assessments revealed a wide range of health problems that would otherwise have gone untreated. Thus the linkworker activity promoted access to and engagement with mainstream services, a way of working that has been applied with other marginalised groups such as the homeless (McGee and Barnard 1999). The aim is to facilitate social integration so that individuals are valued and supported on the same basis as everyone else. Thus the facilitation is more about in-reach, that is to say, reaching into the mainstream services, rather than reaching out. In-reach is the antithesis of separate services in which minority groups are ghettoised and further excluded. Such apartheid service provision is not consistent with culturally-competent care.

e) New Irelands

The older adults in this study left Ireland as young people. Many were still teenagers when they arrived. Over the ensuing forty or fifty years, as family members and friends died, links with home were gradually broken. Those who went back to visit could feel like outsiders even though their relations welcomed them. Homesickness and regrets for the lives they might have had persisted over many years. The problem was that the homes they left were gone; not only did parents and relatives die, Irish society is changing.

In the Republic of Ireland, membership of the European Union has brought an unprecedented level of prosperity, a Celtic Tiger, to Ireland giving rise to a different society in which younger people lead very different lives to those of previous generations. Ireland no longer needs to export young people; in fact they are more likely to migrate there from Poland, Latvia and other European states. However, this economic boom is not evenly spread across the country (Clarke 1998). The rate of suicide in Ireland has risen, especially amongst young men (Lynch *et al.* 2004). Migrants bring or will develop their own mental health difficulties with which Irish mental health services are ill-equipped to cope.

In Northern Ireland, now that the political situation has changed, there is a new, different Ireland emerging. Inevitably, in the aftermath of the Troubles, there are a number of mental health issues. An estimated one in four people consult their GP because of mental ill health and an approximately 83,000 people suffer from some form of mental illness (Eastern Health and Social Services Board 2003). There is an urgent need to introduce talking therapies. Nevertheless, change is happening and redevelopment is taking place.

Thus it is no longer appropriate to conceptualise Ireland as a homogenous entity. Rather there are now multiple Irelands: traditional, Celtic Tiger, the Northern Ireland of the Troubles, Northern Ireland after the Troubles; the Ireland of immigrants and immigration and finally the Ireland of the tourist. All are competing for cultural space, reconceptualising old values and configuring new approaches to life.

Implications for practice and service provision

Practitioners and service providers who were not born and educated in Ireland knew little about Irish culture and tradition. What knowledge they possessed appeared to come from two sources: Irish colleagues and, for some, Irish parentage. Useful though these sources were, they depended on solely on personal contact. Learning from parents was inevitably focused on family rather than Ireland and this primarily about personal ties rather than professional practice (Walter 2001). Thus people with Irish parentage might know little about Ireland except as it impinged on their own family. Those who attended English schools will have learned to see the Irish through a prism of Englishness. In order to develop a deeper understanding of their Irish clients, practitioners and service providers need to know something about the context from which they originated and their lives in England. The experience of displacement, the pressure to send money home, coping with racism are all familiar themes in relation to other migrants but, for older Irish people, there is the additional legacy of their status as a suspect community (Hillyard 1992).

All these factors have implications for mental health but care must be taken to avoid perpetuating stereotypical assumptions. Whilst some people did suffer terrible abuse, poverty and many other serious difficulties before they left Ireland, it does not follow that everyone in and from Ireland should be regarded as a victim. Not everyone was dysfunctional. There were many parents, members of religious orders and priests who did not ill-treat children or perpetrate any other form of abuse. Some Irish people did well in England; married, bought houses, brought up children. Indeed one of the characteristics that emerged in listening to practitioners with Irish parents was the apparent absence in their lives of the drinking and violence that blighted the lives others who ended up as service users. Thus it is essential to ensure that any staff development programmes that focus on Irish mental health present a balanced picture.

A second consideration is the cultural value placed on privacy. Irish people can be very reluctant to seek help about medical problems. This research has demonstrated the vital role that linkworkers can play in facilitating access to services. If in-reach is to be successful, practitioners and service providers need to establish regular liaison with

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linkworkers to support clients in navigating their progress through the mental health system.

Liaison with linkworkers will also be beneficial in establishing therapeutic relationships that provide clients with spaces in which to tell their stories. Capturing the client's readiness to tell his or her story requires considerable skill; an ability to recognise the significance of seemingly innocuous signals and to respond appropriately because the client will probably only make one attempt (Benner 1984). Services in Ireland do not necessarily have more practitioners than those in Birmingham but those they have are embedded in the local culture. They are, therefore, attuned to the social and cultural signals that clients provide. Receiving the story, and the client's closely guarded secrets, also requires skill. Some of the stories and secrets collected in this research were extremely painful to hear; listening to such accounts takes patience, empathy and time. Even more challenging are those stories that cannot be told verbally because the client has no words for what happened. Sitting in the room with the man who arranged tissues was probably a very unsettling experience for the practitioner but she was able to recognise the man's actions as non-verbal storytelling. Consequently, she accepted the story, and the secrets within it, even though she did not know what these were (PIE 6).

Conclusions and recommendations

Recognition and understandings of the cultural differences between Ireland and England is an important step in providing culturally-competent mental health care. Inherent in this step is the need to avoid stereotypical thinking; Ireland is not a homogenous, static society but one in which a great deal of change is taking place. There are now multiple Irelands with differing cultural values and beliefs.

Nevertheless, caring for older adults does require some understanding of traditional Irish society and the lives of those who migrated to England to find work. Sending money home, working in manual jobs, living in rented accommodation became, for many migrants, a permanent way of life. Factors such as exposure to anti-Irish racism and, for some, the legacy of trauma and abuse that caused them to leave Ireland, are all have a bearing on their mental health.

Added to this, is a cultural value placed on privacy and not talking about private matters outside the home. Older Irish people tend not to seek help with health problems. The role of linkworkers is highly beneficial in enabling them to access and use mainstream health services thus promoting social inclusion. The skills of mental health practitioners

Irish mental health in Birmingham: what is appropriate & culturally-competent primary care? and service providers are important in establishing therapeutic relationships in which older Irish clients feel able to tell their stories.

Finally, Irish migrants appear to share many of the experiences of other minority ethnic groups and further work is needed to document the ways in which being Irish, in a city such as Birmingham, has changed over time. This could have important implications for future health planning and for the Birmingham Irish community as a whole. It might also allow for the development of some comparative studies that examine Irish experiences alongside that of other minority groups, a factor that receives very limited attention from researchers*.

It is, therefore, recommended that

- ii) Professional education and staff development should aim to present a balanced view of Ireland that takes account of the
 - a) the ways in which Irish cultures differ from those in England;
 - b) changes that have occurred in both the Republic of Ireland and Northern Ireland.
- ii) Consideration should be given to supporting and further developing the linkworker role to facilitate in-reach that:
 - a) enables Irish clients to access, negotiate and integrate into mainstream services as a strategy for improving health and promoting social integration;
 - b) supports, or liaises with, local mental health and Irish welfare organisations.
- iii) Attention is focused on the specific ways in which practitioners can use their expertise to work therapeutically with Irish clients, particularly those with histories of trauma.
- iv) Further work be undertaken to document Irish people's experiences of coming to England and living as members of a minority group, in different decades, with a view to identifying changes in health needs and promoting more comparative research.

iv) Born in England: the hybrid generation

Growing up in England as the child of Irish migrants gave rise to many experiences that have only recently received attention from researchers. There is growing evidence that, as in other minority groups, the children of Irish migrants are finding ways of

* The project team wishes to thank Dr Louise Ryan, Middlesex University for this point.

establishing their own identities; neither wholly Irish nor completely English. Some of the issues raised by participants have implications for mental health practice and are discussed below.

a) Who am I?

Participants such as SU3 and SU17 illustrated the dilemmas surrounding identity for those who were not born in Ireland. Like many others they went to Ireland in the school holidays to visit grandparents; an exciting trip but in adult life engagement with Ireland was more problematic. The absence of an Irish accent as the key marker of ethnicity, coupled in some instances with an English surname, could mean that any claims to Irishness were met with disbelief, hostility and the abusive term '*plastic Paddy*' (SU3).

The source of much of this hostility appears to be Irish people themselves. Gray (2006) suggests that the Irish people born in Ireland tend to be dismissive of second generation people. Indeed one of the largest groups is the "English", the children of the people who left Ireland in the 1950s, who have come to live in the places their parents left, and who are often looked down upon by those who believe that Irishness can only be transmitted by two Irish parents and birth in Ireland (McWilliams 2007, Gray 2006). Thus, those who left for England were not only leaving home but leaving the chance to create a new generation of Irish people. Any children they brought or sent back '*didn't meet the criteria*' and so could not be accepted (Gray 2006 p214).

These children grew up negotiating the dual culture of the home provided by the Irish parent or parents and the English society in which they lived. Just as their parents, identities were bound up with home, that is to say family and farm, so theirs became connected to the cities in which they grew up. Thus new Irish identities developed based on English cities: London Irish, Birmingham Irish, Manchester Irish. These add a new, fluid dimension to the concept of Irishness and Ireland that allows for selective engagement. Participants could chose when and where to bring their Irishness to the fore and when to lay it aside.

b) Cultural brokers

The fluidity of this identity meant that children with Ireland-born parents were able to successfully negotiate problematic aspects of life in England on behalf of adults. This was particularly the case following the Birmingham pub bombings in 1974. Irish accents meant that their parents would not be served in shops and so the children had to the shopping (SP7). Poor levels of literacy meant that children might be required to

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help with writing letters or addressing envelopes to send money home (SP7). This type of activity continued in adult life when parents needed help to communicate with officials (SU23).

Such activities can be seen as a form of cultural brokerage in which an individual mediates between two different cultures (Jezewski 1990&1993). Acting as broker requires the ability to communicate effectively with both parties and mediate between the two, something that the children of Ireland-born parents seem to have taken on, in much the same way as young people in other minority ethnic groups. As far as Irish people are concerned, this is a neglected topic. Nothing is known about the extent of this type of cultural brokerage, in part because of the stereotypical assumption that language and literacy levels are not matters of concern when dealing with Irish people.

However, the findings of this research indicate that many Irish people speak English using a distinctive idiom that may not be readily understood, especially when it is accompanied by an unfamiliar accent. Findings also suggest that a small number of older Irish people are either completely or functionally illiterate and that, for some, English is not a first language. This obviously has implications for therapeutic interventions as well as issues relating to patient information and consent. It is worth noting that the recent trend in favour of Irish medium schools, in both the Republic of Ireland and Northern Ireland, may mean that future Irish migrants will be more comfortable expressing themselves in Irish rather than English.

c) Silences, secrets and family life

Half the participants in this group talked about their relationships with their parents. Parental behaviour was, in some instances, unpredictable and violent. From their children's point of view it also seemed disconnected, unrelated to anything they had or hadn't done: the news on the television, potatoes, anything seemed likely to trigger a parental response out of all proportion and relevance to what was happening around them at the time. It is important to note that not all parents behaved in this way. Some were simply embarrassing, for instance, shouting and accusing people in the streets with the florid manifestations of their mental ill-health. Even where aberrant behaviour was not reported, relationships with one or both parents were strained.

These findings are consistent with several issues arising from the literature. Herman's (1997) writings about the legacy of abuse indicate that profound psychological trauma can interfere with normal development and the essential structures of the self. Individuals become disconnected from others '*they lose their trust in themselves, in*

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other people, and in God. Their self-esteem is assaulted by experiences of humiliation, guilt and helplessness' (Herman 1997 p56). Associated with this may be an ever-present memory that can easily be triggered by seemingly innocuous events such as those recalled by participants. These triggers may be part of the apparatus that transmits violence and trauma from one generation to the next without any explanation as to what happened to start it off in the first place (Mollon 2000).

Breslau *et al.* (2007) offer a different explanation. In their view, migrants could, and according to their survey did, arrive with good mental health which did not last. Migration during childhood and long length of stay for those who arrived as adults, both contributed to a deterioration in mental health. The transition from low to high risk for mental health problems can occur rapidly and within a generation. Thus '*protective factors are not preserved across generations among immigrant communities*' (Breslau *et al.* 2007p193) which may explain why some of the participants born in England developed mental health problems.

A third explanation is that parental behaviour was consistent with the cultural value placed in Irish society on silence; certain things and events were not to be discussed outside the family which in this case meant the family, at home, in Ireland. Children born in England were and were not a part of this family. They might be taken home to visit grandparents during the summer holidays but they did not fully belong. It was their parent's homes that they visited and not their own. In not telling their children about family secrets, especially those that might be horrible or shameful, parents excluded their children from being family. Thus children could not develop an understanding of why their parents behaved as they did but, nevertheless, carried the symptoms of those people's distress.

Implications for practice and service provision

The children of Ireland-born parents face a number of challenges in negotiating their own identities as hybrids. Those whose parents were very damaged people seem to have become symptom carriers of their distress. Practitioners need to be aware of the potential for trauma to have a long-term impact that is transferred across generations. Acting as cultural brokers may also have impacted on their developing identities as it creates the potential for disruption in normal parent-child relationships. Thus in assessing and working with clients whose parents were born in Ireland, it may be useful to enquire not only about family relationships but also the ways in which children supported the family through acting as brokers.

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Linkworking would seem to be a form of professional brokerage that facilitates access to services and a pathway through officialdom. Linkworkers regularly helped older Irish people to fill out forms, negotiate with officials and generally deal with the business side of life. Much of this activity appears to be undocumented. Linkworker roles are well established in relation to other minority ethnic groups but little recognition has been afforded those working with Irish people. Linkworkers have much to offer practitioners and service providers in terms of their knowledge of their clients and Irish culture. In sharing their expertise, mental health practitioners can, in return, inform the development of in-reach work.

Conclusions and recommendations

The children of Irish migrants occupy a unique position with regard to Irish and English societies. Their identity appears to be characterised by hostility from those born in Ireland, fluidity and selectivity; they can choose whether to accentuate their Irish or English dimensions in any situation.

Many of the issues that they face are similar to those experienced in other minority ethnic groups but these have not been sufficiently documented in relation to Irish people. These issues include cultural brokerage on behalf of their parents. Practitioners and service providers need to be aware of the issues and experiences of the children of Irish migrants and how these may impinge on their mental health.

Linkworking can be seen as a form of cultural brokerage that, in relation to other minority ethnic groups, is well established. However, whilst linkworkers do excellent work with older Irish people, little attempt has been made to document their activities or the contributions that they make. It is, therefore, recommended that

- i) The children of Irish migrants should be regarded as a separate group.
- ii) More research is needed to explore the idea that the children of Irish migrants are symptom carriers of the trauma experienced by their parents.
- iii) Irish welfare organisations should emphasise their inclusive approach, welcoming the children of Irish migrants.
- iv) Linkworkers' activities should be documented as a basis for comparison with similar activities in other minority ethnic groups.

Conclusion

This report highlights the complex nature of the health needs of Irish people in Birmingham. In particular it has demonstrated the importance of recognising the Irish as a separate, minority ethnic group and some of distinctive features of Irish culture.

The report raises a number of issues for mental health practice. The project team hope that practitioners and service providers will find the recommendations constructive as a basis for providing culturally-competent care Irish clients in order to improve their quality of life.

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