



THE HIDDEN MINORITY

MENTAL HEALTH AND THE IRISH EXPERIENCE IN BRENT

by
ELIZABETH FARRELL

a



and
EQUAL ACCESS
report



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Every care has been taken to ensure the accuracy and currency of all information in this report. Neither BIAS, Equal Access or Elizabeth Farrell can be held responsible for any errors, changes, or omissions to details in this report.

The names of the users in this report have been changed to protect their identity.

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Soreword

During the 1990s, BIAS has noticed a significant increase in the use of the agency's services by Irish people with mental health difficulties. As an agency, we have been concerned that the needs of Irish people experiencing these difficulties are not ignored by statutory providers of services such as local authorities and health agencies. This report produced in partnership with Equal Access records the experiences and needs of Irish people with mental health difficulties in the London Borough of Brent and makes a clear recommendation to statutory service providers about how these needs can and should be met.

I look forward to the recommendation being implemented.

Colum Moloney

Chairperson of BIAS

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About the Author

Elizabeth Farrell has worked in Brent for several years in day-care and residential settings and in the community. She has also been involved in health and Social Services management developing day care services, facilitating Users Forums and devising training packages around disability awareness, advocacy and equality practice. Her previous research focused on the resettlement process for a group of users from a long stay hospital and recounted their experiences of community care. She is a freelance trainer and is currently employed as a mental health Social Worker in the London Borough of Haringey.



Brent Irish Advisory Service (BIAS) was established in 1978 and are now in their 18th year of operation. BIAS is a community development and welfare organisation which is non-party in politics and religion and provides a practical, essential service to all Irish people in the Brent area of North West London and beyond. The large and diverse Irish community forms a substantial proportion of the resident population in Brent and is the Borough's largest national group which originates from any single overseas country in the world. Indeed Brent's Irish population is the largest of any local authority in London.

With an ancient cultural heritage combined with a modern lifestyle, Irish people who emigrate from their own country to find employment and make a new life have contributed much to the development of industry, commerce and services in Britain. Even today, as we move through the 1990's, young migrants still come to Britain to seek work and accommodation. As foreigners in a strange land, many Irish people, especially those from rural and Irish speaking backgrounds, may experience cultural shock, alienation and racism. Some of them may have problems with housing, jobs, social security and welfare.

Within the Irish community, there is a disproportionate number of older Irish, people with disabilities and mental ill-health, and homeless people. There are also groups of Irish people who have particular needs, including women, young people, pensioners, travelling people and the unemployed.

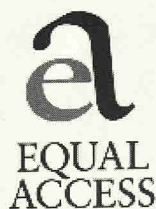
BIAS provides free and confidential services through the BIAS Information Centre, telephone 0171 328 1188 and their Community Service on 0171 328 3368.

BIAS is located at 76 - 82, Salusbury Rd, London, NW6 6NY



Irish Youth
Foundation

Brent and Harrow
Health Authority



In 1994, Parkside Health were commissioned by Brent & Harrow Health Agency to set up an Equal Access project to identify the barriers that people from ethnic minorities face in accessing health services in Brent. In partnership with

health service planners and providers, and with voluntary sector groups, Equal Access has until the 31st of March, 1997 to investigate the health concerns of the marginalised groups in Brent in order that their needs are addressed and resourced appropriately. The project is staffed by a team of outreach workers who are representative of the Irish, Asian, Afro-Caribbean and Refugee communities in Brent.

Mental illness is a particular Irish community concern which needs to be raised at every opportunity. As part of on-going consultation with front-line Irish organisations, the Irish Outreach Worker at Equal Access is continually made aware of the escalation of the problem and the inappropriateness of the generic response by health services. Her role as an inter-agency link with the Irish community serves to highlight these issues; however she recognises that real change can only be achieved by provision of mental health services which are culturally sensitive to Irish people's needs and expectations.

Equal Access works in partnership with Brent & Harrow Health Authority, Central Middlesex Hospital Trust, North West London Mental Health Trust and Parkside Health.

Equal Access is located at 122 High Street, Harlesden NW10 4SP Telephone 0181-961 9005



newspapers from home

Executive Summary

The purpose of this report is to enable Irish user's perspectives of the psychiatric and mental health services in Brent to shape on-going demands for culturally specific services for the Irish community. By commissioning this investigation, Brent Irish Advisory Service and Equal Access seek to expose the conspiracy of silence which masks the extent and nature of mental illness within the Irish community, and present these concerns for the attention and immediate action of all mental health service providers in Brent.

A resume of the main points of the investigation are as follows:

- a. The Irish community, despite under-enumeration in the 1991 census, is the largest ethnic minority in Britain and the second largest ethnic minority in Brent;
- b. The perpetuation of anti-Irish racism has led to present day discrimination and disadvantage within all sections of the Irish community;
- c. Poor housing and living conditions, low paid employment and unemployment, harassment and unfair policing has had a devastating causal effect on the physical and mental health of Irish people in Brent;
- d. Despite indicators of poverty, stress and inequality, little research has been undertaken on the health of the Irish, and their specific experiences have been subsumed by the White British experience;
- e. Irish women are often vulnerable to mental health problems due to the burdens of migration, family responsibilities and the constraints that the church often imposes on women;
- f. Irish people are often mis-diagnosed by British psychiatrists who do not have the cultural perspectives to enable them to understand the social and spiritual dimensions of the Irish psyche;
- g. Alcohol mis-use by some Irish migrants can be one of the responses to being homesick or to discrimination, which when compounded with poverty, discrimination, unemployment or homelessness, can inflict huge psychological distress on an Irish person's well being;
- h. A disproportionate number of Irish people are compulsorily detained under the Mental Health Act and Electro Convulsive Therapy is more likely to be administered to Irish patients;
- i. The Irish when in psychiatric care in Brent are often denied the significance of their own experience, and the socio-economic and political dimensions underlying their mental distress are rarely taken into consideration, resulting in an inaccurate assessment of need;
- j. The Irish are often not given access to appropriate community care assessments, although the Local Authority has an obligation under the 1990 NHS and Community Care Act to address the specific cultural and religious needs of members of all ethnic minorities;
- k. A community intervention model more responsive to Irish people's needs has recently been disbanded by the local Mental Health Trust in favour of a more medically focused approach which will fast track Irish people to inappropriate hospital services;
- l. There are no Irish specific social workers or outreach workers employed in the mental health field in Brent or Irish psychiatrists practising in any of the Borough's hospitals; nor are there any Irish specific mental health provisions similar to those provided for other ethnic communities who, like the Irish, suffer dis-proportionate levels of mental illness compared to the host community;
- m. There is a general lack of awareness amongst staff in mental health services about Irish issues;
- n. No specific prevention work around mental health has been targeted at the Irish community and the escalation of our mental health problems continues unabated.

Irish Users Charter For Change

Irish users want preventative care in the community. They want practical help and support in their own homes where they feel relaxed and comfortable. They want their experience as Irish people to be respected, understood and taken seriously. They want their GP's to take time to listen to their concerns and offer alternative methods of treatment apart from a quick prescription for tranquillisers. If they feel anxious and depressed they want a therapeutic space where they can ease their suffering and receive one-to-one counselling. They want to be offered the choice of Irish practitioners i.e. counsellors, social workers, outreach workers. etc., within the mental health services in Brent. If they reach a crisis state they want to receive help in a staffed community resource where they can recuperate and be facilitated to resettle back into their own homes.

If they are admitted to hospital they don't want to be labelled and they want their cultural needs as Irish individuals to be addressed in the psychiatric assessment process. They want to be offered the choice of treatment and also wish to participate fully in the treatment plan. They want to be informed about medication and its side effects in language they can understand. Irish women want the choice of a separate space where they feel safe and are not vulnerable to harassment and abuse. They want their specific needs as Irish women to be acknowledged on a different agenda. Those users who are being discharged from hospitals want discussions with service providers so that they have a common understanding of rehabilitation in the community. They want decent housing and a decent standard of living.

Irish users want community care information that is accessible, appropriate and informative. They want culturally sensitive services so that they feel able to express their Irishness and this dimension is interwoven into their assessment of need and delivery of care. Their community care assessment has to take account of a personal support network which includes family and Irish community support systems both locally and nationally. Employment is also an important area of need and some users want to be involved in voluntary work to pave the way for permanent employment in the future. Most of the users want a place where they could meet other Irish users, receive advice and information on matters of concern, get involved in personal development/self help groups and take part in Irish cultural activities.

Introduction

The Irish community is the largest ethnic minority community in Britain. It comprises of an estimated two million people who were either born in Ireland or are children of one or both Irish born parents (see Pearson & al, 1991). However obtaining precise data on the size of the community in Britain remains problematic, because of inadequacies in official statistics. While the Centre for Research in Ethnic Relations recently published a census statistical paper for Irish born people in Britain they argue that the size of the Irish ethnic group is much larger since many people born in England, Wales and Scotland to parents born on the island of Ireland (or with Irish grandparents) regard themselves as being Irish.

The most recent census of population failed to identify Irish people as a separate ethnic group merely categorising them in the section "born in Ireland". Murphy, Flynn and Tucker (1993) in their report "Identity Crisis - A Study into the Experiences of Irish People, Travellers and Single Homeless People" describe how it has been common practice to subsume the Irish experience into that of the British born white population. Few attempts are made by bodies promoting racial equality to address Irish peoples experience in policy development, research and analysis and in community consultation initiatives. It is only since February 1995 that the Commission for Racial Equality have formally recognised the Irish as a separate ethnic group and issued instructions to Local Authorities and Health Authorities to instigate an Irish category in their service and staff monitoring.

Rack, in his book "Mental Health Race and Culture" points out how membership of an ethnic minority is inherently stressful due to exploitation, deprivation and hardship. He sees the reality of having to live with a contemptuous view of oneself coming from other people as constituting a serious psychological burden. In 1991 the University of Bradford conducted a large scale survey of Irish people in Britain drawn from readers of the leading Irish community paper, the Irish Post. It was the first major Britain wide study of its kind aimed at providing a portrait of the Irish community. One of its findings revealed,

'The one safe conclusion from the findings reported ... is that a considerable number of Irish people in Britain feel uneasy about their relations with the English as well as suspicious that the English look on them unfavourably'. (Irish Post, Jan 9th 1993)

In Ireland a stigma is attached to relying on the welfare system for support. Subsequently, Irish people are reluctant to utilise service agencies and many fail to claim the benefits they are entitled to. Evidence from Irish agencies suggest that Irish people have a low expectation of British institutions and are very often the least likely to approach local authorities for services and are therefore less likely to appear in official statistics.

In terms of socio/economic disadvantage it is clear that Irish people fare no better than other migrant groups (see Connor, 1987). However in areas such as mortality rates and mental hospitalisation they fare considerably worse (Madden et al, 1991). Cochrane and Bal carried out research on mental hospital admissions rates for England and Wales in 1977. This was repeated for England in 1981 and as listed below shows that Irish people from both the Republic and Northern Ireland had, and continue to have, the highest rates of admission to mental hospitals of any immigrant or ethnic racial group (Cochrane & Bal, 1989).

TABLE A: Age Standardised Rates of Admissions per 100,000 Population Aged 16 and Over. England 1981: (Cochrane & Bal 1989)

Country of Birth	Male	Female	Total
Irish Republic	1,054	1,102	1,080
N. Ireland	793	880	838
England	418	583	504
Caribbean	565	532	548

It was also found that Irish women have the highest rate of admission of all groups for every diagnosis except schizophrenia. They have an exceedingly high rate of admission for the diagnosis of depression - more than twice that for Irish men and 2.5 times the rate for English-born women.

Yet considering the severity of the problem, very little investigation has taken place to offer an explanation as to why Irish people seem disproportionately likely to suffer psychological distress. It remains an invisible statistic and little attempt is made to address the issue at both local and national level.

Studies have been commissioned by Irish Practitioners/Agencies in Brent, (see 1989 'Factors in the Genesis of Stress and Mental ill-health among the Irish in Britain', 'Irish Mental Health Forum', the 'Report by the Social Worker at BIAS on the Irish Experience of Mental ill health' BIAS 1993, 'Who cares for the Irish Community', Patterson, C and Glackin, J, 1994, 'Alcohol and the Irish in the London Borough of Brent', McCollum, S). Yet very little has been done to address Irish mental health issues in a Borough which contains the highest proportion of Irish-born residents within the whole of Britain. The problem of escalating mental ill health within the Irish community still remains an invisible statistic

This fact is noted by Greenslade analysing mental illness among the Irish community in Britain in his paper "White Skin, White Masks" (1991). He refutes the medical model of illness, placing it instead within the wider context of the socio/economic/political and historical circumstances that surround the sufferer. He attributes the incidence and characteristics of mental illness among the Irish to the sustained economic, cultural and social effects of colonialism upon the Irish people at home and abroad. He uses the term "colonized psyche" and submits that Irish people exist as the "guilty conscience" of colonialism and as such their problems are a peculiarly difficult issue to face up to. He relates the distressing effect of migration and settlement on mental health and remarks on the relative invisibility of Irish people when they come to England. In this milieu they are literally invisible until they open their mouths. The very familiarity of Irish people with British society and culture, the fact that they are usually white and share a common language leads people to compare their circumstances with those of all white people. Their different needs and distinct culture is often denied and invalidated.

Acknowledging a mental health problem in a society which responds with hostility or rejection is a difficult process. For Irish people living in Britain this is even harder because they already face a host of prejudices. In Connor's words it is easier to "keep your head down and your mouth shut" and thus avoid being the focus of attention (Connor, 1987). In a similar way Maynes in "Good Practices in Mental Health for Irish Women" explains that being the object of anti-Irish racism and colonialism can stimulate intolerable feelings of self hatred, consequent denial and refusal to admit that anything is wrong.

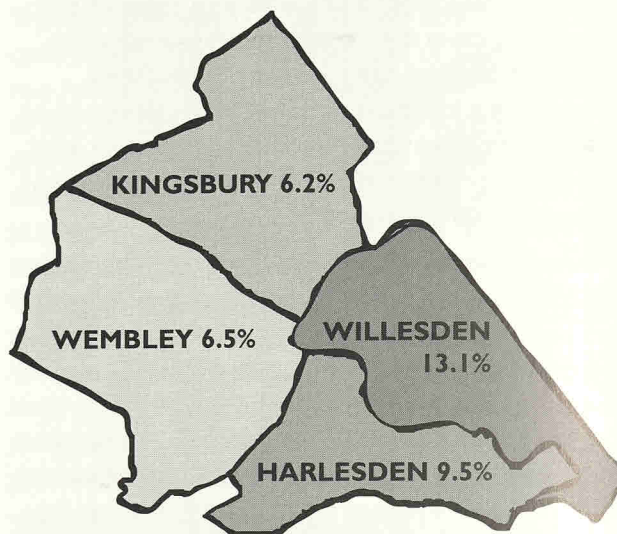
Methodology

Sources for this investigation were derived through structured meetings with mental health service providers and through interviews with Irish users. This investigation is essentially a "snapshot" of the mental health needs of the Irish community in Brent. The report will address equal opportunity issues and will therefore take account of the socio/economic and political factors underlying the aetiology of mental distress.

This is first and foremost a qualitative investigation. It is to do with the stuff of peoples lives, how they live which has an essential "quality" about it. I used a tape recorder in my interviews with Irish users because I wanted to capture their words and ensure the full truth and nuance of their experience was heard and reported in this piece of work. As they told their story I structured questions around significant events which shaped their lives: reasons for leaving Ireland, arrival in London, work and living conditions, perceptions of statutory social and psychiatric services they encountered and ways forward for the future. My line of enquiry with the statutory mental health provider sector posed questions concerning access to culturally appropriate services in response to the needs of the Irish community. I have narrated an account of my work as a practitioner with users who primarily presented psychological stress.

My search for relevant data revealed an absence of research documentation on the Irish experience examined and analysed within the context of mental health. Major organisations such as the NHS' Ethnic Health Unit, the Health and Race Unit, Good Practices in Mental Health and the CRE were unable to supply information on the subject matter. In two of the principal texts concerned with transcultural psychiatry (Littlewood and Lipsedge, 1989 and Rack, 1982) the issue of Irish psychological distress rates barely a paragraph. I received a mental health bibliography from the Share Project, an NHS funded mental health national information resource base on black and ethnic minority communities. The Irish were not mentioned in the 134 projects, services and areas of research listed apart from the study by Cochrane and Bal on mental hospital admission rates. I finally managed to compile data from Irish individuals, community groups and organisations who have published reports and studies on the Irish experience and have taken the lead role in identifying areas of need.

Brent Profile



Percentage of Irish in Brent by District

Brent has the highest proportion of ethnic minority residents amongst all authorities in England and Wales. In total the non-white population number 44.8% of the borough's population. Of this 17.2% are Indian, 10.2% are Black Caribbean and 4.1% are Black African. The white group includes a substantial number of Irish people with 21,983 residents being Irish born. According to the 1991 census the Irish make up 9% of the total population and Brent has the highest proportion of Irish-born residents of any borough in Britain (see 1991 census - Ethnic Groups in Brent - Environmental Services - Brent Council). This takes no account of the 2nd and subsequent generations of Irish people born in the Borough. Recent re-enumeration by the Action Group for Irish Youth (AGIY) to take account of these factors estimates that Brent's Irish population is in fact 22.5%, making it the largest ethnic minority in Brent. (1991 Census Briefing, AGIY, 1995)

The Irish are largely concentrated in the south east wards such as Kilburn, Willesden Green and Cricklewood. Generally a high proportion of elderly were Irish born particularly in Kilburn and Willesden Green. The Carlton ward which also has a large Irish population has the highest proportion of household residents with limiting long term illness. In terms of housing tenure the Irish are disproportionately represented in private rented accommodation, Kilburn and Cricklewood next to Mapesbury containing the highest rates in this particular sector.

However the census figure must be qualified if an accurate prediction of the Irish in Brent is to be achieved. As previously stated, the census did not include an "Irish" ethnic classification, thereby excluding those born in the United Kingdom who consider themselves Irish i.e. second, third generation Irish. Irish women marry more frequently than their male counterparts and often to non-Irish men. This conceals their national and ethnic identity behind that of their husbands. The nature of Irish people's tenure is such that they are less likely to be included in census returns. Given that they are heavily dependent on the private rented sector they often live in houses of multiple occupation and/or with resident landlords. Consequently they are less likely to be registered in returns for a number of reasons including tax fears of landlords or only one form delivered to shared houses. Recording for Irish Travellers in census returns is very patchy.

Brent Council has separated the purchaser/provider role so that each role is clearly distinguishable within the Borough's overall structure. It has organised its services into three specialist divisions which comprises of Children and Families, Elders and Mental Health and Disability. The Mental Health Team in the East Sector serves the south east wards which contain the largest concentration of Irish people within the Borough.

Nature of Work Carried Out

Meetings were held between the 1st February and 31st July 1995 with key people within the statutory mental health provider services in Brent which included mental health outreach workers, social work team leaders, approved social workers, mental health day care manager and workers, NHS sector managers, day hospital workers and Community Psychiatric Nurses (CPNs). I also met with voluntary sector agencies. Some were directly involved in the mental health field such as Brent Mind, others were in daily contact with Irish users such as Cricklewood Homeless Concern and BIAS.

Access to Irish users was not easy. Their way of keeping safe and surviving in the community is to maintain a social invisibility. However through my contact with health and Social Services providers I conducted ten detailed interviews (6 female, 4 male) as well as many other discussions with Irish users. Interviews were held between the 1st February and 30th April 1995 at Twyford Day Hospital, John Wilson House (Day Centre), the South East Sector Mental Health Outreach Team and Care in the Community, a project for former long stay hospital clients.



Irish Dancers at BIAS Christmas Party

Across the Water

THE IRISH MIGRANT

A person's culture is not like a suit of clothing that can be discarded or exchanged for each new lifestyle that comes along. What it provides is a meaning system for its owner, a blueprint for behaviour and it is never more precious to the individual that when he/she is adrift in an alien and confusing environment. Several of the Irish users I interviewed spoke about acute feelings of homesickness on their arrival in London. They came from a community where they had a name and a recognised face and they felt a great sense of loss and grief on their own in a strange and unfamiliar landscape. One user fleeing abuse in Ireland relates his first impressions:-

"This was a very sad time for me. I missed my family and my community. I didn't feel I belonged

anywhere. I had no friends and would have liked a meeting place for Irish people where I could relax and be comfortable." (Michael, interviewed February 1995).

The family orientation of the Irish community influences its social and welfare network and single men and women may not have very strong links with it. This only serves to reinforce their isolation as the community does in its own way provide a safety net for its members. Seven out of the ten users I interviewed were single. They were soon made aware of their "difference". One Irish user recalls the unfriendliness of the new environment:-

John Wilson House, Day Centre



"I felt terrible when I came to this country. As soon as I opened my mouth they said 'Oh Irish'. I remember looking for a room as my bedsit was damp and the notice board said 'No Irish, no coloureds, no dogs'. This started me realising that people didn't like us over here." (Margaret, interviewed March 1995).

This sentiment is echoed in Liz Curtis's book "Nothing but the Same Old Story, the Roots of Anti-Irish Racism". She places the origins of anti-Irish racism within the historical framework as identified earlier by Greenslade leading to present day discrimination and disadvantage within the Irish community. She relates how constant denigration of Irish culture and traditions has led many migrants to deny their Irish identity. When this happens what it effectively amounts to is an amputation of the past self, an abandonment of cultural values and traditions that support a person's emotional security. Uprooting, especially separation from both place and group is inherently stressful. However when this is compounded by an actively racist society resulting in a sense of self that is somehow "flawed", the

subsequent cultural dislocation and denial that often follows for the Irish person can fundamentally effect their physical and mental well-being.

The Myth of Return

A PERPETUAL BEREAVEMENT

London is a well trodden path for the Irish. All migrants travel to improve their lot. One way or another improvement is the motive behind the move. Closeness of Britain makes emigration easier. It sometimes allows for the illusion that it is possible

to stay for a short time and eventually return home. However given the discrimination and oppression experienced by Irish people what often happens is that jobs don't materialise, housing is sub standard but pride obliges the Irish person to maintain the pretence of success. She/he cannot tell the family back home that they are a failure. The myth that life is better in Britain has been sustained in Ireland over the years and for these reasons many Irish emigrants find it difficult to talk about the problems they encounter. People at home don't want to talk about the failures of their emigrants as the assumption is that people who have got out have to be doing better than

those who are left behind.

Choice also plays an important part in reasons why people leave Ireland. It affects the resettlement process and also determines the ongoing relationship with family and community. Two users in this particular study left to escape sexual abuse. Three female users wanted more freedom and choice in their life and felt quite oppressed by the role of women in Irish culture. Other users left mainly for social and economic factors. What is important is that the concept of "going home" touches the Irish person in a very special way. The extended family is an important component in Irish society and often forms part of an individual's personal support network. When this is absent it can lead to much distress and loneliness. Users I interviewed often recounted their difficulties in securing paid work. They were generally living in poor housing conditions and existing below the poverty level. They not only faced discrimination as Irish people but also had to deal with the stigma of mental illness. They were also aware that this stigma extended into their country of origin.

Although many expressed a desire to return home they felt that they had not quite made it in England and would go home when they were "well enough". The years pass and they still remain in London. They lose their ties with their family and friends and find themselves "stranded" between the two cultures never fully able to identify with either. As they talked about their early childhood their voices were tinged with sadness as they relived memories of the homeland. It was as if they lived in a state of perpetual bereavement. Their emotional roots lay in Ireland but the journey was too precarious and was never a possibility open to them. Two users who went home for a short break became very depressed on their return and suffered breakdowns as a result. One user describes her experience in the following words:-

"I had a nice time at home. I felt at ease there. When I came back I could not settle down. I kept having visions of people from home and I started to get very confused. I used to think Woolworth's and Marks and Spencers were department stores from home. I couldn't stop crying. I just fell apart. I'm scared to go home now because the last time I didn't want to come back and I was so ill afterwards. What's also stopping me is pride. I don't want to go home and say I can't make it in London." (Kathleen, interviewed March 1995).

Another user I interviewed used to periodically put a deposit on the coach fare to Ireland. She would always come back to BIAS and ask for support to get her money back. The desire to return was always on the horizon but she was never quite able to take the final step.

Similarly these issues are also highlighted by Cricklewood Homeless Concern, a project offering day care and a resettlement service to single homeless people. Their annual report 1994/95 shows an average daily attendance of 71 people, 70% of the clientele being of Irish origin and 47% who identify with mental health problems. One of their front line workers identified some of the dilemmas faced by Irish clients. She relayed how difficult it is for them when they come to London and have nowhere to live. They can't find any work, have no address and drift unintentionally. Their Irishness is thrown in their face and they feel embarrassed because of their accents. They feel ashamed of their situation and guilty because they feel they are letting their family down.

Stress Indicators in the Aetiology of Mental Distress

The Irish community exist in a climate of disadvantage. In employment they are predominantly to be found in manual, unskilled and personal service areas. With an unemployment rate nearly twice as high as the British born, only people of Caribbean origin were found to have a higher rate of unemployment (O'Flynn, J. and Murphy, D. 1991). A survey carried out by a major Irish housing association stated how the Irish in London are still very much over represented in private rented accommodation. This is characterised by insecurity of tenure, poor conditions and vulnerability to harassment (see Cara Report, 1995). Not surprisingly these factors have a corresponding relationship to the health experience of Irish people in Britain who have the highest mortality rate of any ethnic group in English society. (Greenslade, L. 1991). Furthermore Irish men are the only migrant group whose life expectancy worsens on migration to England (Marmot et al, 1984). Recent data indicates that this shortened life expectancy extends into the second generation (Raftery et al, 1990).

One thing all marginalised and oppressed groups have in common is increased levels of poverty. This includes lack of money, lack of entitlements and lack of access to opportunities. Poverty is also to do with people's feelings. It is to do with how people feel about themselves and how they are regarded by other people. One user epitomizes his feelings around poverty, suffering and stigma:-

"I felt bad being homeless and not having any money. I felt so low, such pain, such grief. I was suffering in my mind. It was sheer torture. I want to be at peace with myself and not live on a knife edge. I want to be treated as a whole person and not as a headcase." (Thomas, interviewed April 1995).

The 1991 census on ethnic groups in Brent mirrors the national figure and shows the Irish disproportionately over represented in the private rented sector in Cricklewood, Kilburn and the Carlton Ward, the latter having the highest proportion of household residents with limiting long term illness. A study by Brent and Harrow Health Authority in July 1993 indicates that the Irish suicide rate in Brent and Harrow is over 50% higher than the average for all ethnic groups in Brent.

Case Study 1

Siobhan is a 40 year old woman born in Ireland. Her mother was not married and due to the stigma attached to single parenthood in Ireland, her mother was unable to care for her as a baby. Subsequently Siobhan was placed in care and fostered by an elderly couple when she was 2 years of age. Initially her mother used to visit her and pretend she was her aunt. However the visits stopped completely when her mother got married and Siobhan has not seen her mother since.

Siobhan's foster parents treated her badly and didn't show her any real love. She remembers being beaten with a blackthorn stick when she was a child. She was sexually abused when she was 6 years old by a relative of her foster parents. When she told her foster mother, she was told off for lying. She found out years later that the same person had abused her two foster sisters.

Siobhan didn't enjoy school as the education system was harsh and disciplinary, but she achieved well in her leaving certificate and went on to secretarial college. She really wanted to go on to teacher training college but her foster mother contracted cancer and she was obliged to stay at home and look after her. When her foster mother died, she left all her money to the church and Siobhan found herself homeless and ill prepared for living on her own. She was 18 years of age.

She went to Dublin to stay with her foster sister but soon came back to her home town as her foster sister was heavily involved in the drink and drug scene. Shortly afterwards in 1975 she came to London and stayed in Sudbury with another foster sister. She then rented a bedsit and started to work in an office. She was treated like a skivvy and left the job to become a trainee costing clerk in an Irish family business. The work was very demanding and she was given no training or pay rises. She stayed there for four years and found the whole experience very demeaning and she lost a lot of confidence in herself. She then got herself a job in Marks & Spencers' food department.

Throughout this time her living conditions were very unstable. She was constantly on the move, living in cold and damp bedsits. She experienced a lot of anti-Irish racism when she applied for accommodation and in the workplace, both of which affected her sense of identity and self worth. Siobhan has moved 14 times since she came to Britain.

She became involved in a relationship which was

very abusive. This connected to her earlier abuse and when the relationship ended, she started to have panic attacks. She went to her doctor at work but did not find him sympathetic. The panic attacks increased and she started missing days off work. She began to drink heavily. She felt she had no one to talk to who would really listen to how she was feeling. She started to break down and shut herself away in her bedsit. In the end they had to break down the door out of concern for her safety and she started screaming and throwing things around the room. She attempted to jump out of the window.

She felt in pieces and was taken to Pond Ward at Central Middlesex Hospital. Everything was a blur to her at this time but she remembers feeling very angry. She was kept in hospital for two weeks and then attended Roundwood Day Hospital for 3 months. She was put on tranquillisers and then discharged although she did not feel ready to cope with everyday living.

She went back to work and then went on holiday to Ireland. She enjoyed her holiday but became very depressed when she came back to London. She could not settle and was admitted to Roundwood Day Hospital for a year. She was very ill. ECT treatment was suggested but she refused and was given a high dosage of medication instead. This made her feel worse, so she discharged herself from the hospital and tried to get to work but lost her job due to frequent absences. She had worked for Marks & Spencers for 12 years. Her doctor then referred her to Social Services and she became the responsibility of the Mental Health Outreach Team.

She is currently in the care of the Outreach Team but she does not feel her needs are being met. She is still lonely and isolated. She wants to go to Ireland for a holiday, but doesn't feel well enough to go as the return would be so painful.

Case Study 2

Michael is a 30 year old man who was born in Britain of Irish parents. He is the eldest of a family of four children. The family went back to southern Ireland when he was 2 years old. He was sexually abused when he was 10 years old. It happened on several occasions. He was too frightened to talk about it at the time. He was extremely damaged by the experience and effectively blocked it out for 20 years until he started to talk about it in 1994.

Growing up he felt his life was meaningless. His 12 year old sister was killed in a car accident outside his home. He was deeply shocked by the accident. He went out drinking as it helped to dull the pain and made him feel good for a while. He hung around the house and his relationship with his father grew steadily worse. He was not able to talk to him and express how he was feeling. This made Michael angry and frustrated.

He was 19 years when he became involved in his first relationship. His parent did not approve as his girlfriend's parents had a bad reputation in the town. Michael came from a small community and the relationship became the 'talk of the town'. Michael resented his parent's disapproval and continued to see his girlfriend. Eventually she became pregnant and this caused enormous conflict in the family. By this time Michael realised he was not in love with his girlfriend, but that she helped ease his aching loneliness and enabled him to get through his day to day existence. He wanted to protect his family's reputation so he asked her to go to London with him so that they could get away from it all. She refused, and he went with his mother to a family counsellor. He talked the situation through and the counsellor suggested that it was not a good idea to stay in the relationship just for the sake of the child. She felt it would be better for Michael to go to London as arrangements could be made to ensure that his girlfriend would be okay. Michael felt he was a great disappointment to his family and soon afterwards he left home and came to London. He was 23 years of age.

His family relatives found him accommodation and a job in London. He lived in a bedsit in Wembley and worked as a labourer on the building sites. This was a very sad time for him. He missed his family and his community. He didn't feel he belonged anywhere. He had no friends and would have liked a meeting place for Irish people where he could relax and be comfortable. He soon left the labourer's job and found a job in a factory. He has been working there since 1989 but finds it an uphill struggle.

He feels stigmatised as an Irish person in the

workplace and is treated with disrespect. He gets anti-Irish jokes and is made to feel inferior. The attitude at work is that Irish people are "angry and unapproachable".

He has moved on several occasions since he came to London. He has mainly lived in the private rented sector in sub-standard accommodation, usually bedsits and shared houses. He started to drink heavily and became involved in the drugs scene. The numerous moves coupled with poverty and discriminatory working conditions really affected his physical and mental well-being. His health began to deteriorate and he took days off work due to stomach problems. He found it difficult to cope at work and started to have stress attacks. He felt very shaky and the Personnel Department sent him to the works doctor. He was put on tranquillisers and referred to a Harrow Hospital who diagnosed irritable bowel syndrome. Meanwhile his housing conditions worsened. He got a letter from his doctor and tried several agencies in Brent for accommodation but was unsuccessful. He also tried Council housing but was told he did not qualify as he didn't have enough points.

Around this time he went over for a holiday to Ireland. He really enjoyed himself but started to feel depressed when he came back. He began to break down and felt on the verge of suicide. He went to his doctor and said he couldn't take it anymore. He was put on tranquillisers and allocated a Social Worker. He was offered an assessment but didn't find it beneficial. The Social Worker did not understand his needs and told him to "*pick himself up and get on with it*". However, she did refer him to a supported MIND house where he now lives at present.

It was while watching a television programme on sexual abuse in 1994 that he suddenly started crying and realised he was not the only one. He cried for days and then went to his local health centre. He was referred to a psychiatrist and he started to talk about his earlier abuse. He now sees the psychiatrist on a fortnightly basis and finds it very helpful.

When he looks back he says he would have liked someone to talk to about his childhood experiences. He would like to confront the abuser but doesn't feel able at the moment. He would also have liked family therapy as he feels his family are part of the problem. He thinks he "*spared his family and suffered because of it*". He would like to assert himself positively at work and he feels lacking in self confidence. Ultimately he would like to develop educationally and would like to do an art degree. He would like a place on his own as he is currently in shared accommodation. Housing is always on his mind. He does not feel ready to go back to Ireland (financially, educationally, emotionally) and wants to "*put himself right*" before he goes back home.

All of the users that I interviewed experienced problems around access to a stable living environment. One female user spoke about how she lived in bed and breakfast accommodation and was then referred to a women's hostel in the heart of the red light district in Kings Cross.

Irish elders return home for a holiday



She had started to feel ill when she was in bed and breakfast accommodation. She began to hear voices and felt very frightened and very isolated. She went to her GP, but she did not find her very sympathetic and felt as if she had been thrown out into the wilderness. Her social worker referred her to a Women's hostel in King Cross but she found the hostel environment violent and unsafe. She eventually ended up on the streets in Kings Cross in a chaotic state and luckily was picked up and brought home to her parents. The whole experience traumatised her considerably and soon afterwards she broke down and was sectioned.

Another user spoke about victimisation from neighbours in the form of excrement through the letterbox, smashed windows and two break ins. It took two years for the family to get a management transfer.

She was living on the Stonebridge estate when a family moved in opposite who were very noisy and disruptive. She complained to the Council about the noise and the family started to threaten and terrorise her on a regular basis. She remembers coming home one day and the front door was smashed in and the place was a complete wreck. Her entire family was stressed by the housing situation. The harassment continued and she made several pleas to the Council for a transfer but they failed to take any

action. In the end she took the matter to her local Councillor and was finally re-housed after a two year long battle. The experience wore her down and affected her physical and mental well-being.

When she moved she started to have panic attacks and was put on major tranquillisers. Nothing fundamental was done to enable her to deal with the root causes of her stress. In this particular case a referral to a counsellor would have been far more beneficial than a prescription for tranquillisers.

For Irish users with children there are added pressures. One single parent spoke about her harrowing experience living in a small bedsit with her baby daughter. She went to Social Services for support and eventually her child was taken into care. When her child was adopted into an English family this triggered her first breakdown.

Some users just felt like putting an end to it all. Ann attempted suicide three times and was in and out of psychiatric hospitals for several years:-

"I was constantly on the move, living in tiny rooms with noisy neighbours. Sometimes I used to feel the whole house was collapsing. I felt very anxious and very alone. I just wanted to finish it." (Ann, interviewed March 1995).

Sean also describes his feelings around his housing situation:-

"Housing was always on my mind. I have moved so many times over the years living in bedsits and shared houses. It did my head in. I felt suicidal." (Seán, interviewed March 1995).

Lack of decent and affordable housing can be an intensely traumatic personal experience. It can effectively deplete a person's emotional and other resources rendering them less able to deal with other issues of survival. The ability to deal with feelings of stress, anxiety, fear and loneliness can be thus inhibited. In 1993 BIAS compiled a report identifying major difficulties Irish people have with regard to housing and homelessness. The report stated how a large number of Irish people were living in the private rented sector where they were vulnerable to harassment and illegal evictions. In addition many were living in bed and breakfast, hostel accommodation and resettlement units where they often experienced violence and aggres-

sive behaviour by other residents. This was another contributory factor in causing stress and related mental health difficulties. The report cited that at any one time, there are a large number of Irish people in Brent with mental health problems, many of them alone and isolated especially in the inner city parts of Cricklewood, Harlesden and Willesden and on the Borough estates (Who Cares For the Irish Community, 1993).

Making the Case for Irish Women

Motherhood within the confines of marriage is woven into the Irish image of women (O'Connor, 1989). Women's role in Article 41 of the Irish Constitution enacted in 1987 states that 'by her life within the home, women gives to the state a support without which the common good cannot be achieved'. The special position of the Catholic Church is also enshrined in the Constitution. The result of this is that on social and sexual issues in particular its views are also imposed in the form of legislation. The state's attitude towards contraception, divorce, illegitimacy, homosexuality and abortion ignores women's needs. This places additional pressures on Irish women and large numbers emigrate every year. Many come to London which is their nearest port of call.

As in other areas of women's history, when we look at the picture of migration, Irish women's voices are silent. They are doubly invisible as members of an ethnic minority whose work is hidden in scattered homes, hospitals and offices. Many aspects of Irish community life are male dominated and it is difficult to participate especially if you are on your own. There is little to offer in the community if you do not fit into either the church hall, the Gaelic Athletic Association or the pub culture. Lennon, McAdam and O'Brien (1988) in their exploration of Irish women's lives in Britain comment on how so many women coming to this country are totally unprepared for the hostility they encounter when they try to express their Irishness and their separateness. This is further reinforced by negative representations of Irish people on radio, TV and in the newspapers. They recount how Irish women are under greater pressure than Irish men to integrate into British society due to their family role and responsibilities. They go to health centres, schools, hospitals and playgrounds. These are also the areas where attitudes to the Irish, reactions to Irish accents are

unavoidable and can have a real bearing on the treatment they receive.

Channel 4 recently showed a series of programmes on women's issues entitled "First Sex". In their programme on women and mental health (Channel 4, 21st June 1995) Liz Sayce, director of Mind stressed how, out of 45 million psychiatric drugs prescribed every year, 30 million are handed out to women. This very much correlates with female users description of events when they started to feel unwell. Their first line of contact was always their GP. The real issues were not dealt with but 'controlled' through mood changing drugs. Generally what was needed was a 'listening ear' and a preventative package of care delivered in a culturally sensitive way. One user recalls her particular situation in this respect:-

"I was living in bed and breakfast. I felt very ill. I used to think the radio was playing music especially for me. I was lonely and very frightened. Finally I managed to go to the doctor. I wanted to talk to her but all she did was to give me tranquillisers I felt I was pushed out into the wilderness. When I came home I threw the tablets on the floor. I felt very vulnerable." (Roseleen, interviewed April 1995)

Roseleen stayed in bed and breakfast for three months and was then housed in a women's hostel in Kings Cross. She was beaten up by one of the women who accused her of stealing her purse and then sent her out on the game to earn the stolen money. She remembers walking around Kings Cross at 5.00 am in the morning in a confused state with a torn dress and bruises all over her body. Luckily she was picked up by a kindly resident who out of concern for her safety put her in a taxi and took her home to her parents. She broke down afterwards and was admitted to the psychiatric wing of the local hospital for six months.

Irish people invest a lot in their children. They are very important in the culture to sustain the sense of the family over the generations. Women users engaged in the practical work of raising children have different and separate concerns. One user sustained physical abuse repeatedly over the years. She stayed in the relationship because of the children. Her husband had head butted her on Christmas Eve 1994. She was quite stressed and also felt physically unwell for several years. She was prescribed tranquillisers by her GP. After a lengthy period of time a scan showed she had Multiple Sclerosis and that the physical symptoms over the years were due to the

onset of the disease. As a result of her declining health she felt powerless and unable to leave the marriage.

Another user was convinced her child was not thriving. When she requested a specific examination from her GP and several paediatricians they refused to take her seriously stating her child was doing well. Finally after battling with the system for a year she managed to have her child examined and he was found to have a life threatening illness. He was rushed to Great Ormond Street Hospital and barely survived the operation. Her child fully recovered but soon afterwards she started to have agoraphobia and panic attacks. She was later sectioned under section 136 of the Mental Health Act. Her one recollection of the whole episode was of an immense feeling of anger and rage at the medical establishment when she reached the hospital.

The Irish Children and Families social worker based at BIAS pointed out how Irish women are reluctant to approach statutory services fearing their children will be taken into care. In fact this happened to two of the users that I interviewed for this study. Langan and Day (1992) in 'Women, Oppression and Social Work' discuss how social workers are often urged to protect children and disregard the feelings and needs of mothers. They go on to state how women who are seen as not coping are more likely to lose their children or their liberty.

The Loss of the Irish Language

Language is the badge of a society. It is the medium through which culture is transmitted. Language and culture embody a person's sense of themselves. The loss of the language for Irish people created a linguistic upheaval breaking the thread of a cultural heritage that goes back further than any other in Western Europe apart from the Greeks. Subsequently our language is directly translated from the Gaelic which affects our usage of words and the different meaning attached to those words. The relationship between language, power and status in society is crucial. It has a direct bearing on structural oppression and disempowerment. The words '*that sounds very Irish*' is a term used for something when it fails to make sense and is a commonly used phrase in British society. When Irish people open their mouths they are often slighted because of their accents and told their use of the English language is incorrect. This is like a double assault.

The first assault occurred under colonial rule in the 1800's when the Irish language went into decline. All of these factors place a considerable strain on Irish people in this country.

Cultural Differences in the Manifestations of Stress

There is a widely held belief among the Irish community that Irish people are misdiagnosed by British psychiatrists ignorant of the background from which those people come. The Irish Mental Health Forum in reviewing mental ill-health among the Irish community relate how British society in general and psychiatry in particular have few categories to enable them to understand the cultural, social or spiritual dimensions of the Irish psyche (see Finnegan and Harrington, 1989). An article by Neil Doolin in the Nursing Standard emphasised how Irish women who have talked of seeing visions of the Blessed Virgin or have insisted they have seen statues moving have been labelled schizophrenic by a profession unaware of the role religion plays in Irish cultural life. Doolin also puts forward the fact that Irish men are more likely to be diagnosed as alcoholic than schizophrenic in Britain suggesting the stereotypical and racist views of Irish people being drunk and prone to violence have been internalised by the medical profession. This ignores the possibility that the men may suffer from schizophrenia and also drink heavily. Minority beliefs can often be equated with madness and in the end this is an injustice.

Alcohol plays an important part in the social gatherings of Irish people. It is present in places where Irish people meet to sustain their sense of community. It often serves an analgesic function for the Irish migrant dulling the pain of homesickness and discrimination. It is important to acknowledge that different patterns of behaviour may be just different responses to a similar situation. The Irish have the highest death rates due to alcohol mis-use of any ethnic minority in the London borough of Brent. Research carried out last year (McCollum, 1994) showed high levels of psychological stress associated with these individuals who presented with alcohol related problems. This was further compounded by the effects of migration, homelessness, sub-standard housing, unemployment, poverty and racial prejudice.

At Cricklewood Homeless Concern 63% of the 71 Day Centre users have identified alcohol related

problems. The CPN employed at the project viewed her large caseload of Irish clients within the context of a "moving community". They were constantly on the move with regard to their housing situation and often found it difficult to acquire a GP. Their health frequently deteriorated due to limited access to treatment. She commented on the clear links between substance misuse/ psychological distress and physical health problems. This was the case for many Irish clients in her work practice. Physical symptoms included chest problems, liver damage, heart disease, diabetes, ulcers, asthma and high blood pressure.

Alcohol misuse also posed a problem for two of the Irish users involved in the study. They had both reached crisis point and found it difficult to carry on with their lives. Alcohol helped to dull the pain for a while and made them feel more relaxed and at ease with themselves. One user gave up drinking when he developed irritable bowel syndrome. The other user had a breakdown and later benefited from a detox programme which enabled her to curtail her drinking. However she still has bouts of asthma and suffers with rheumatoid arthritis.

The Reed Committee Report (1993) draws attention to the high proportion of people from black and ethnic minorities diagnosed with mental ill-health, receiving high doses of Electro Convulsive Therapy and being compulsorily detained under the Mental Health Act, 1983. Two users I spoke to had been admitted to psychiatric institutions for a number of years and were given ECT on several occasions throughout their stay. Both suffered poor concentration and memory loss as a result of the treatment. The manager of the psychiatric unit at Central Middlesex Hospital in Brent remarked on how it is generally Black and Irish people who are compulsorily detained. Excessive use of police powers can have serious repercussions for Irish users. Recent evidence (Woodhouse et al, 1992) indicate that the Irish suffer a different pattern of day to day policing from the rest of the white population. They were more likely to be stopped and searched and more likely to be charged with an offence thereafter. The high profile cases of the Birmingham Six, the Guildford Four, the Maguire family and the Winchester Three gives Irish people reasonable cause for concern about their expectation of fair and equal treatment.

One user I interviewed was sectioned under section 136 of the Mental Health Act. She was beaten up and handcuffed by the police. She arrived at Central Middlesex Hospital with bruises all over her body.

The person who examined her was shocked at the bruising but nothing was done to challenge the abuse. Her words typify how she was feeling:-

"I was relieved when I got to the hospital. The Irish nurse treated me like a person. The police treated me like a piece of scum." (Teresa, interviewed March 1995).

Front Line Work with Users

Assessment of need is the key to the process of service allocation. Lack of access to a community care assessment was a major contributory factor in prohibiting Irish users from obtaining a service. Several users I worked with had gone to the Mental Health Team in the East Sector but had not been offered help or support. Other users had gone directly to BIAS and the agency had applied for an assessment on their behalf but had made limited progress. The response from the Mental Health Team was that the users didn't fit the appropriate 'category of need'. They needed to come under the mental health specific category (i.e. schizophrenia, manic depression, severe psychosis) to fulfil Brent's eligibility criteria.

Smith in her article "Social Need" (1980) compares the assessment process to an audition where clients success is dependent on the criteria employed by social workers to ascertain if a person fits into the appropriate category of need. Littlewood and Lipsedge (1993) in their book on ethnic minorities and psychiatry mention the indiscriminate use of labelling on black and ethnic minority groups. They state how the act of "pigeon holing" is an invalidating experience and how demeaning is to fit into someone else's shorthand.

I worked with one user whose needs were a combination of social problems, anxiety and depression. She was living in sub-standard accommodation and the surveyor from Brent council had deemed the property to be a health and safety risk. She was existing below the poverty level and was not claiming the benefits she was entitled to. She was addicted to Valium and her use of medication was not being monitored at the local health centre. She was also in the early stages of cancer and was not able to attend the hospital for treatment due to the other debilitating factors in her life. Her needs were complex and wide ranging and required urgent attention. When I contacted Brent Housing Depart-

ment they refused to take any action without intervention from the Social Services Department due to the user's mental health needs. The Mental Health Team in the East Sector were not prepared to offer an assessment as they felt the user did not fit the correct category of need. It was only when I wrote a report highlighting the risk factors with accompanying letters from the user's GP and the Housing Department that the Mental Health Team agreed to carry out an assessment and offer a subsequent package of care. The concept of assessment was dominated by the concept of risk. It was only because I was familiar with the procedures that this particular user was then granted a service.

Another user was admitted to Central Middlesex Hospital with bowel problems. He was prone to bouts of anxiety and severe depression and was addicted to Valium. He was also homeless and was fleeing abuse from his former partner. He underwent an operation and the discharge arrangements were unable to be finalised because the ward staff were unable to allocate a social worker to carry out an assessment of need. Several weeks after the operation I was contacted by the ward sister who informed me the user was being discharged because he was occupying a bed space which was urgently needed for another patient. After frantic intervention on my part the hospital Mental Health Team reluctantly agreed to do the assessment at the same time stating the user did not comply with their eligibility criteria. However due to a breakdown of communication between the social worker and ward staff this particular user was discharged late afternoon and when he reached the Housing Department it was closed. He had no money in his pocket and nowhere to live. He was homeless until he went along to Housing section the following day. He was placed in bed and breakfast accommodation and was offered a permanent home several weeks later. This is what happens with rigid eligibility criteria. No one is prepared to accept responsibility.

I attended a community care assessment at a user's request which was held in the Mental Health Team's offices in the East Sector of the Borough. The meeting took place in the same building where several years previously the user's two children were taken into care. She was naturally apprehensive and tense. She had been given no explanatory notes about the assessment procedures nor was she made aware that she could invite another person along for support. Socio-cultural sensitivity was not introduced into the assessment process. No mention was made of her needs as an Irish woman and how this affected the social realities of her life. A personal

support network was not identified on her behalf. The assessment did not record significant life events which shaped her mental health history and brought her to the attention of the social services in the first place. She was not given a written account of agreements reached and did not receive a copy of the completed assessment form. This was hardly a user involvement exercise. The balance of power rested with the professional and only served to reinforce the powerlessness Irish users face in a system which fails to acknowledge cultural diversity and difference.

I visited another Irish user who had recently been taken off a section and discharged from hospital into the community. Discharge arrangements were not adequate and he was finding it difficult to cope on a daily basis. He wanted to do voluntary work and get involved in social activities but found it difficult to leave his flat due to debilitating depression. His television was not working. He had no curtains in his bedroom and his bed was too small. An individual care plan was devised by the social worker but no outreach support was available to enable him to live an independent life in the community. Several weeks later he was hospitalised again. I attended two section 117 meetings at the Central Middlesex Hospital. The user in question asked for an Irish social worker and was also interested in participating in Irish cultural activities in the community. These specific issues were not recorded in the minutes of the meeting and the Irish dimension was notably absent from any dialogue around the user's needs. The social worker was not present at the meetings and the ward sister was busily progressing plans for the user's departure and seemed to be unaware of the role the social worker played in the resettlement period. This was not collaborative practice. What it amounted to was a fragmented service which ultimately has a direct bearing on a service user's 'quality of life' in the important transition from hospital to community based care.

Users I worked with were not aware of their entitlements under the NHS and Community Care Act 1990. They had no knowledge of Brent's mental health provider structure nor of decision making processes and channels of complaint should they be unhappy with current delivery of service. They were unable to access services and thus were excluded from a whole range of opportunities, resources and networks in relation to their particular needs.

The issues I have outlined in this section are very familiar to BIAS and to the Equal Access Team. They are recurring threads which continue to give these



agencies cause for concern. BIAS has noted a steady increase in the amount of vulnerable Irish people requesting support and in the severity of the presenting problems since the onset of community care in 1990. The Children and Families social worker at BIAS has a caseload of 75 cases (from October 1994 until August 1995) of which 25 individuals present with major mental health difficulties. This is a disturbing picture of a community under considerable strain and requires immediate debate as to the delivery of an effective service to this particular minority group.

Overview from the Statutory Provider Section

John Upton in his article in *Critical Social Policy* (Winter Issue 94/95) conveys how the Patients Charter does not adequately address the concerns of users of mental health service. He mentions how they are often denied even the basic right to define the significance of their own experience. When Irish users are admitted to the psychiatric unit of the Central Middlesex Hospital they are likely to be particularly vulnerable and stressed. They are hardly likely to mention discrimination and social injustice because the practising psychiatrist is seen to be a member of the establishment who would not be

expected to listen to such complaints. Subsequently users seldom get a chance to tell their story and a great deal of their experience remains unnamed for them. The socio/economic and political dimensions which are contributory factors underlying their mental distress is rarely taken into consideration. This represents diagnostic pitfalls for the practitioner who may not be able to translate the user's concepts into his own conceptual framework. She/he will not be working within the user's frame of reference and this can therefore result in an inaccurate assessment of need.

As at the 1st of December, 1995 there were no Irish psychiatrists practising in adult mental health at the Central Middlesex Hospital. Irish users are quite subdued and are not forthcoming with information when they are first admitted to the hospital ward. Medical files only highlight alcohol problems for those Irish users with dual mental health/alcohol difficulties. The Irish manager based in the psychiatric unit of Central Middlesex Hospital felt that Irish people preferred a home treatment service and asserted community outreach on a continuous basis. He saw the mental health service as essentially a hospital based provision which was too remote from the community and therefore not connected to the concept of community care. There was an inherent lack of resources, acute bed shortages and everything closed down at 5.00 pm on Friday afternoon.

There was a real need for a 24 hour crisis service, more day care and respite care, assertive community outreach and a 24 hour CPN service.

I spoke to an Area Manager for the CPNs who works in the West Sector of the Borough. He stipulated how the North West London Mental Health Trust is committed to the care programme approach. This involves joint working together so that people's needs are met. The remit for CPN's in Brent is to provide a service for long term mentally ill people. Essentially care programme planning is targeted at people in contact with formal psychiatric services. There appeared to be no place for primary "preventative" care in the community. The "medicalization" of stress prevailed where the most likely form of treatment offered was medical. The CPN talked about the need for GP's to attend section 117 meetings due to their central role in patient care. However they rarely attended and were least involved in collaborative developments around community care. One user interviewed stated *"the reality is if you don't have a good GP and you're not very vocal then you are not in a position to access services through GP referral"*.

The Community Intervention Project (CIP) was a multi-disciplinary team which was set up by the North West London Mental Health Trust. It aimed to provide a responsive service to Brent residents experiencing mental health problems as an alternative to hospital admission. I worked with one user who had been excluded from the Irish Travelling community due to his mental health difficulties. He had attempted suicide several times and was addicted to temazepam. He had previously made contact with the Social Services Mental Health Team but had not been offered support. I referred him to the CIP and after the initial assessment I was able to access a range of expertise within the team. Consequently the user received a holistic package of care which was culturally appropriate and related to his specific needs. Unfortunately the CIP is now closed and the North West London Mental Health Trust has sectorised its services with the aim of making co-operation with other care providers easier and improving local responsiveness. Team members from the CIP have been incorporated into separate community teams in Brent. The Area managers for CPNs are no longer based at day hospitals but act as co-ordinators to the community teams located in close proximity to the Social Services' Mental Health Teams.

What seems to be fundamentally missing is the "social function" which combines health care and

social care at the interface of multi-agency working. The new teams appear to be medically focused and appear not to contain the wide range of disciplines of the former CIP.

The team leader from the Mental Health Team in the Social Services North West Sector described how his team of social workers have become casualties of Brent Council's contract culture. They have to follow rigorous guidelines in relation to mental health criteria and were largely working with people with acute mental health problems. They were faced with scarce resources, heavy and demanding workloads and had little space for preventative care within their framework of provision.

John Wilson House is a Day Centre situated in the heart of the Irish community. Twenty Irish users attend the Day Centre facilities on average per week. This seems disproportionately low if we consider the size of the surrounding Irish population. This figure also has to be measured against the number of Irish people using day care facilities at Cricklewood Homeless Concern who present with mental health difficulties. The manager at John Wilson House voiced her concern at the lack of a culturally sensitive service for Irish users. There are two separate day care facilities which caters to the needs of the Black community and the Asian community within the Borough of Brent. However there is no specialist provision for the Irish community.

Brent MIND who are commissioned to provide mental health services have a designated Irish house, but it is not staffed by Irish workers.

I visited the Outreach Team in the South East section of the Borough. They receive referrals from the Mental Health Team in the East sector. Team members admitted to supporting only a 'handful' of Irish users and expressed surprise at the low number given the location of the team in a predominant Irish area. I also visited the Outreach Team in the North West section of the Borough. The Irish team leader spoke about the disproportionately low numbers of Irish people using outreach services.

As at the 1st of September 1995, there were no Irish outreach workers in the Outreach Team which serves the Irish community in the South East section. There are also no social workers employed specifically to work with Irish people with mental health problems.

The advice worker at BIAS sees little partnership work between the statutory mental health provider sector and the Agency. She feels that generally BIAS has become the 'dumping ground' for all things Irish.

No real collaboration takes place where power is shared and professionals are working together for the common good of the service user.

The reality in Brent for Irish users is that they can't get access to a community care assessment and thus access day care, outreach services and a range of support in the community. The facilities provided by social services are culturally inappropriate and the support systems are 'service led' and not suited to their individual needs. It is therefore difficult for them to comment on how services could be made better if they have little access to services in the first place. There is no Irish cultural dimension within the NHS adult mental health services. Hospital aftercare provision is limited, patchy and uncoordinated. The medical model appears to prevail and there is no consideration of alternative ways of managing stress. Funding appears to be targeted at acute mental health provision. I saw little evidence of preventative measures to sustain Irish users quality of life and enable them to live fully independent lives in the community. There is no 'meeting point' in the encounter between the professional worker and the Irish user. There is a general lack of awareness among staff teams about the mental health experience of Irish people. The message that comes across is 'you don't matter' or more oppressively still 'you don't exist'. We are in danger of creating a minority community who don't have a voice and whose lives are stitched with inequality and oppression.

Brent Council's joint mission statement with Brent and Harrow Health Agency discusses how the mental health needs of a community and the people who make up that community are profoundly affected by social, cultural, economic and environmental conditions. It seeks to address the needs of all ethnic and cultural groups and those suffering discrimination and disadvantage. These key priorities which are incorporated in Brent's Community Care Plan 1995 - 98 are clearly not evident in statutory provider services in relation to the mental health needs within the Irish community.

The views put forward by Irish users is fundamental to effective community care practice. It relates to one of the key recommendation proposed in the Government's White Paper 'Caring for People' (1989) which is embodied in legislation in The National Health Service and Community Care Act (1990). The White Paper seeks to promote the development of domiciliary, day and respite services to enable people to live in their own homes and to encourage the targeting of home based services on

those people whose need for them is greatest.

Not all mentally ill people are known to community mental health services. Our knowledge of mental health in Brent is largely based on those people who are in contact with formal psychiatric services. This leaves out a sizeable proportion of Irish users whose daily lives are a combination of social problems and disabling emotional difficulties such as mental distress, anxiety and depression.

What is needed by all ethnic minorities, including the Irish, is an intervention at all levels which does not just provide a crisis response but also indicates a long term strategy as well as a preventative dimension. A mental health strategy must have as its aim the development of a mechanism which brings maximum co-ordination and integration between agencies so as to achieve an appropriate balance of prevention, treatment and rehabilitation. The services we need to develop should not just identify and treat, but should also prevent the onset of mental illness.

Health service purchasers and providers need to familiarise themselves with Irish culture and not just the nuts and bolts of how Irish people live but also with the beliefs and value systems which underline their behaviour. Failure to recognise Irish ethnicity and the distinct emigrant experience results in a service provision which is culturally inappropriate and not suited to Irish users needs.

The real choice for practitioners is between recognising differences and doing their job well or failing to recognise differences and doing it badly.

Recommendation

There is a crucial need for statutory mental health services in Brent to address the identified gaps in current provision and to provide a framework for good practice in mental health care within the Irish community.

BIAS and Equal Access will actively explore the possibility of joint funding arrangements from Brent & Harrow Health Authority and Brent Council to provide the following service, from 1997 onwards;

An Irish Mental Health Assessment Team, consisting of 2 social workers involved in community care assessments of Irish people in Brent, 1 admin support worker and 2 outreach/development workers engaged in addressing the cultural inappropriateness of current service provision for the Irish .

An application to the joint finance scheme may also be considered.

During these negotiations with both the Council and the Health Authority, protocols will be drawn up to finalise the details of how this team will be set up and operate; points of access for members of the local Irish community; how the team will work with the generic services and monitor the implementation of individual care plans; and how existing services can become more appropriate to the needs of the Irish.

Only through the establishment of this multi-disciplinary team can the issues raised in this investigation be truly addressed, and the Community Care obligations of health service providers become a reality for Irish people in Brent.

Conclusion

The lack of resources, respect and dignity allocated to Irish people experiencing mental health difficulties in Brent is a matter for serious deliberation. Policy makers/practitioners must acknowledge and work with the fact that Irish people need support to achieve autonomy and a lifestyle they value. They have a right to a service which is fair, culturally appropriate and ethical. The differential uses of treatment have to be corrected if they represents practices which are unjustified. The mental health of the Irish community in Brent is a legitimate area of concern and study.

This investigation has touched on the issues and realities of their daily lives. Irish users have told their story and their needs are articulated in the proposal for an Irish specific mental health team. It is now time for policy makers/practitioners in Brent to be accountable to Irish users and to implement this mental health strategy which caters to their needs. The themes of partnership, choice, empowerment and needs led assessment are cornerstones of service delivery. We need to apply these principles in practice if we are to achieve a Community Care system which centres on user led/needs led services.



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"The Irish experience in British society is often not appreciated nor understood. It is important to bear in mind how social, economic and political structures continue to disadvantage and oppress Irish people. If practitioners ignore anti-Irish racism then they fail to take into consideration key elements of organisational and professional power. An understanding of Irish culture has to be integrated with an understanding of the social conditions which disable individuals experiencing mental distress within the Irish community. Stress indicators such as emigration, loneliness, loss, isolation, poverty, the myth of return, homelessness, sub-standard housing, unemployment, exclusion and discrimination have to be taken on board as causal factors in the Irish mental health experience. Mental ill-health is sometimes the price they have to pay for adaptation to a society which is accepting only on racist terms". Elizabeth Farrell