Irish Aged 50+ in Calderdale Health Study

Draft Final Report

March 2009

CRESR
Centre for Regional Economic and Social Research

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A Project Supported by NHS Calderdale

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- 'The Irish Post' newspaper
- 'The Irish World' newspaper.

We would especially like to thank the Irish community in Calderdale for taking the time to speak to us and share their stories, invaluable insights and experiences. This report is dedicated to them.

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Executive Summary

This report commissioned by NHS Calderdale examines the health status of the Irish aged over 50 in Calderdale with specific reference to their health needs and concerns, their use and experiences of health services and their willingness to engage in future health consultations. The research findings are underpinned by a review of the current literature on the experiences of the Irish community in Britain. Evidence was gathered from a representative sample of the Irish community in Calderdale, through the analysis of 113 self-completion questionnaires, 2 focus groups involving a total of 20 participants and in-depth interviews with 14 individuals. The research took place over a three-month period concluding in March 2009. The findings include:

- although Irish people in Calderdale aged over 50 were aware of health problems affecting themselves or family members, they were unaware of the particular health risks or inequalities experienced by the Irish population in general. Six contributory factors to ill health were identified: the experience of migration, socio-economic factors, the historical physical environment in Calderdale; health hazards in particular occupations; genetic susceptibility and lifestyles

- the majority of research participants reported themselves to be 'very' or 'reasonably' healthy. However, the participants did identify a range of physical and mental health concerns, the most prevalent being high blood pressure, high cholesterol, heart disease and diabetes

- a significant minority of participants had personal or family experience of mental health problems although there was a marked reluctance to discuss mental health within the community. It was also evident that unless participants had direct experience of mental health within their own families there was a general lack of awareness of the prevalence of mental health issues amongst the Irish population

- research participants identified key strategies for health and wellbeing, including feeling fit and active and engaging in social and cultural activities such as using the Irish Centre in Calderdale. The Catholic faith and Church were very important to the well being of a large proportion of the research participants

- awareness of health risks and the importance of a healthy diet and exercise varied amongst the research participants. There was a general reluctance to engage with formal health service providers, often arising from the experiences of the first generation in Ireland and this often resulted in delaying seeking treatment, tolerating a condition or relying upon informal sources of advice or remedies

- overall, satisfaction levels with the health services that participants used was very high, particularly regarding the quality of care given by health staff. However, a number of problems were identified, including waiting times for appointments, the limited time available in GP consultations and difficulties with booking appointments

- the majority of research participants did not seek or desire greater influence over their health care or service provision, although there was a notable willingness to use private health services

- almost one in five survey respondents identified the need for greater cultural awareness of the Irish by health service providers, and individual participants identified problems in communication or a lack of understanding linked to their ethnicity

- awareness of public participation mechanisms within Calderdale NHS was very low amongst the elderly Irish population. However, a majority of survey respondents did express a willingness to consider becoming more involved, to varying degrees. Participants who had been involved in consultation events, such as those held previously at the Irish Centre in Halifax, were generally positive about the experience

- the study has generated a number of recommendations relating to: education and awareness raising about the needs of the older Irish population amongst health service providers; health provision and health promotion activities within and for the older Irish population; and facilitating the greater participation of the Irish population in NHS consultation mechanisms.

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1. Introduction and Background to the Report

Why a health study of the Irish aged 50+ in Calderdale?

There is an increasing body of research evidence that suggests that the Irish population in England is a significantly older population and one suffering relatively poor health, including high admission rates for mental health services, compared to the host population and other Black and Minority Ethnic (BME) groups (Tilki, 2003; Walls, 2006a; Tilki, 1998; Bracken, 1991). Further, unlike other minority ethnic groups, the health status of the second and third Irish generations does not appear to improve over time and health inequalities therefore persist through the generations.

In the 2001 Census the Irish population in Calderdale was 2,082 as compared to 32,735 in Yorkshire and the Humber, and a total of 624,115 nationally. It is probable that the proportion of Irish people recorded in the Census is an underrepresentation of the size of the actual Irish population. This complex issue is discussed more fully in *England: the Irish dimension - an exploration of 2001 Census* data (Limbrick, 2007). In Calderdale 64 per cent of the Irish population are aged 50+ compared with 34 per cent of the overall population. The specific age profile of the white Irish population, with its bias towards older people, has implications in terms of care needs, as has the high proportion of two-pensioner households. The Irish community is dispersed across the Calder Valley with no discernible clusters of population (See Appendix 1). The Halifax and District Irish Society support the Irish community in the Calderdale area and have raised concerns with the PCT about the health status of older people in the district.

NHS Calderdale, in partnership with Calderdale Council, has committed to undertaking a Health Needs Assessment (HNA) of the Irish population who are 50 years of age and older in Calderdale. The HNA is intended to contribute to the Joint Strategic Needs Assessment (JSNA) process in relation to local prioritisation of services and resources. This study represents the main qualitative research component of the JSNA (other elements include analysis of the 2001 Census and stakeholder's views).

Aims of the research

The aim of this research is to present a comprehensive and accurate analysis of the contemporary and future health needs of the Irish population in Calderdale. The following objectives formed the basis for the research:

- to identify qualitatively the expressed health needs of the 50+ Irish population in Calderdale
- to identify qualitatively the formal and informal health and health-related services that the 50+ Irish population are accessing and the extent to which they are doing so
- to identify future health-related involvement opportunities with the Irish population in Calderdale.

Research methodology

The research methodology was informed by three guiding principles. First, the working definition of "Irish" referred to individuals of Irish origin whether they were born in Great Britain (or elsewhere) or the island of Ireland[1]. This study therefore included those who were born in Britain whose parents, grandparents or great-grandparents were Irish, as well as those who were born in Ireland. The inclusion of second and third generation Irish people in the study is important, not least because many of the health, welfare and social issues are present within the Irish population in Britain over several generations. It is also an acknowledgement that being Irish is not limited to those who were born in Ireland, but also encompasses those who define themselves as Irish.

Second, an equally broad definition of 'health' was used in the study, which included aspects of participants' physical, emotional and social health and well-being. This interpretation of health recognises that appropriate access to services, both statutory services provided by the PCT and the Council as well as more informal services provided through the voluntary and third sectors, are also important to individual's health and well-being.

Third, the study sought to recognise the diversity of the Irish population in Calderdale (e.g. age, gender, religion, country of birth, housing tenure and occupation) and the varying degrees of individuals' involvement in Irish community activities. The study is therefore based upon a diverse sample of Irish individuals.

Research methods

The research was conducted between January and March 2009. The research commenced with an extensive review of the literature and research evidence about the Irish community in Britain. This literature review informed the development of the research instruments including the survey and interview questions, as well as subsequent analysis of the findings.

A survey (see Appendix 2) was undertaken in order to gain a snapshot profile of the Irish population in Calderdale. This involved a questionnaire seeking information on a broad range of health issues, including the health status of respondents, their views on health and well being and their experiences of health services. The questionnaire aimed to: provide basic demographic information including age, gender, tenure, place of residence; reach a broader range of individuals than would be possible through focus groups and interviews; and to recruit a representative sample of participants for the one-to-one interviews and focus groups. A total of 600 self-completion questionnaires were distributed across Calderdale, in venues and services frequented by Irish people, including the Halifax Irish Centre, local libraries, and the main Catholic Churches.

A number of approaches were used to advertise the study and to recruit participants with the aim of minimising any possible bias from disproportionate representation from any one source of recruitment (Scanlon *et al*, 2006). The study was publicised nationally and at the local level. Respondents were recruited from an article in the *Irish Post* and the *'Irish World'* newspapers, the weekly newspapers for the Irish in Britain. Information about the study was placed on the Federation of Irish Societies website. A weekly Irish radio programme on 'Phoenix Radio' Calderdale community radio station, 'A Little Bit of Ireland', featured a discussion about the study with one of the report's authors. Two articles about the study in the *Halifax Courier* local newspaper also generated much interest. Finally, a briefing was given at the monthly Luncheon Club for Irish Elders (at the Halifax Irish Centre) about the study and surveys were distributed amongst attendees.

[1] The term 'island of Ireland' used here encompasses Northern Ireland and the Republic of Ireland

In total, 113 out of 600 questionnaires were returned, which represents a response rate of 19 per cent, a satisfactory response rate for a self-completion questionnaire. Almost three quarters (72 per cent) of questionnaires were completed by those whose 'country of birth' was the island of Ireland (i.e. first generation Irish) whilst just over a quarter of survey respondents (27 percent) were born in England (i.e. second and third generation Irish). Table 1.1 gives the detailed breakdown for the gender and country of birth of survey respondents.

Table 1.1: Profile of Survey Respondents

	England	Republic of Ireland	Northern Ireland	Other	Total
Gender					
Male	13	31	6	0	50
Female	17	35	6	1[2]	59
Total	30	66	12	1	109

N = 109 respondents

The next phase of the research comprised: two focus groups designed to explore in detail the views, attitudes and experiences of participants. The first focus group was held at Halifax Irish Centre, and the second focus group took place at Halifax Central Library. Although the focus group discussions were guided by a number of broad themes relating to health and well being, the emphasis was on what the participants themselves thought was important and relevant about these issues.

A series of one-to-one interviews with Irish individuals were subsequently carried out which allowed for more in-depth discussion of issues that were pertinent to the individuals' health experiences in Calderdale. The one-to-one interviews gave participants the opportunity to raise issues about their own health and well being that may not have been forthcoming in the group discussions. These interviews were informal and the topics covered varied greatly from individual to individual as the profile and personal circumstances of interviewees varied. Interviews lasted between one to two hours and took place in individuals' own homes.

In total, 20 respondents took part in the focus groups and 14 one-to-one interviews were carried out. Two of the focus groups and the majority of the interviews were digitally recorded to facilitate accurate transcription of participant's views.

Table 1.2: Number of Participants by Research Activity

Activity	No. of participants
Questionnaire	113
Focus Groups	20
Interviews	14
Total	**121**[3]

A total of 121 Irish participants took part in the study.

The health of the Irish in Britain - the research to date

It is important that the research in Calderdale is placed within the context of the wider research into the wider health of the Irish population in Britain. The Irish population comprises ten per cent of the ethnic minority population[4] of England and is the third

[2] United States of America
[3] This total reflects the fact that some participants took part in more than one research activity
[4] The ethnic minority population is defined here as all those who do not identify as White British in the Census, and includes those in the 'White Other' category

largest ethnic minority, after those of Indian and Pakistani ethnicity (Limbrick, 2008). Irish migrants in Britain comprise two main groups: older Irish people who migrated in the 1950's, who mainly primarily in manual occupations and social care (Irish nurses and carers), and younger immigrants who came to Britain in the 1980's and 1990's. Research has revealed differences between migrants from the Irish Republic, who tend to be more disadvantaged on key indicators, and those from Northern Ireland who are closer on average to the overall British population on indicators such as employment rates and educational qualifications (Hickman and Walter, 1997).

Many Irish groups and individuals in Britain have conducted a long running campaign to be recognised as a separate ethnic group in their own right. Prior to the 2001 Census the Irish were not considered to be a minority ethnic group, and hence were rendered effectively invisible in official statistics. The implicit assumption underlying this position is that the Irish, as a result of close geographical proximity, a common language and being predominantly white have been assimilated into British society, and consequently, have no *particular* needs to be addressed (Casey and Flint, 2008, p.4). There is a body of research evidence however that effectively challenges that position, particularly studies that point to stark health and social inequalities.

One of the key areas of concern for health practitioners is the above average incidence of primary, preventable diseases such as coronary heart disease, and cardiovascular disease amongst Irish immigrants. The Irish have the second highest rate for coronary heart disease in Britain (FIS, 1996). In addition, both first and second generation Irish people have very high levels of respiratory disease and TB, both of which are closely correlated with poverty and poor housing (FIS, 1996, p.49). Standard Mortality Ratios (SMR's) for lung cancer are 52 per cent higher for Irish men and 36 per cent higher for Irish women between 16 and 64 while "other" cancers are elevated by 20 per cent for Irish men and 32 per cent for Irish women compared to the general population (Harding and Balarajan 1996). There is also evidence to suggest that Irish people are comparatively less likely to feel themselves to be in good health. The 2001 Census asked about people's views of whether they were in good health or not. For each age group, for both men and women, the trend is for more Irish people than white British people to indicate 'not good health' (Limbrick, p. 5, 2007).

The statistics on poor health and the prevalence of diseases such as coronary heart disease and lung cancer would seem to suggest that Irish health behaviours are implicated in Irish health. In particular, attention has been drawn to the high rates of alcohol consumption and smoking rates amongst the first and second generation Irish in Britain. This evidence is far from straightforward however, with studies pointing to a complex picture of use, misuse and non-use of alcohol (Walls, 2006). Analysis of the 1995 General Household Survey (GHS) regarding patterns of alcohol use found that the Irish first and second generations are no more likely to drink than the host population, but if they consume alcohol at all, they are more likely to do so at higher levels than their British counterparts (Greenslade *et al*, 1995; Walls, 2006). This work also drew attention to the high rates of excessive drinking among Irish females, and higher rates of consumption among the second generation compared to the general population.

The health status of the Irish population also has to be put into the social context of Irish experiences in England, which in some cases encouraged the development of unhealthy life styles: the general relative socio-economic disadvantages for large sections of the population; poor housing; a concentration in the construction industry; racism and discrimination and the isolation arising from the experience of migration, for example (Walls, 2006, p.77).

The statistics for mental health provide further evidence of significant health inequalities suffered by the Irish population in Britain. Irish-born people are more than twice as likely as native born people to be hospitalised for mental distress (Bracken *et al*, 1991).

The Irish in Britain are over-represented in most mental health diagnostic categories, but the figures for depression and alcohol-related disorders are particularly notable (Casey and Flint, 2008, p.5). Rates of admission to hospital for depression show that those born in the Republic of Ireland are two and a half times more likely to be admitted than their British counterparts (Mind: 2007). Men born in the Republic of Ireland have approximately nine times, and women seven times the rate of alcohol-related disorders. However, there is much concern within the Irish community sector regarding the extent to which GP's fail to deal with the mental health issues that may be the underlying causes of alcohol dependency (Bracken *et al*, 1991). Research has also drawn attention to how previous negative experiences of psychiatric services, anti-Irish stereotypes and lack of knowledge militate against some Irish people effectively using mental health services (Walls, 2004; Horn *et al,* 2008).

In summary, there is a body of evidence that shows that the Irish in Britain do suffer health inequalities which are sustained between generations, and relate to both physical and mental health problems. The comparatively high levels of health problems within the Irish population are compounded by the lack of ethnic monitoring and hence, the invisibility of the Irish community to public health authorities and service providers more generally (Greenslade et al, 1991; Mac An Ghaill, 2000)

2. The Health and Well Being of the Irish[5] in Calderdale

Health status of participants

This study set out to ascertain the health needs of the Irish population aged 50 years and over in Calderdale and their perceptions and experiences of health and health related issues. To this end the prevalence of health-related problems that affected the research participants and their families were explored. Participants were asked to identify what health issues affected both themselves and any members of their immediate family. The most common health problems cited were cancers (in particular cancer of the lung, bowel and prostate), heart disease, high cholesterol, blood pressure, diabetes and arthritis. Participants were inclined to include not only their immediate family's health history (siblings, spouses and children) but also their extended family (aunts, uncles, grand-uncles etc) in their descriptions of their own health. They invariably pointed to a family history of the diseases in question and tended to track their health problems through the generations up to the present.

> *'A lot of my relatives died young. My father died of a heart attack. My grandfather had Prostate Cancer and another two uncles in Birmingham had it too. I kept checking myself and found a lump eventually'* (male, interview No.3)

> *'Myself and my brother have Osteoarthritis and he has bad knees. My Mam and Dad had Arthritis too. Now neither of us did the same kind of work as they [parents] did, so we're convinced it's come through the family'* (female, second generation Irish, focus group No.2)

This points to individuals having awareness of some inter-generational aspects to familial health. However, there was a lack of awareness amongst the research participants about the overall health risks amongst the Irish in Britain. Just under one half of survey respondents (45 per cent) thought that Irish people were not particularly prone to poor health while a further 30 per cent 'did not know' whether they were (or not). This was reflected further in the focus groups and interviews where participants expressed their surprise that Irish people had any significant health problems over and above what might be expected in the general population. On the contrary, participants were keen to point to how physically robust Irish people were by comparison to other minority ethnic groups.

> *'The Irish had to be healthy, didn't they….working in the foundries was hard, dirty work. When the Irish were gone from those jobs they were replaced by Pakistani men and they found that they couldn't do it….weren't strong enough'* (male, focus group No.1)

This lack of awareness of the particular health problems experienced by the Irish population needs to be addressed, particularly if it is replicated within the health professions and health service providers in Calderdale.

[5] The study focused solely on those who were 50 years of age and older

Beliefs about ill-health

The study set out to explore what factors participants attributed to their own health status. Participants were asked to reflect on what the main causes of ill-health for them and their immediate family might be. The migration experience, the physical environment in Calderdale, occupation, genetic susceptibility and life style were identified as the main contributory factors.

The majority of first generation Irish people in the study arrived in England in the 1950s and 1960s. A significant percentage of these were from rural backgrounds and had migrated when they were in their late teens and early twenties. Many Irish men had been farm labourers before they came to England and the contrast between rural life and industrial West Yorkshire in the 1950s, combined with feelings of loneliness and isolation was not thought to be conducive to a healthy lifestyle. There was an absence of any kind of Irish community centre or formal support for these migrants and they relied on a network of family, friends and the Church in order to access housing and employment.

> *'It's not like it is now with a lot of support for different ethnic groups. When we came over we were on our own. You got no help, only from the Church'* (male, focus group No.1)

Participants recounted the overcrowded and poor living conditions to which they were subjected and their struggle to get a decent place to live. Single men, in particular, living in bedsits and housing in multiple occupation (HMOs) in the private rented sector led unhealthy lifestyles centred around the pub, excessive alcohol consumption and smoking. A minority of those, who never married, failed to make the transition from this poor accommodation and continued to lead a 'bachelor' lifestyle with direct repercussions for their health in later life.

The general physical environment in Calderdale in the 1950s and 1960s was also thought to be responsible for a lot of the health problems that now surfaced within the Irish population. The high levels of pollution from the mills and foundries were cited by a number of participants as one of the main causes of respiratory failure and lung diseases.

> *'Halifax was a very dirty place in the [19] 50's. If you went to Leeds and came back on the bus you'd see a cloud of black smoke hanging over the place'* (female, interview No.4)

Although pollution was a problem for the general population it was an even greater problem for Irish people given their high concentration in the heavy industries around Calderdale.

Participants made a direct link between the current state of health of Irish people and their past employment in heavy industry. Irish people were employed in large numbers in modern foundries, the mills and factories in the Calder Valley. The nature of the work that Irish people tended to do had had an impact on their long-term health. Irish people suffered from respiratory problems in particular. While one focus group participant attributed this to smoking, a former bus driver said it was more complicated than that. He spoke about the fact that the air was heavily polluted in Halifax in the 1960s and 1970s and he had to have the headlights in broad daylight because he couldn't see out the window.

> *'When I was a bus driver there'd be 50 buses starting up at the same time in the depot. Everyone was revving up to get the air pressure up, and the air was thick with smoke. It was pure poison'* (male, focus group No.1)

Another participant gave the example of work in the furnaces where it was 'red hot'. He had worked in a 'modern foundry' in the 1960s and '70s and reported that 90 per cent of the workforce there was Irish.

> *'It was rough work, dirty work'. There was one Irish chap he went back to Ireland after working 10 hours a day, for 27 years in a foundry. They were treating him for 'Farmer's Lung', which he didn't have as it turned out. Lucky for him a doctor who was from Sheffield originally examined him and diagnosed what the problem was. The overhead cranes were shaking out sand and the smoke was going up in the air all the time. An image of everything they were going to cast was made in sand. The sand settled on the lung...that was the problem* (male, focus group No.1)

It was also reported that many of the Irish men who worked in construction now suffered from Asbestosis. This particular illness was not confined to those working directly in the factories and construction where Asbestos was used, as Irish women who washed clothes that had been in contact with Asbestos were also affected.

Many of the other reported health problems such as hearing difficulties stemmed from working in the foundries and the mills, and affected both men and women in their later years.

> *'When we worked in the mill it was very noisy and we didn't get ear protection. We didn't get ear plugs.... it was deafening* (female, focus group No.1)

Irish men, working in ground work in construction were also afflicted with Arthritis in their later years:

> *'They're bent, they're crippled and they're knackered' (male, focus group No.1)*

> '*You'll see these people at the Irish Centre....they're going in there now in their late 60s and 70s and you can see they're all bent down and they can't walk because they've been down trenches and crippled with Arthritis from having being bent down and soaked through, working all day 'cos if you didn't work you didn't get paid'* (male, interview No.12)

Some participants also suggested that unhealthy lifestyles were also a reason for poor health amongst the Irish. They described how in the face of hard economic circumstances, poor housing and the desire to socialise with other Irish people they had drifted into spending long hours in the Irish Centre 'having the craic'. There was no opportunity to have any privacy in lodging houses where Irish men slept up to six to a room (a common practice in Calderdale and elsewhere in the 1950s and 1960s) and no living room available to them to relax after a hard day's work. Alcohol was considered such an integral part of Irish culture and social life that it was hard to avoid it. Kieran, now in his 70's, recalled how he had got into drinking as a result of living in lodgings and not having anywhere to relax in the evenings beside the pub.

> '*The landlady, she was a nice woman and all that, she was Irish...but she didn't want you there in the evenings, and at the weekends. I came over when I was 18 and didn't start drinking until I was 21. There wasn't much else to do only the pub'* (male, interview No.13)

Another participant made a direct link between his unhealthy drinking and smoking habits over the years and his current health problems:

> *'I've smoked for 50 years and drank seven nights a week. Now I'm suffering the consequences. I got Angina when I was 55 years of age'* (male, Interview No.12)

Problems with alcohol were not confined to Irish men, with a couple of examples in the study of women who had been forced to give up drinking alcohol for health reasons. One participant in particular recounted how the apparent social acceptability and pervasiveness of alcohol consumption amongst the Irish community had caused great difficulties for her mother when she had to give up drinking alcohol:

> *'The Irish Club is alcohol based so when my mother discovered she had an alcohol problem she had to stop going to the Irish Club, where a lot of her friends went'* (female, interview No.11)

Smoking was also very common amongst the Irish in the 1960s and 1970:

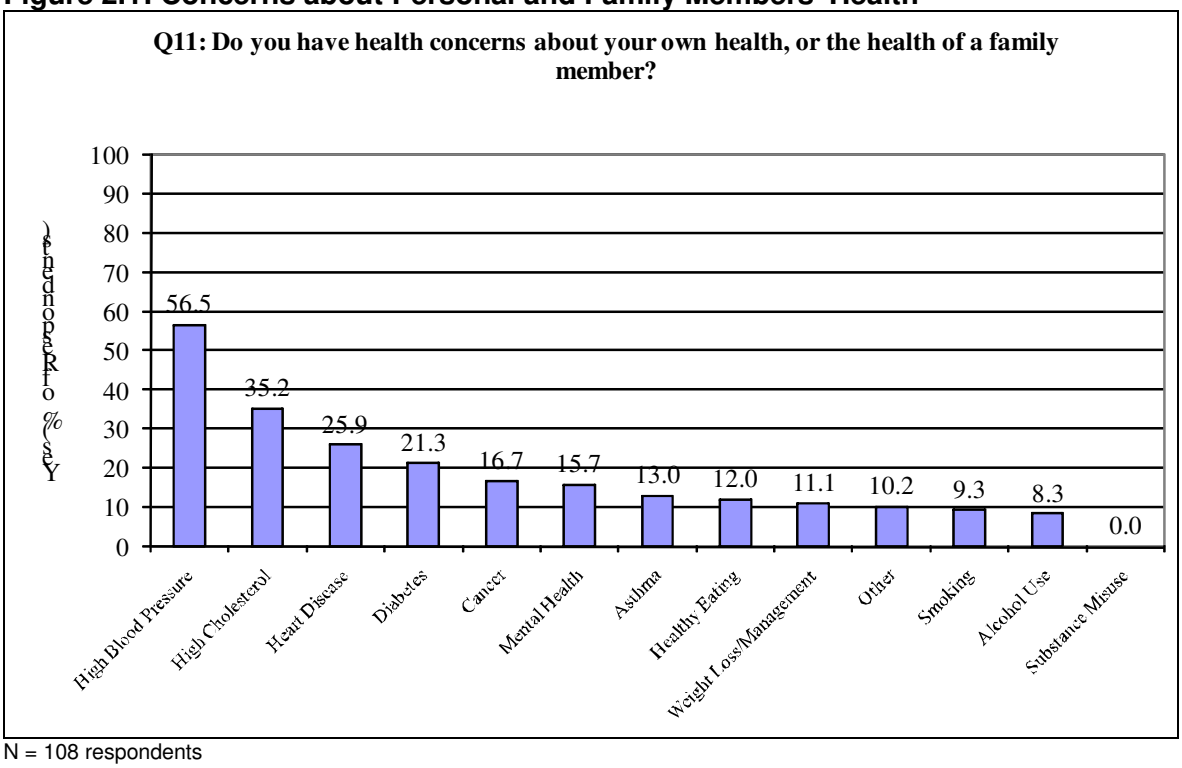
> *'Smoking was very popular - we were all smoking away. That didn't do us any good, did it? But now that we realise a lot if people have given up'* (female, focus group No.1)

Although statistics point to significant health inequalities within the Irish population (FIS, 1996) the study sought to ascertain how Irish people themselves viewed their own health and well being. When asked to describe their own state of health the vast majority of survey respondents judged themselves to be 'very healthy' or 'reasonably healthy' (17 per cent and 70 per cent respectively). The majority of participants also thought that it was possible to be healthy and yet have some kind of illness. There was a general belief that having a disease or a health condition was not in itself a barrier to having a reasonable quality of life. It is interesting that the majority of participants thought themselves to be very or reasonably healthy despite the incidence of serious illness. It was notable that when asked a direct question about their health status participants stated their health was satisfactory before then identifying a number of health problems that they were experiencing, a finding that has been confirmed in other studies (Tilki, M., 1998; Cara, 1995).

Health issues: physical and mental health

The study explored what health issues were of concern to the older Irish population in Calderdale. It was clear that participants' concerns about their health were highly individualised, varied and complex. There were however, some health problems that were of more concern than others. Insert Figure 2.1:

Figure 2.1: Concerns about Personal and Family Members' Health



N = 108 respondents

Approximately one quarter (26 per cent) of survey respondents had concerns about heart disease, while one fifth (21 per cent) listed diabetes as a concern. Cancer (17 per cent), asthma (13 per cent), healthy eating (12 per cent) and weight loss (11 per cent) were also issues for survey respondents. 16 per cent of the survey sample cited mental health as a concern.

Heart disease and related illnesses such as Angina, high blood pressure and high levels of cholesterol appeared to be a major health issue for the research participants. It was also apparent that participants were aware of the link between high cholesterol levels, high blood pressure and heart disease, and the importance of having a healthy diet. Poor eating habits and an unhealthy diet were given as one of the major contributory factors to ill health. Irish people's tendency towards eating fatty fried food, particularly in the past, was cited as one of the main reasons why so many of them now had heart problems:

> *'You're more aware of what you're eating now. All that salt and butter can be bad for you'* (Male, in his 60's, focus group)

However, there was a poor understanding of what constituted a good diet with confusion over such issues as the benefits or otherwise of having a simple diet, or the nutrition afforded by frozen or tinned foods, for example. The vast majority of participants were aware of the benefits of eating healthily, although this did not necessarily translate into more healthy eating habits. Padraig, an ex-foundry worker articulated the gap between awareness of healthy eating and the motivation to put this knowledge into practice:

> *'We see it all the time in the newspapers and on the telly – eat more of this and more of that, this is bad for your heart, don't eat this....eat more fruit and the like. But we never ate fruit really. It's hard to get in the habit'* (male, interview No.1)

> *'People get into a rut. They might change their diet for a few weeks but then fall back to their old ways'* (Female, in her 60's, Focus Group 2)

Diabetes was a cause for concern for some of the participants, often because either they or a member of their family suffered from the disease. The diet necessary to manage diabetes was seen as being difficult to get used to and quite restrictive. Alternatively, they knew friends who had the disease and had only a vague idea of what diabetes actually was. Knowledge about diabetes and insulin dependency was poor and gleaned from information in the newspapers, day time television and occasionally from friends. Yet it was a concern for some participants who were non-diabetic because they were apprehensive about developing the disease themselves.

Another cause for concern was cancer. Participant's knowledge of cancer was mainly based on either their own experiences, or those of close family and friends. As found in previous studies, it was clear that many participants lacked a comprehensive understanding of the complex nature of different kinds of cancers and how they manifest themselves (Scanlon, 2006, Randhawa and Owens, 2004). Having 'a lump' or unusual and persistent pain were the most common signs and symptoms of cancer. There was a high level of awareness of the link between lung cancer and smoking, but no mention of the link between cancer and alcohol consumption.

It was evident that there was a lot of fear regarding cancer. Some participants expressed a fatalism about contracting the disease, particularly if there had been a history of cancer in the family. They were also very pessimistic about the chances of surviving cancer or going into remission for any length of time. This was usually based on their personal experience of having a number of cancer-related deaths in the family, irrespective of age or life-style. Catherine, a woman in her 70's comments as follows:

> *'My Uncle Sean, he died of cancer and he never smoked or drank. A sister of my Father's she died of it too and she liked to have a drink, but she wasn't what you'd call unhealthy'* (female, interview No.10)

Many participants also spoke about the late detection of cancer in their family, and also the difficulty in diagnosing certain cancers. This contributed to the pessimism about success rates in treating cancer. The perceived likelihood of getting cancer if there was a history of it in the family, regardless of lifestyle, was a recurring theme in discussions around cancer. The corollary of this, that there was little chance of developing cancer if there wasn't a family history of the disease was also evident, although only with a small number of participants.

Mental health

The study set out to explore the mental health needs of the Irish in Calderdale. It was clear from the outset that there was a marked reluctance to engage with the issue of mental ill-health within the community. As has been found in other studies (Tilki, 2003) it appears that mental health is not an easy topic to broach with Irish people because it is regarded as a stigma and a secret to be kept within families.

> *'They don't want to talk about it because there's a stigma attached to it…much more secretive about anything to do with mental conditions'* (female, interview No.5)

It was also evident that unless participants had direct experience of mental health within their own families there was a general lack of awareness of the prevalence of mental health issues for the Irish population. Mary, an Irish woman in her late 60's, described how it took an incidence of mental illness in her own extended family (that of an Irish cousin), to alert her to the fact that there were other Irish patients in the local psychiatric hospital. This was something that she had been completely unaware of up to this point:

'He was very depressed, suicidal….said he was going to throw himself off a bridge. There were several other Irish people in there [local psychiatric hospital] at the same time and it's not a big place. I didn't realise that until my cousin was in the Dales' (female, interview No. 4)

As a result of this reticence, the two focus groups yielded little information or views on the subject of mental health problems beyond a discussion about the possibility that depression may be an issue for Irish people. In instances where mental health issues such as depression were acknowledged, the focus group participants linked it directly to the socio-economic circumstances and harsh material conditions that people were confronted with in the 1950s and 1960s rather than arising from psycho-social causes.

'An awful lot were depressed…those in the single category…never married, been all hard work and nothing to show for it in the end…living in bad accommodation' (male, interview No.7)

However, this study did find that that mental health was a concern for a significant minority of the research participants (16 per cent). The issue of mental health was explored further in the one-to-one interviews where participants shared their own experiences of mental health, which ranged from mild depression and loneliness to on-going problems with severe anxiety and stress. Bridie, a woman with grown-up children, expressed her sense of loneliness when she first came to England at being without her extended family and friends. Although these feelings had diminished somewhat over the years she still felt the loss of the strong social network she had left behind:

'You're much more lonely. You've no brothers and sisters here, people you went to school with' (female, interview no. 5)

Not having siblings and extended family members close-by was seen as particularly difficult when there were occasional family crisis' or emergencies, and re-enforced for Bridie, the sense that although she had lived in Calderdale for many years Ireland would always be 'home'.

Depression was an issue for a number of respondents. Catherine, a widow in her late 70's, had suffered with 'her nerves' and depression for many years. She had endured twenty years of domestic violence and had sought help from her GP in order to cope. She was prescribed anti-depressants, which she found to be of only limited use in addressing her anxiety and distress and abuse at the hands of her husband:

'I started to lose weight. Anti-depressants helped, but not all the time. They weren't much good if you were on the moor walking around with the children, locked out of the house [by her husband] at all hours of the day and night. My nerves were in tatters' (female, interview No.10)

Depression and anxiety relating to childhood physical and sexual abuse was also an on-going problem for one participant. Michael, a single man in his 60s, had been brought up in a series of orphanages run by religious orders in Ireland in the 1950s and moved to Calderdale when he was 16 years of age to join his family. He reported 'self-medicating' on alcohol for a number of years subsequently, unable to seek come to terms with the trauma. However, he made the decision to begin to address his problems, stop drinking and seek medical help. His GP was very sympathetic, particularly in view of the fact that he was trying to help himself by 'going dry':

'The GP was smashing...he was sympathetic anyway but my feeling was that he knew I was serious about trying to face up to reality when I went off the booze' (male, interview No. 2)

Michael has suffered significant mental health problems, including agoraphobia, panic attacks and severe anxiety as a direct result of his childhood abuse. These problems have had a major impact on his well being and ability to lead a fulfilled life:

> *'I have difficulty travelling on my own and feel vulnerable. I might have to break appointments because I might not be feeling my best'* (male, Interview No.2)

Although he was offered medication he turned it down preferring instead to use self-help books and voluntary work as a means of coping. This demonstrates a remarkable degree of self-reliance and resilience in the face of serious health issues, a theme that will explored further in section 2.??.

The research participants' experiences of physical mental health and access to health services were influenced by cultural issues and religious beliefs. Catholic tenets such as the sanctity of marriage and the family had a bearing on participants' willingness to ask for medical help. The church was seen as the 'first port of call' with some participants relying on prayer and the priest's counsel to help them to cope with marital problems and with their children. When participants did consult with their GP's they had usually exhausted all other possibilities:

> *'Being Irish and a Catholic I didn't want to give up [on her marriage]. I couldn't have gone to the priest because he wouldn't have believed me...that my husband was beating me and the children. I had to go to the doctor in the end...I was at my wits end'* (female, interview No.10)

However, when participants did present to mental health services, they reported that their Catholic beliefs were not understood and were not take into account by health professionals. Participants reported having great difficulty in communicating the importance of keeping the family together and addressing family relationships within the home, rather than simply prescribing medication. One respondent eloquently describes her experience of trying to deal with her son's mental health issues within the context of trying to keep the family unit together:

> *'In the field of mental health there is a gap between what I say and how I am understood. My son has experienced mental trauma since childhood and is now an alcoholic. I would have preferred help in sorting out family relationships to giving one family member tranquilizers. Culturally, I think the Irish of my generation do not find breaking up the family a solution. We use different terms in describing a situation and so are not understood. Our answers are skewed to fit into the boxes.*
>
> *My son has been sectioned in the past because the state of his flat suggested he could not look after himself and so was a danger to himself without medication. He is now a danger to himself through alcohol and cannot receive treatment without his consent'* (female, survey respondent)

Views on health and wellbeing

When asked their opinions on what good health was the research participants cited a variety of physical and mental attributes that contributed to well-being. There was a lot of emphasis on feeling fit and active: 'feeling fit, young and active' and 'keeping busy'. Spending time with grandchildren, babysitting for example, was a valued activity, both for simply keeping in touch with family but also helping out and being made to feel useful.

Keeping mentally alert was also highlighted as a key contributory factor to well-being. Hence, 'having an interest in things' such as politics, current affairs and various hobbies was also identified as an aspect of good health. Indeed, having an interest in current affairs was seen as a distinctly Irish trait and as something which bode well for the Irish community. For Josie, a retired nurse, it was very important that 'you keep your mind occupied', which she did by playing Scrabble and doing crosswords on a regular basis. Reading newspapers on a daily basis and going to the library was also a popular means to keeping mentally alert. There was a high level of awareness of the prevalence of dementia and Alzheimer's disease in older people through having family members or friends living with these conditions. This had spurred some participants into preventative action, notwithstanding the conflicting messages from the media and television about the efficacy of keeping mentally fit and alert. There was also a lot of confusion about the difference between senility and different types of dementia, and a lack of knowledge regarding genetic susceptibility to dementia.

There was a clear emphasis put on the social and community aspects of health and wellbeing. When asked to describe a 'healthy person' participants articulated a conception of health that was much broader than the absence of illness, and which encompassed some of the key definitions of a social model of health[6]. When asked about their own well-being participants broadened their interpretation to include aspects of the community and their social networks. Participants stressed the importance of being able to meet other Irish friends on a regular basis 'and 'socialising with other people' at the Irish Centre, for example. Spending time with other Irish people with whom they had a shared history and culture had a significant positive impact on some respondents' quality of life and well-being. Having Irish friends and getting together for social events such as Irish music, bingo and dancing meant that participants could maintain friendships they had built up over the years, and which had been a source of solace when they had first arrived in Calderdale, in some cases alone and without any family support.

Visiting the Irish Centre helped to mitigate the stresses of day-to-day living and foster a sense of self-esteem amongst some research participants that in the not so distant past was in danger of being eroded in the face of discrimination and racism. This was particularly acute at the height of the 'Troubles' in Northern Ireland from the 1960s to the early 1990s. Participants spoke about racist experiences in their places of work and in contacts with the employments services in the 1950's and 1960's.

> *'My husband was asked: "how can you be the boss – you're Irish"'* (female, interview No. 6)

The same woman recounted that herself and her husband, by virtue of being from Northern Ireland, were made to feel fearful and *'like we'd done something wrong'* by the Police Special Branch who followed them around for a number of weeks when they first arrived in Calderdale. They attributed this covert surveillance to the fact that they had Northern Irish number plates on their car and were also new to the area.

Another participant, Bridie, described her feelings of humiliation at attempting to register for unemployment benefit:

> *'It was the most humiliating time of my life. I said I'd come from Ireland because of my husband's job. They said "You should have stayed there in your own job.*

[6] The social model of health carefully considers how wider determinants than the presence or absence of disease have an impact on people's health. Some of these wider determinants are a person's culture and belief system or levels of relative income, access to housing, educational attainment and opportunities as well as the wider environmental, political and socio-economic conditions in which people live. People's social and community networks also have an impact on health.

We're not giving you a penny". I was absolutely mortified.....I never got a penny' (female, interview No.5)

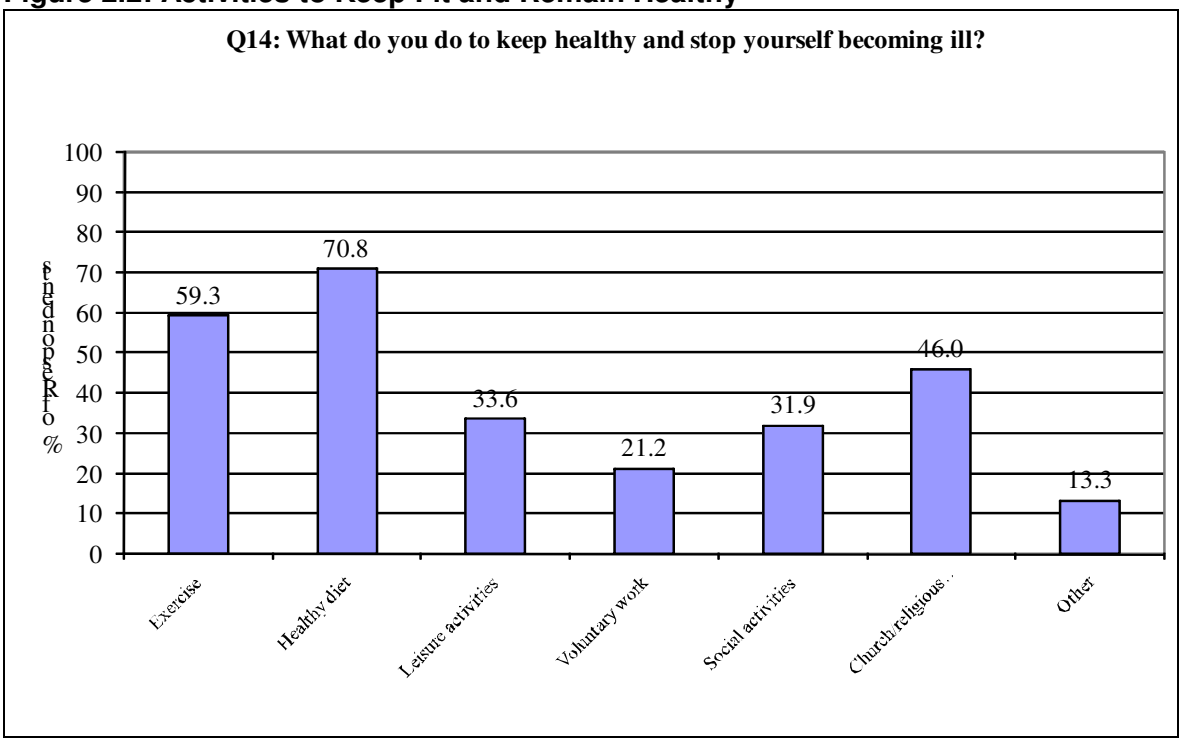
The Irish Centre in Calderdale was also the target for racist attacks. One club member, Kieran, recalls how he had to cope with abusive phone calls made to the centre on a regular basis. One such anonymous caller had asked him:

'What does it feel like to be a murderer'? (male, interview No.13)

He also saw graffiti daubed on the side of an Irish person's house which said 'Irish Get Out'. The mental distress and anxiety of being a 'suspect' community (Hickman, 2008) and the possible effects on long-term health long after such events have passed, albeit difficult to quantify, cannot be discounted without further investigation. Although the political situation in Northern Ireland has changed considerably there is still a legacy of sticking together in the face of adversity amongst the older generation, which means that Irish community activities continue to play a significant role in participant's health and well-being.

Ideas of what constituted good health and well-being also influenced what activities participants engaged in to stay healthy and prevent themselves from becoming ill.

Figure 2.2: Activities to Keep Fit and Remain Healthy



There was a high level of awareness amongst the research participants that exercise was a key factor in a healthy lifestyle and over half (60 per cent) of survey respondents recorded that they engaged in some sort of exercise. This was explored further in the focus groups and interviews and a more nuanced picture about exercise and physical activity emerged. It appeared that awareness about the benefits of exercise did not necessarily translate into action. 'Exercise' included short walks in the countryside, and walking around town while shopping. Although participants were amenable to the idea of walking it was more likely to be done in the course of carrying out tasks such as doing errands rather than 'for its own sake'. Swimming, playing golf and fishing were popular forms of exercise, all activities that can be carried out outside a formal or group setting, suggesting a reluctance to engage in formal exercise classes. On the other

hand, there was a large degree of scepticism about the benefits of exercise, particularly regarding it's efficacy for older people:

> *'Irish people don't like to exercise. They need educating about exercise and keeping fit'* (male, focus group No.2)

> *'We weren't brought up to go for a walk, swimming or anything like that...too busy working. People would have thought you were mad if you went for a swim on the beach...the sea was for catching fish and that was it. A lot of Irish people can't swim'* (Focus Group No.1)

A distinction was made between exercise taken in the course of an average day and formalised exercise taken in groups at fitness classes. There was a distinct lack of enthusiasm for organised fitness activities. Gender was an issue with more women than men willing to investigate fitness classes or attend swimming classes, for example. Men in particular were not keen on organised group activities citing reluctance to go to anything where they did not know anyone, and a lack of information about what was on offer. Socio-economic factors were also seen as having an influence on whether participants exercised or not. Men who had worked all their lives doing hard physical labour simply did not have the habit or inclination for taking exercise. Putting on weight was an issue for some men who had retired from the building trade and heavy industrial work, but who continued to eat unhealthily and do no exercise. This was coupled by a resistance to the idea that exercise was of benefit to older people, regardless of their weight or health status. However, one participant was an enthusiastic member of a local exercise class, the 'Up-beat' keep fit group, which he had heard about at the Irish Centre. Several participants at one of the focus groups suggested that Irish people were more likely to join a keep fit class if there were other Irish people of their own age group present because:

> *'You need someone to go with of your own age...you [need to] meet up with your own people'* (Male, focus group No.2)

Although the majority of participants were retired a significant percentage (21 per cent of survey respondents) engaged in voluntary work, such as looking after sick friends or shopping for elderly neighbours. Kieran, a man in his 70's, recounted how he took it upon himself to visit Irish people in hospital including those who were living alone and did not have any immediate family living in Calderdale. Every patient visited (including second generation Irish people) would be given a £1 from the Irish Club fund.

> *'I'd get people at the [Irish] club to let me know who was in hospital and I'd go and visit them....I went to 8 different people in one night. Every one of them got the princely sum of a £1 just because they were in hospital, regardless of their circumstances. Everyone got the same amount'* (male, interview No.13)

Some research participants continued to visit other Irish people in hospital, albeit on a more informal basis. A lot of care was also put into ensuring that Irish people's funerals were well attended, whether or not they had families of their own, or were single and without any family.

The Catholic Church and their Catholic faith was also a key aspect of some participants' sense of well-being. In total, just under a half of the survey respondents (46 per cent) cited religion and church activities as one of the means by which they stop themselves becoming ill.

> *'My faith is very important to me…..it's a great comfort when things aren't going right'* (female, interview No.10)

'Catholicism stays with you for the rest of your life…wherever you go it's something you always have….whatever life throws at ya' (female, interview No.11)

'The Catholic Church and well-being in your mind…it does help - it's a great thing' (Male, Focus Group No.2)

When participants did become ill the Church was also a source of huge comfort. It was very important that patients were able to receive the sacraments of the church while in hospital and in care homes and hospices. Being able to attend mass, or watch mass on the television despite ill-health was an integral part of people's faith. Simple gestures such as making sure that people had their rosary beads and Holy Water by their side on the bedside locker took on an even greater significance when Irish people were ill. Participants spoke of what a comfort it was to get a visit from a priest, and receive Holy Communion while in hospital. However, this vital social service was quickly diminishing due to the dwindling number of Catholic priests in Calderdale. In the past Irish nurses and doctors, who were employed in large numbers in hospitals in Calderdale, were fully conversant with Irish cultural and religious practices surrounding the care of the ill and dying and ensured that Irish Catholic patients had access to a priest. However, it was felt that this cultural and religious awareness had been lost over the years due to a lack of Irish nurses and the increasing secularisation of the National Health Service (NHS) itself.

It is evident that people taking part in the study took a holistic view of health which incorporated not only physical and mental aspects but also social well-being. Religious beliefs and the Catholic Church also played a significant role in participant's sense of well-being.

Resilience towards and denial of personal health risk

A principle feature of the findings from the research is that participant's attitude towards their own health encompassed a large degree of resilience and fortitude in the face of real or potential health problems. This self-reliance manifested itself in a reluctance to visit a GP in anything other than an emergency. Reluctance amongst Irish individuals to engage with health services has been noted elsewhere in other studies (Tilki 1998; Walls 2006 (b)) and was borne out in Calderdale. Although a majority of Irish people were registered with a GP they were inclined to wait as long as they could before consulting with a doctor. Participants attributed this resilience in part to high levels of tolerance towards pain and discomfort:

'Our tolerance levels are higher. It's an Irish thing. "If it's not an emergency I'm happy to wait my turn" - that sort of attitude is fairly common with Irish people' (female, interview No.8)

Cultural attitudes towards doctors and hospitals were also strongly implicated in participant's wishes to avoid contact with health services. Doctors were seen as figures of authority, on a par with priests and the Garda Siochana (the Irish police), in whom people were slow to confide or reveal any personal details about their lives, including their health:

'There was the doctor, the Gardai (Irish police) and the priest. They were figures of authority...you didn't tell them anything. There's a lot of that around still' (male, interview No.9)

'Doctors, priests and teachers were seen on a pedestal. They had status in society...So you had to be quite poorly to go to the doctor' (female, second generation, focus group No.2)

Fear and ignorance of improvements in modern health care was also seen to be a factor. One participant noted that hospitals were also closely associated with death and the TB epidemic in Ireland in the 1950s and 1960s which influenced older people's attitudes towards accessing health services. Participants carried these beliefs with them when they migrated to England. Attitudes towards the medical profession were perceived to be passed on to second and third generation Irish people, who were also thought to have a 'healthy disrespect' for health professionals. The following excerpt from Maura, a second generation Irish woman highlights how health beliefs are transmitted from Irish parents to their English-born children:

> *'My mother was terrified of doctors. She had a brother who died of TB and that put her off doctors...She was afraid of hospitals. My mother had a very health disrespect for health visitors. They expected her to feed babies baby food from a jar. She'd have pureed her own food, but she used to make a great show of putting a jar of baby food on the table when the health visitor was there...I'm the same about doctors etc, very sceptical. I have to be nearly dead before I go to one. It must have come from my mother that'* (female, second generation interview No. 11)

Some participants suggested that many older (first generation) Irish people were still influenced by childhood experiences of delaying seeking medical care because of the financial implications of doing so, as has been suggested in other studies (Scanlon *et al,* 2006). The complete absence of a national health service in Ireland and the resultant high costs of going to consult a doctor meant that Irish people grew up with the culture of going to see a GP only when it was absolutely necessary:

> *'There was never the money to go to the doctor when we were growing up...so it never crossed your mind to go unless you were very, very sick'* (male, focus group No.1)

The general attitude towards having as little as possible to do with doctors and putting up with significant amounts of pain and discomfort before presenting to a GP, which was the norm for Irish people over the generations, contributed significantly to participants having low expectations of health and health services.

As a consequence of not engaging with health services when people did present they were often in the late stages of whatever health condition they were afflicted with:

> *'An awful lot of them aren't registered with a GP, [they think] they don't need the doctor, they're alright. But the day they do need the doctor it's the blue flashing lights of the ambulance all the way to the hospital. Single men who've ended up cut off from society…a classic example of one man who died before our eyes. We asked him if he wanted to go to the doctor and he said no, he couldn't be persuaded to go'* (male, interview No.7)

These delays in seeking treatment could reduce the likelihood of recovery and thereby perpetuated the commonly held belief that there was 'nothing to be done' about diseases such as cancer or coronary heart disease, hence there was no point in getting treatment or taking preventative action in the first place.

> *'If you've got a heart problem you can't do very much about that'* (Male, in his 70's, focus group)

Another factor in delays in seeking medical advice was participants' fear of a diagnosis and being told that they had a life threatening illness. Several of the participant's

narratives suggested that many Irish people would prefer not to know if they did have a serious illness.

> *'They don't want to know the unknown'* (male, interview No.14)

More specifically, this was thought to be more likely to be true of Irish men than Irish women. The following account brings to light the complex needs of one elderly man, who had been living alone for many years in private rented accommodation, and whose recovery from illness was a long process:

> *'One fella took three months to fall into place with modern living. He wouldn't let the care assistant into his room to clean it at first. He put wet paper round the door frame to see if anyone had been in his room...when he had to go to hospital it all came to light, Rheumatism, very bad breathing, stomach problems. He came round when he got nourishment. He was a different man'* (male, Interview No.14)

Irish men were reluctant to share their fears about symptoms, preferring instead to confide in close friends and family rather than health professionals. Consequently, avoidance of routine medical tests such as cholesterol and blood pressure checks was commonplace. A common refrain was that people would prefer to remain in 'blissful ignorance' if there really was a serious health problem.

Informal self-help health behaviours

When asked how they addressed real or potential health problems participants described a range of informal practices which they used in order to avoid or delay engagement with formal health services. The most common strategy used was to confide in family or close friends regarding worrying symptoms or illnesses. In the case of some older women daughters provided a steady source of reassurance and guidance about medical matters. In a couple of instances family members were themselves trained nurses, which made them ideally placed to give such advice. However, it was more common for participants to rely on anecdotal health advice from family and friends that they met socially. One participant had found himself in the position of giving advice to several (now) elderly men over the years who sought his opinion on their various ailments, but who invariably refused to go to the doctor. In some instances, Irish people were simply too shy to go to the doctor with any embarrassing illness. The following was a typical case this participant had encountered in the Irish Club:

> *'They'd ask someone else rather than ask the expert, and it was usually when it turned out to be too late. One fella was quizzing me about his aches and pains and I said "why don't you ask the doctor, I can only give you an opinion". His reply was "if it's bad news I'd prefer not to know"'* (male, interview No.7)

Family and friends were relied upon to give their 'expertise' on health matters which at times led to the circulation of incomplete, inaccurate and ill-informed information about diseases such as heart disease, for example. Although the first option was to seek help from their families when they were concerned about symptoms some participants held back from asking advice on the basis they did not want to worry or trouble their families. Nora, an elderly participant, went weeks and even months went by without seeking any help at all:

> *'I just didn't want to trouble my sons. They have enough to do with their own families...they have enough of their own worries without me adding to them. I should have gone sooner'* (male, interview No.14)

Another participant who did seek medical advice did so without informing his family for a similar reason:

> *'I was diagnosed with high blood pressure and kept it to myself…didn't want to worry the family'* (Male, survey respondent)

A small number of participants used the internet for health advice but this was unsatisfactory because they were over-loaded with information, and ended up feeling confused as a result. The information available was also quite narrow in scope and did not provide the comprehensive advice that participants were looking for:

> *'It [the internet] gives you a load of stuff about the symptoms but is so general that you'd end up thinking you had a load of things wrong with ya. It's all about the symptoms but not a lot about what causes things or how you can tackle it'* (male, interview No.3)

Another avoidance strategy for not consulting a doctor was to seek health care from complimentary medicine practitioners. A small minority of participants expressed positive views about a range of 'alternative' medical treatments such as reflexology and iridology.

> *'I think alternative medicine is good. My wife is also going to a chiropractor…alternative medicine has a place'* (Female, interview No.8)

> *'I would look for advice, alternative medicine, anything else before I'd go to a doctor'* (female, interview No.11)

Summary

This research has identified that, although Irish people in Calderdale aged over 50 were aware of health problems affecting themselves or family members, they were unaware of the particular health risks or inequalities experienced by the Irish population in general. Six contributory factors to ill health were identified: the experience of migration, socio-economic factors, the historical physical environment in Calderdale; health hazards in particular occupations; genetic susceptibility and lifestyles.

The majority of research participants reported themselves to be 'very' or 'reasonably' healthy. However, the participants did identify a range of physical and mental health concerns, the most prevalent being high blood pressure, high cholesterol, heart disease and diabetes. Although there was a general reluctance to discuss mental health conditions, it was evident that a significant minority of participants had personal or family experience of mental health problems. The self-esteem of older Irish individuals had also been adversely affected by anti- Irish racism, although this was less prevalent than in the past.

Research participants identified key strategies for health and wellbeing, including feeling fit and active and engaging in social and cultural activities such as using the Irish Centre in Calderdale. The Catholic faith and Church were very important to the well being of a large proportion of the research participants.

Awareness of health risks and the importance of a healthy diet and exercise were varied amongst the research participants. There was a general reluctance to engage with formal health service providers, often arising from the experiences of the first generation in Ireland and this often resulted in delaying seeking treatment, tolerating a condition or relying upon informal sources of advice or remedies.

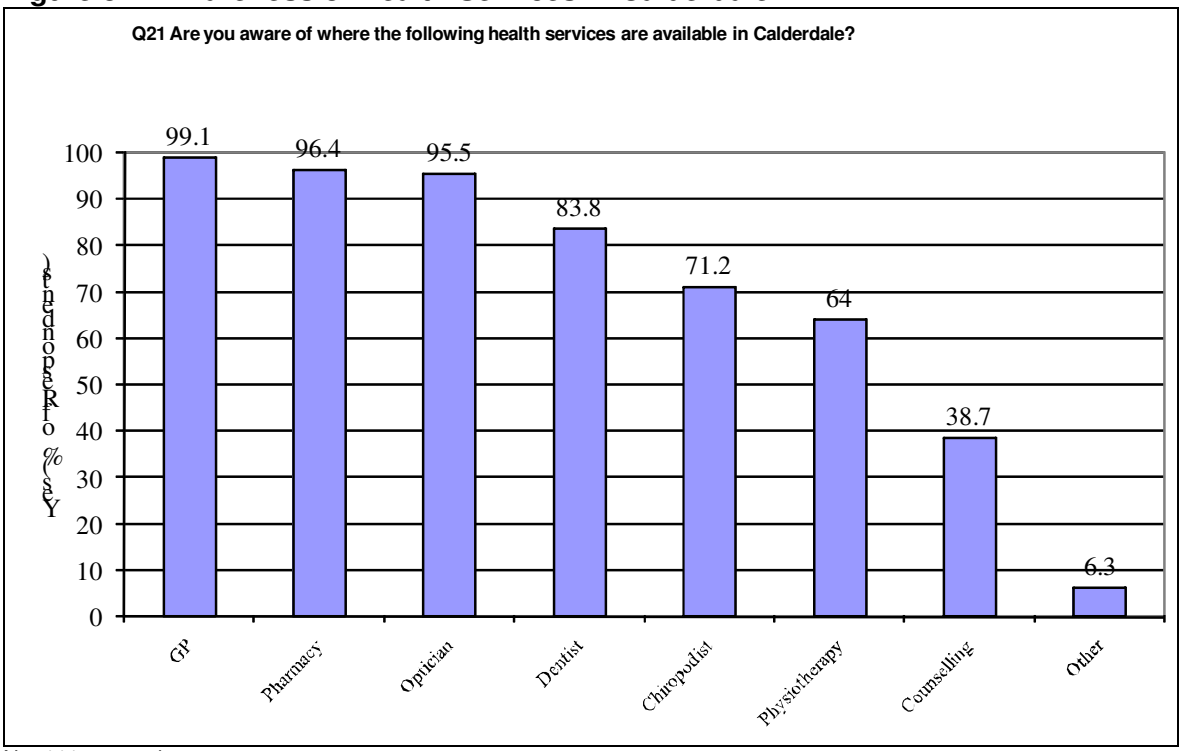
3. Use of health services: knowledge, experiences and barriers

Concerns about the health of the Irish in England are often focused on whether health services are accessible, sensitive and non-discriminatory (Walls, 2006, p.96). In this chapter of the report these issues are discussed further, in particular Irish use of GP services in Calderdale, which for many people is the first and only point of access to health care.

Use of health services

The study endeavoured to discover the extent to which participants were accessing health services; the breadth of awareness regarding health services available to them and experiences and barriers to accessing health services. Figure 3.1 indicates that levels of awareness of a range of health services were high amongst survey respondents. Clear majority were aware of where they could find a GP (99 per cent), pharmacy (96 per cent), optician (95 per cent), dentist (83 per cent), chiropodist (71 per cent) and physiotherapist (64 per cent) in Calderdale. By contrast, less than half of survey respondents (39 per cent) were aware of where they could locate a counselling service in Calderdale.

Figure 3.1: Awareness of Health Services in Calderdale

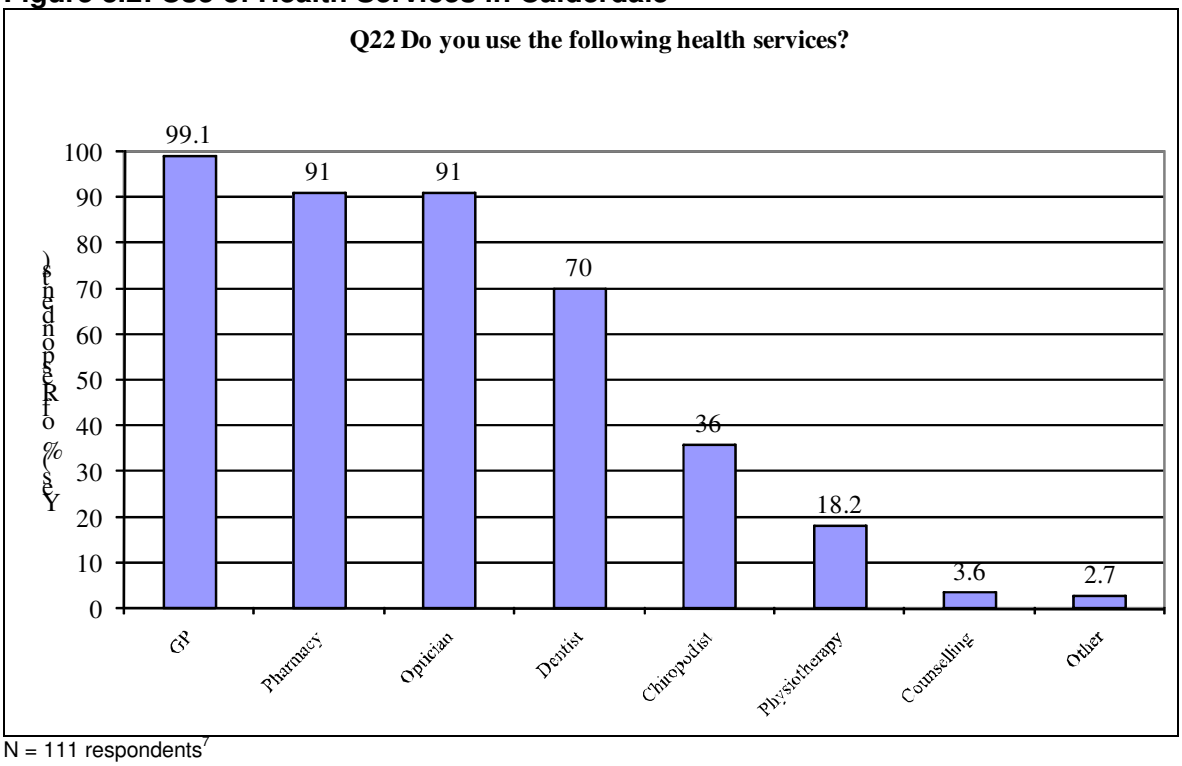


N = 111 respondents

There was a contrast in levels of accessing different health services, with very good use made of a narrow range of health services, i.e. doctor; pharmacy, opticians and dentist and lower numbers of participants using a small number of other services (Figure 3.2).

Despite a widespread perception amongst participants that many Irish people were not registered with their doctor, ninety-nine per cent of survey respondents confirmed that they themselves used the service of a GP. A total of 91 per cent of survey respondents used a pharmacy, 91 per cent made use of an optician and almost three quarters (70 per cent) accessed the services of a dentist. Significantly fewer respondents made use of a chiropodist (36 per cent) or a physiotherapist (18 per cent). Reflecting the relatively low awareness of the availability of counselling services in Calderdale a very small number of survey respondents (four per cent) accessed this type of service. Other health services used by participants included: reflexology, iridology, chiropractor, audio clinic, and a pain management clinic.

Figure 3.2: Use of Health Services in Calderdale



N = 111 respondents[7]

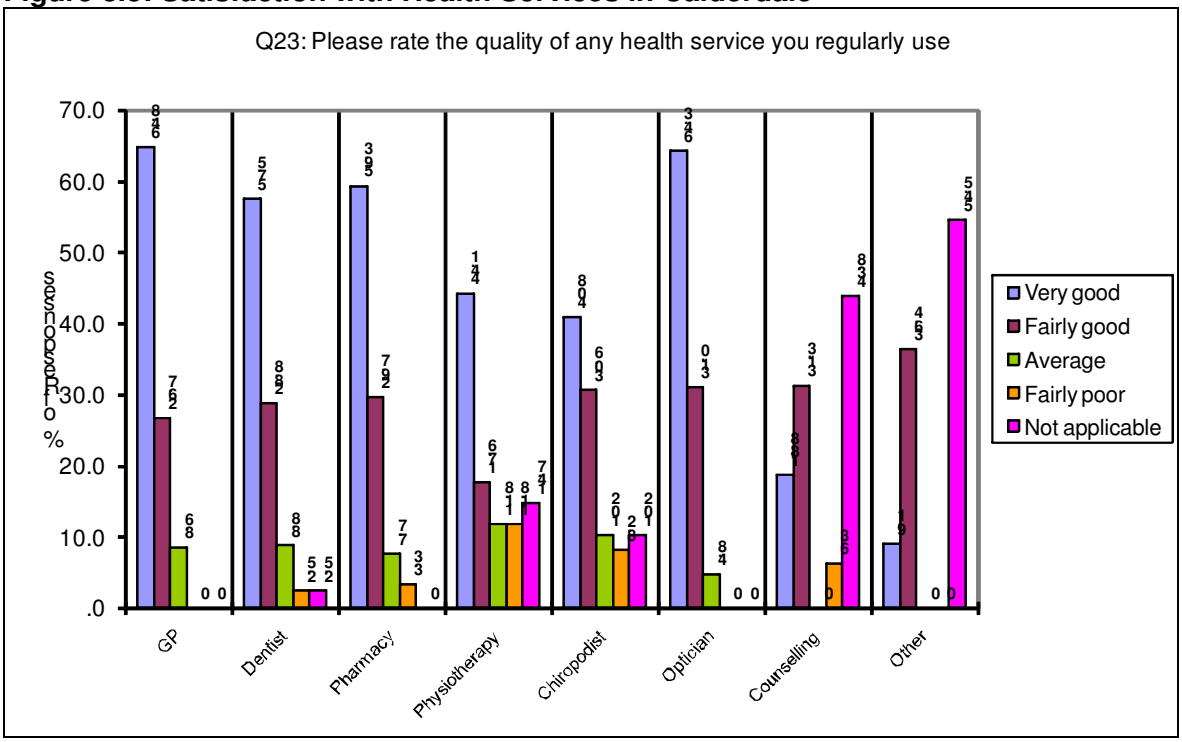
The survey did not elucidate the experiences of using these health services, a topic that was subsequently explored in the focus groups and in-depth interviews.

Experiences of local health services

A notable finding from the study was that the Irish people in the study had largely positive experiences of health services. The majority of participants were keen to put across their high regard for the NHS, the doctors, nurses and other health professionals who had looked after them and their families, and the consistently high medical standards they had experienced. This was borne out in the survey which recorded respondent's levels of satisfaction with the quality of the services they regularly used (Figure 3.3).

[7] The 'Other' category in Q.22 included bereavement counselling, audio clinic and reflexologist

Figure 3.3: Satisfaction with Health Services in Calderdale



In total, 91 per cent of survey respondents who answered the question rated the quality of their GP as either 'very good' or 'fairly good'. A further 86 per cent rated their dentist as 'very good' or fairly good', while 77 per cent rated the quality of the pharmacy as being 'very good' or 'fairly good'. The majority of respondents also rated the quality of less used services such as physiotherapy and the chiropodist as also being either 'very good' or 'fairly good'.

However, not all participants had a positive experience of the NHS and recounted not being understood or listened to when they went to their GP. One elderly woman was upset at her doctor's apparent unwillingness to take on board her concerns about her health and to prescribe medication for the pain she was experiencing:

> *'I found my GP very unhelpful lately. I had my blood pressure taken at the Irish Club and it was high. I went to him with aches and pains...I had to beg for painkillers and got them in the end'* (female, interview No.5)

She did not feel that the doctor was taking her seriously and also wondered whether this had anything to do with her age.

If participants had had a negative past experience of the health service they were less likely to approach their GP should a health issue present itself again. In the following excerpt an elderly woman recounted how a serious instance of cultural misunderstanding regarding birth control and family size on the part of a health professional had caused her to avoid any further contact with her GP for a significant length of time.

> *'I was pregnant with my fourth child. The doctor said it was a disease having that many children. He said I should have an operation to stop me having any more after that one. But I didn't want to do it. I didn't go back to him for a long time after that'* (female, interview No.10)

The same participant went on to have a fifth child, which had been her intention in any case.

Participants made a distinction between the doctors, nurses and other health professionals, whom they rated very highly, and the NHS 'system' which rationed resources, access to services, waiting lists and patient consultations. Although participants felt that, in general, the services provided to them were of a satisfactory standard there were concerns regarding the lack of time available in GP consultations and waiting times for test results. The NHS was seen to be struggling to cope with the sheer volume of patients registered at GP practices and participants spoke of feeling 'rushed through' their appointments with the doctor. The lack of time allotted to them at GP appointments was the main point of contention for the majority of those who did have an issue with the NHS. Participants were of the opinion that they were entitled to only a minimum of time with the GP, and if they took up a lot of time talking to their doctor in the course of telling her or him their health problems, then this would be less time for other patients. A small number of participants expressed frustration at not being given the chance to talk properly to their GP, but the overwhelming sentiment from the majority was a sense of stoicism and resignation at the situation. This stoicism may also arise in part from the low expectations that some Irish people have of health services engendered by the lack of access to health care with which they grew up in Ireland (see p.21?):

> *'No-one is interested in why you have it [Arthritis]. They do treat you well, but they don't listen to you'* (female, second generation, focus group No.2)

> *'Sometimes I'd like to chat to the doctor but they just don't have the time. That's the fault of the system, not the doctors themselves* (male, interview No.9)

The waiting times for test results was a common problem and was the source of a great deal of frustration and worry. Although people were resigned to having to wait for test results they identified this issue as one of their few grievances about the health service:

> *'When you go to the doctor it takes a while to find out what's wrong with you. The waiting times for tests – it's way too long. You'd be worried half to death before you get them'* (female, focus group No.1)

However, in the majority of cases participants accompanied any implied or explicit criticism of shortfalls in the NHS with the suggestion that this was a question of resources about which not much could be done.

The spirit of self-reliance in not accessing health care identified in the previous chapter of this report also manifested itself in an apparent willingness to pay for private medical care in the face of long waiting lists or unsatisfactory treatment options. Perhaps reflecting also the system of private health care in Ireland with which many participants had first-hand experience, a small number of Irish people in the study were prepared to fund their own consultations and treatments. Participants were prepared to pay for the privilege of seeing the same doctor or dentist and were willing to travel some distance at their own expense to do so. One middle class professional woman went to some lengths to ensure that she could see the same dentist even after moving some distance away from the dental practice:

> *'I travel 60 miles to see the same dentist – and he's a private dentist, not the NHS. I do pay for the dentist because I'm willing to do that for the sake of my teeth'* (female, interview No.11)

Paying for private health care was not the preserve of Irish professionals. It also extended in one instance to one man who had been in the army for a number of years who was not financially well off, and who borrowed a significant amount of money to fund his heart surgery:

'In 1992 I was diagnosed with high blood pressure that was down to high cholesterol. I had to have a triple by-pass…I had to borrow eight and a half thousand pounds for the operation. There was a 20 month waiting list at the time on the NHS so I went private. I have paid back the eight and a half grand with no help from the council or anybody else' (male, interview No.14)

Opting out of the NHS is one strategy for exerting influence over personal health care. The following section explores further whether participants felt that they exerted any influence over their own health care, and the extent to which they wished to do so.

Influence over personal health care

When questioned as to the amount of influence they felt they had over their own health care, it became clear that having influence over their own personal health care was not something that the majority of participants either desired or expected to have. Participants appeared to be more than willing to defer to professional knowledge and expertise of medical practitioners. This was viewed as being a generational issue where older Irish people had been brought up with the idea of the doctor being in a position of great authority, where the *'doctor knows best'*. It simply did not occur to people in their 60's and 70's to question the expertise of any health experts that they came in contact with. One woman summed up the general attitude towards doctors in the following comment:

'You're in their hands and that's the best way to be. Too much knowledge is a dangerous thing' (female, focus group No.1)

Participants were quite content to take the doctor's advice about the best course to take in regard to their health care because they had no confidence that they were in any position to know any better. Indeed, on occasions where participants were asked to express an opinion on their medication, for example, they were not at all comfortable doing so and felt that it placed an undue burden on them to make any decisions affecting their treatment. In the words of another participant:

'I'm on tablets for my Thyroid…on 100 grams. I was asked if I was alright on that. Maybe there's too much onus on you to make that decision' (female, focus group No.1)

It was notable though that this was less the case in the second generation. The following comments express the sentiments of two second generation Irish women who were very articulate and pro-active in making their opinions known to their doctor:

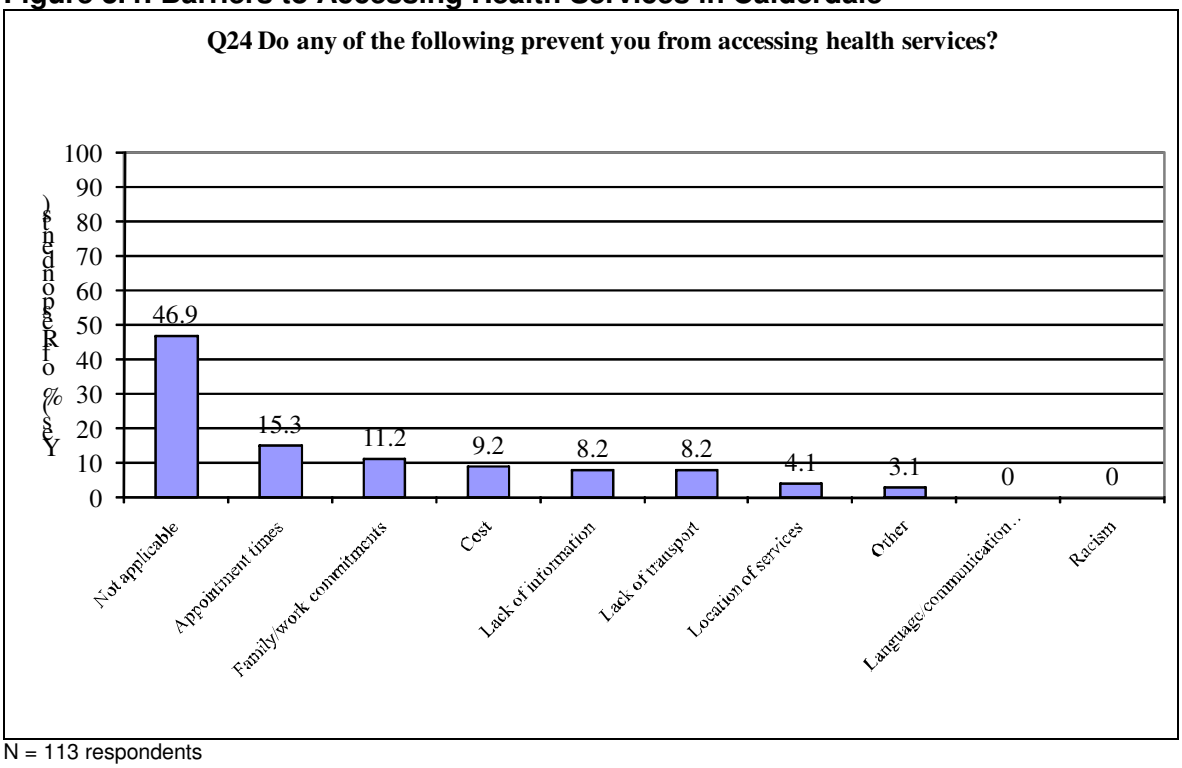
'If I don't feel right I don't accept it [medication]. I will question it, I definitely will' (female, focus group No.1)

'I'm not keen to have a lot of people looking at my body. I'm not good at having trainees examining me. Some people feel obliged to say "yes", but I say "no" (female, interview No.11)

Barriers to using health services

The research sought to identify any barriers that prevented the older Irish population from accessing health services (Figure 3.4).

Figure 3.4: Barriers to Accessing Health Services in Calderdale



N = 113 respondents

Figure 3.4 reveals that a high almost half (47 per cent) of the survey respondents did not identify any barriers that would prevent them accessing health services. Appointment times were an issue for 15 per cent of survey respondents, and family and work commitments were of concern to 11 per cent, themes that was explored in more detail in the focus groups and interviews. A minority of participants were employed full time and found it very difficult to fit in doctor's appointments in the course of a normal working day. One working mother had this to say:

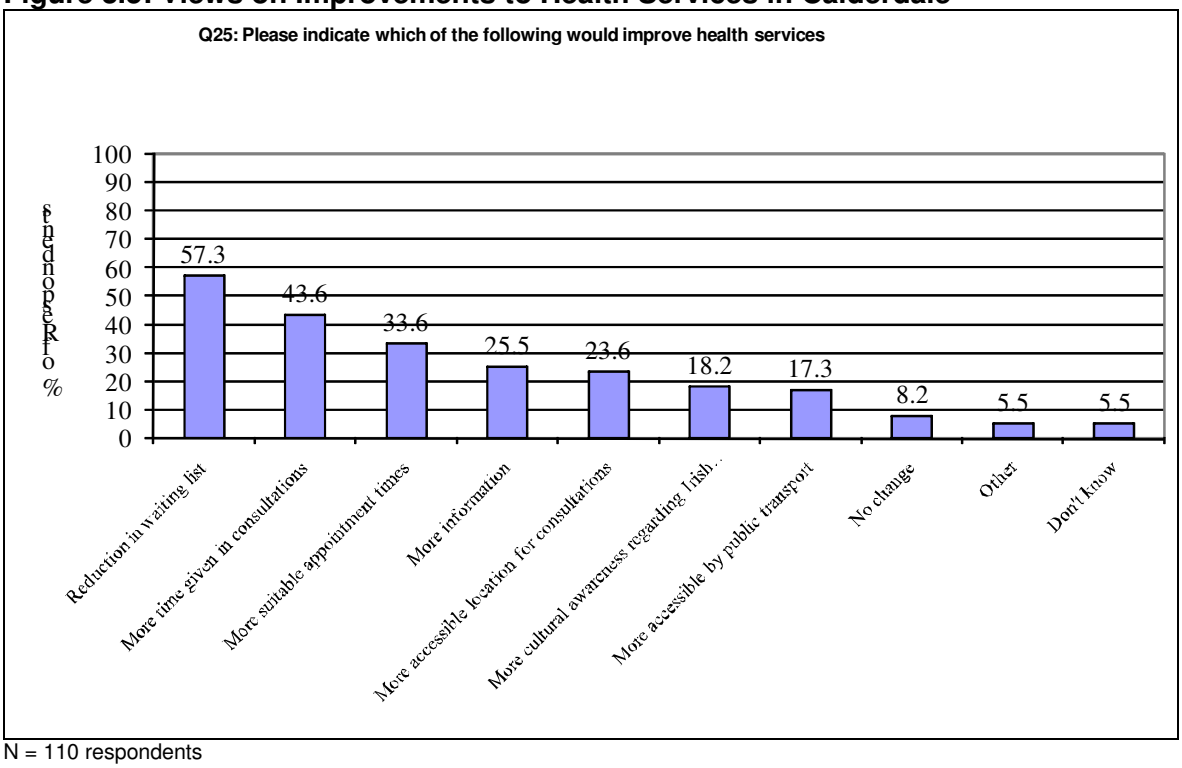
> *'My only complaint [about the NHS] is having to book an appointment at the doctors early on the same day. It would be so much better if you could pre-book appointments'* (female, survey respondent)

Having to book appointments on the same day meant that it was difficult to give any notice to employers of any temporary absence that ensued as a result. While many of the participants were retired or working voluntarily and hence had a more free time they nonetheless were constrained by the fact that they were often relying on family members who were working to accompany them to appointments. This was particularly, although not exclusively, the case for those who did not drive. Others had family commitments such as caring for spouses that also placed restrictions on their ability to make appointments. In these instances more flexibility was necessary within the NHS appointment system than was the case at present.

Views on improvements to health services

The research asked participants their views on whether particular actions or reforms would improve health services in Calderdale (Figure 3.5).

Figure 3.5: Views on Improvements to Health Services in Calderdale



N = 110 respondents

Although a majority of participants were satisfied with the quality of their local health services, it was apparent that participants did want to see certain aspects of these services improved. Not surprisingly, in view of participants' concerns referred to above, a significant percentage of survey respondents (57 per cent) cited a reduction in waiting lists, more time given in consultations (44 per cent) and more suitable appointment times (34 per cent) as improvements they would like to see in health services. A further one quarter of survey respondents (25 per cent) wanted more information about health and support services, issues that were explored further in the focus groups and interviews. The desire for more information about health initiatives such as flu jabs and screening for cancers and blood pressure was an issue for some participants. There was also a reported pressing need for information regarding carers and home help for disabled elderly people, and support available through organisations such as Age Concern. It was also thought by participants that the poor take-up of Disability Living Allowances and other related benefits needed addressing through an information campaign directed specifically at the older Irish community in Calderdale.

A total of 18 per cent of survey respondents suggested that more cultural awareness of Irish people would improve the health service, which is an interesting finding given the general perception that racism and discrimination are non-issues for Irish people in their interactions with the health service. The study found that although Irish people did not experience any deliberate discrimination they nonetheless were faced with an inadvertent lack of understanding of their cultural needs and background. Cultural beliefs regarding religious observation, language and the family were identified as areas where Irish people were distinguished from the general population and which had a bearing on their interactions with the health service. Several participants reported difficulties in communicating with their GP practice due to their accent and use of Irish phrases. There was a lack of understanding regarding elderly Irish people's reluctance to attend a GP practice or hospital, and the discomfort and anxiety that Irish people feel

at being in that unfamiliar environment or the levels of stress that being in hospital entailed. One participant shared the story about her husband's first experience of being in hospital at quite an advanced age and the embarrassment he suffered as a result of not being familiar with hospital procedures:

> *'My husband was in hospital...he'd never been in hospital before...He kept his underpants on under his pyjamas. The nurse gave him a bottle to go to the toilet...he didn't know what to do...he ended up wetting the bed'* (Focus group, No.1)

It was suggested that health professionals needed a greater understanding of the Irish migrant experience and the social isolation that some elderly Irish people will have endured before they ever come into contact with the health service.

Cultural sensitivity regarding the second and third generation was also an issue. In one instance an Irish woman, Calderdale born and bred, struggled to have her Irish heritage recognised by her employers:

> *'I am employed in a team that joint works with the NHS. My concern is that my manager derides the idea that I am Irish at all. Born in England is the deciding factor for this manager, [having] Irish parents [and an] Irish passport is an apparent irrelevance. It doesn't bode well for cultural sensitivity does it?'* (female, ?? years of age, Survey)

Summary

The research found very high levels of awareness of key services amongst the elderly Irish population in Calderdale, including GP, pharmacy, optician and dental services, with lower levels of awareness of counselling services. Over nine in ten survey respondents made use of a GP, pharmacy or optician. A lower proportion (seven in ten) used a dentist.

The research participants reported very high levels of satisfaction with the health services that they used, with over nine in ten survey respondents reporting their GP to be 'very' of 'fairly' good and similarly high levels of satisfaction with dentists and pharmacists. In particular, there were high levels of satisfaction with health staff.

However, the research participants did identify a number of problems, including waiting times for appointments and test results, the limited time that GPs could spend on an appointment and difficulties booking an appointment.

The majority of research participants did not seek or desire greater influence over their health care or service provision, although there was a notable willingness to use private health services.

Almost half of the survey respondents did not identify barriers to accessing health services in Calderdale. The barriers that were identified included appointment times, family and work commitments, cost, lack of information and lack of transport, although none of these individual barriers was identified by more than 15 percent of respondents. Respondents' views on what measures would improve health services in Calderdale correlated to these barriers, with reductions in waiting times, more time in consultations, more suitable appointment times, more information (about health, benefits and care for the elderly) and more accessible locations being the most frequently proposed.

Almost one in five survey respondents identified the need for greater cultural awareness of the Irish by health service providers and individual participants identified problems in communication or a lack of understanding linked to their ethnicity.

4. Participation and consultation

Public participation in the design and commissioning of local health services, including that of minority ethnic groups, has become an increasing priority of Calderdale NHS in recent years. To this end, the study explored Irish people's awareness of, and willingness to participate, in local health consultations. The research found that a large majority of participants were not aware of the different methods of voicing their opinions about the health service. Knowledge about Calderdale's Public Patient Involvement programme was almost non-existent and individuals' awareness of how to make their opinions heard was mainly restricted to the complaints leaflets which participants had seen in their local GP practice. There was a generational aspect to participation with younger and second generation individuals being more likely to want to make their opinions known, and to pursue ways of doing so. The following comment in made by Siobhan, a participant in her 50's from Northern Ireland, illustrates this point:

> *'I would make it my business to find out how to compliment and complain'* (female, interview No.8)

A mixed picture emerged as to whether participants wanted some involvement in changing the health service. Just over a third of survey respondents wanted a significant amount of involvement: a total of seven per cent of survey respondents indicated that they wanted to be 'very involved', and a further 28 percent were interested in being 'fairly involved' in changing health services in Calderdale. In total, 40 per cent of respondents recorded that they did not want to be involved at all. A further 26 per cent were undecided about becoming involved in making changes to the health service, reflecting a wider uncertainty about expectations that would be placed on those who 'signed up' for further consultation.

A significant minority of participants expressed the wish to have a moderate amount of involvement. Previous NHS consultations which had taken place at the Irish Centre had been well received by participants. Those who regularly attended the Luncheon Club at the Centre had become accustomed to health practitioners and voluntary organisations such as Age Concern asking them their opinions, and imparting information, on a variety of topics. People were quite comfortable within that setting to take part in group discussions on health related issues, with the important proviso that it did not interfere too much with the entertainment and lunch provided! Individuals particularly valued the opportunity to participate in health checks at the same time, such as blood pressure monitoring:

> *'It's been quite an eye-opener all these health checks…been very good really cos it gets people interested where they weren't before'* (Female, Focus group No.1)

> *'We've got used to different groups coming in…and the more the better to get people better educated'* (Male, Interview No. 7)

Those who did not want to take part in further consultations gave a variety of reasons for not doing so, ranging from family and social commitments to a lack of transport. The lack of interest in consultations may in part be explained by the reluctance of many elderly Irish people to get involved with the 'authorities'. It is also likely that high satisfaction levels with the NHS as it stands may have a bearing on motivation to take

part, so that if a person was content with the NHS they did not see the necessity to become involved. In a related point, misconceptions about the reasons for becoming involved were also evident. It was notable that many participants associated community consultation in a negative way: that the only possible reason to become involved was if a person had a complaint to make, or if they felt their own personal health needs were not being met.

> *'I wouldn't have that much to say really…I've been treated very well by the NHS'* (Focus group, No.1)

Apathy was also an issue and the sense that consultations and information gathering did not necessarily translate into real changes in the 'system'.

> *'Everyone thinks that nothing is ever done…there's general apathy'* (Male, Interview No.9)

Some individuals were also concerned that their contribution would not be 'expert' enough and they queried the idea that their lay perspectives would be of some use to the NHS. The point was also made that any leaflets from the NHS needed to be put in simple language without the use of jargon or acronyms. Clearly, these findings suggest that there are capacity building and community development issues to be addressed in relation to Irish community participation in influencing health services.

Pragmatic concerns were expressed about the time commitments that would be involved in taking part. One participant, Kathleen, had taken part in an induction session for prospective community representatives on one health authority board which had alerted her to the time necessary to take on such a role. In her view, the time commitments would have been too onerous for her to carry out this voluntary task successfully in view of all her other family commitments.

> *'Time is a big factor. It might be alright if meetings were once a month. You need time to consult with people and report back. If I do something I believe in doing it right, so I didn't put myself up for it'* (Female, Interview No.6)

Encouraging participation in public health policy

Those participants who were keen to become involved in consultations with the NHS made the following suggestions to encourage and boost participation levels. Flexibility and variety in consultation methods were key factors. One idea was giving people several options for involvement so that they choose where and when to become involved. Participants suggested that anything that could be done from the comfort of their own homes was a positive thing. Telephone interviews and self completion surveys were useful because they could be done at a time that was convenient for participants. Surveys were also valued because they gave individuals the means to express their own opinion without being influenced by other people:

> *'I think surveys are good. You can take it away with you and do it in your own time…you're not under pressure…not likely to be influenced'* (Male, Focus group 2)

The frequency of any consultation events was also vital to their prospects of success. Health organisations needed to take into account the relatively limited amount of time that individuals wanted to devote to such events and 'ration' the frequency of them in order to avoid information over-load.

The issue of culturally appropriate means of consultation was also highlighted. There were a number of ways to ensure that the methods were appropriate, relevant and

accessible for Irish people. Consultation with Irish individuals and community representatives to ensure that information was given in a way that was appropriate was important. One idea was to have a forum made up of interested Irish people working alongside health practitioners in an on-going exchange of information:

> *'They [the NHS] need to have a rapport with organised groups within the Irish community. We could have a type of a forum made up of Irish people, a health worker, a social worker for an on-going exchange of information'* (Male, Interview No.7)

Targeting particular key events and days such as the St Patricks Day Parade and popular Irish music concerts was also seen as an effective way of sharing health information with a diverse range of Irish people in Calderdale. The Irish Centre in Halifax was also a key hub of Irish activity and hence an obvious place to carry out future health-related consultations, providing these events took place intermittently. However, it was suggested that there needed to be co-ordination between agencies in order to ensure that individuals who attended the Irish Centre were not overly burdened by consultation and 'research fatigue'.

Summary

Awareness of public participation mechanisms within Calderdale NHS was very low amongst the elderly Irish population. However, a majority of survey respondents did express a willingness to consider becoming more involved, to varying degrees and those participants who had been involved in consultation events, such as those at the Irish Centre, were generally positive about the experience.

Many of the barriers to further participation are generic to public consultation and engagement generally: time, transport, lack of confidence and uncertainty about what is required. However, a number of specific responses to these barriers were identified by the Irish population, including linking into Irish cultural events and facilities and establishing a bespoke Irish NHS consultation group.

5. Conclusions

The health and wellbeing of the Irish population of Calderdale aged over 50, their use and experiences of health service provision and their engagement with health service participation mechanisms can be classified into three categories:

1. Issues that are generic to the general population or elderly people in general, including particular physical and mental health conditions, a satisfaction with NHS staff coupled with concerns over systematic problems such as waiting times and appointments, and a lack of awareness of participation mechanisms and confusion over what greater involvement in participation mechanisms would entail.
2. Issues that apply more generally to groups of the population but which arise more frequently and prominently in the Irish population, because of the particular history of their settlement in Calderdale, such as their concentration in poor housing and their involvement in manual working class occupations.
3. Issues that are specific to the Irish population, such as propensity to suffer from particular medical conditions; social isolation arising from many family members still being located in Ireland; experience of racism and cultural stereotyping (including a conflation of mental health problems with alcohol misuse); a reluctance to use NHS services and greater propensity to use private or alternative medical provision arising from their experiences of health care in Ireland; and the importance of faith (predominately but not exclusively Catholic) to their wellbeing and engagement with services.

In conclusion, the study has identified that, although Irish people in Calderdale aged over 50 were aware of a health problems affecting them or family members, they were unaware of the particular health risks or inequalities experienced by the Irish population. Six contributory factors were identified: the experience of migration, Socio-economic factors, historical environment, occupational hazards, genetic susceptibility and lifestyle issues have all contributed to the poor health of Irish individuals. Concerns about health are highly individualised, varied and complex. However, there are also some commonalities in that major health concerns are clustered around a small number of conditions, namely, high blood pressure, high cholesterol, cancer, diabetes and heart disease. A lack of information regarding specific health conditions and health issues more generally have all contributed to individuals' anxiety over their own health and the health of family members.

There is a marked reluctance to engage in the issue of mental health within families and the Irish community at large. Mental health is an issue for a significant minority of Irish people although it is mainly a private concern that is not shared beyond close family. A lack of awareness of mental health problems combined with a reluctance to draw attention to the issue has contributed to the stigma attached to the illness generally. The self esteem of older Irish individuals had also been adversely affected by anti-Irish racism, although this is less prevalent than in the past.

Individuals' conception of health extends beyond the physical, and encompasses a broad definition of well-being including many social aspects. Irish people's well-being depends in large measure on having social interaction with family and friends as well as keeping active and mentally alert. The Irish Centre in Halifax and Irish community activities have made a significant contribution to the well-being of the Irish in Calderdale.

Social interaction with other Irish people mitigates the stresses of every day life and helps foster a positive sense of Irish identity.

The research found very high levels of awareness of health key services amongst the Irish elderly population in Calderdale. Irish people are accessing a number of primary health care services and they have largely positive experiences of doing so. In particular, there were high levels of satisfaction with health staff. However, the research participants did identify a number of problems including waiting lists, waiting times for appointments and test results and time available in GP consultations. Cultural insensitivity, rather than racism or discrimination, had been encountered by almost one in five survey respondents in their use of local health services.

The majority of research participants did not seek or desire greater influence over their health care or service provision, although there was a notable willingness to use private health services.

The research findings demonstrate that the health and health related experiences of the research participants in the study are not simply determined by their ethnicity. Age, social class, gender and religion also influence Irish people's health status, and individual's perceptions and experiences of health services. This is also apparent in relation to participation and willingness to engage with public consultations and health forums. Many of the barriers to participation identified by Irish participants can be equally applied to public consultations generally, including time, transport, and a lack of confidence.

The majority of Irish people living in Calderdale, if not currently practicing, are of Catholic backgrounds. There are also a minority of Irish Protestants who also have strong religious affiliations. For those who are religious (both Catholic and Protestant) this is an important part of their lives. Having respect for the religious beliefs of Irish people, particularly in hospitals, care homes and hospices, is an essential component of the care of Irish people and this needs to be acknowledged and incorporated into NHS policies and procedures.

6. Recommendations

The study identified a range of issues and recommendations that will be of relevance to all public agencies in Calderdale.

Health education

- NHS Calderdale and social care staff should receive training on the importance of the cultural heritage of Irish individuals, and how this impacts on their health and well-being, as part of an overall training package on BME cultural competencies
- NHS Calderdale and other public agencies should facilitate the involvement of Irish users and Irish community representatives in training regarding Irish cultural competencies, possibly with input from the Federation of Irish Societies
- all public agencies should engage Irish community groups and users/carers in the commissioning, design and delivery of more effective health services as part of an overall strategy to address duties under the Race Relations Act
- Calderdale NHS should commit to the publication of a pamphlet that summarises the key findings and recommendations of this report for inclusion in induction packs for all primary care and other health/social care staff.

Health Promotion and Provision

- NHS Calderdale should develop a culturally sensitive health promotion strategy for the Irish community. Consideration needs to be given to the language and delivery of health promotion materials to ensure that they are appropriate for and relevant to Irish individuals. A non-judgemental approach to health advice and health care aimed at the Irish community is advocated
- a review of targets set by health professionals should be carried out as they may unrealistic for the Irish community, who tend to respond more readily to realistic harm reduction strategies rather than targets of total cessation (FIS, 1996)
- specific health interventions, targets and actions which might be achieved locally to benefit the health of the Irish aged 50+ in Calderdale should be implemented in consultation with Irish community members. Actions should be focused on the following key areas of health concern:
  - cancers amongst the first and second generation
  - coronary heart disease and stroke amongst the first and second generation
  - raising awareness of mental health within the Irish community
  - awareness raising regarding healthy lifestyles, diet and exercise
- health service providers and their partners should give a particular emphasis to identifying and supporting socially isolated Irish elderly individuals, for example by linking them to the Irish Centre in Halifax, organising home visits etc.
- recognition of the importance of faith and sensitivity to faith should be extended in hospitals and care homes

- attempts should be made to tackle the stigmatisation of mental health problems within the Irish community
- awareness-raising activities should be undertaken to tackle the conflation of alcohol and mental health problems of Irish individuals amongst some GPs
- health providers should continue to utilise the Irish Centre and Catholic churches/ schools as key interface sites, whilst recognising the need for outreach activities to isolated individuals and the changing practices of younger (second and third generation) Irish people.

Future health-related consultation

- NHS Calderdale should launch a publicity campaign targeted at the Irish community to advertise NHS services and participation opportunities
- NHS Calderdale should consider the establishment of an Irish Health Services Users Group, linked into other participation mechanisms and extending to second and third generation Irish.

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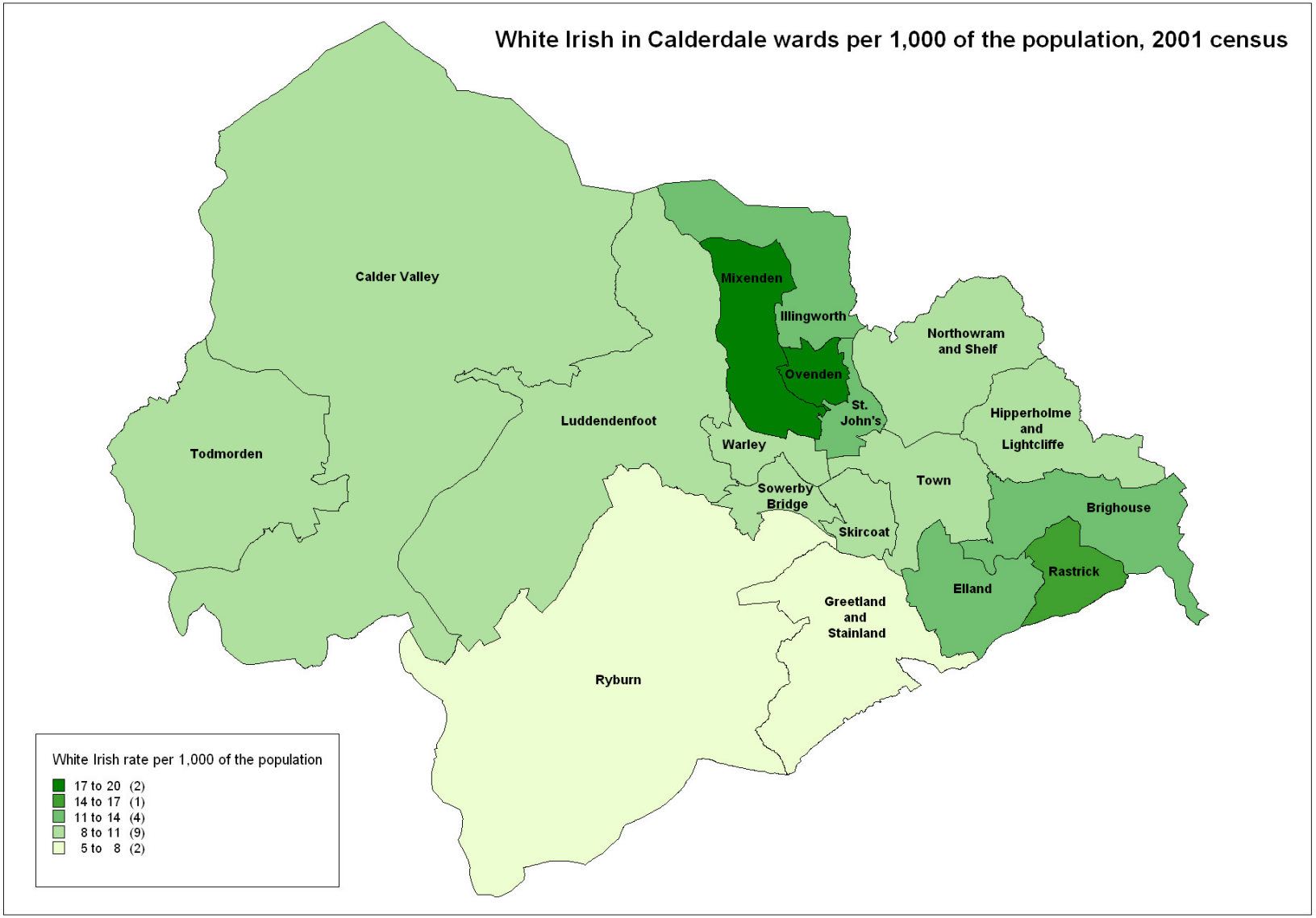
White Irish in Calderdale wards per 1,000 of the population, 2001 census
Calder Valley
Mixenden
Illingworth
Northowram and Shelf
Ovenden
St. John's
Hipperholme and Lightcliffe
Luddendenfoot
Todmorden
Warley
Town
Sowerby Bridge
Brighouse
Skircoat
Rastrick
Elland
Greetland and Stainland
Ryburn
White Irish rate per 1,000 of the population
17 to 20 (2)
14 to 17 (1)
11 to 14 (4)
8 to 11 (9)
5 to 8 (2)

Sheffield Hallam University

CRESR
Centre for Regional Economic and Social Research

IRISH IN CALDERDALE HEALTH STUDY

- **Are you Irish, 50 years of age or older, and living in Calderdale?**

- **Are you second or third generation Irish in Calderdale, 50 years of age or older and living in Calderdale?**

If so, we would like to hear about your experiences of health and well being. We would be grateful if you could spare 15 minutes to fill in this questionnaire.

All information will be anonymised and treated in the strictest of confidence.

By telling us about your health situation you will help us to highlight the needs of Irish people living in Calderdale. This information will be used to address service provision for, and consultation with, the Irish population in Calderdale.

Please put the completed survey in the pre-paid envelope provided and return by post by Monday 16th February 2009.

This survey is being conducted by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University on behalf of NHS Calderdale. If you would like more information about the research, or have any queries or comments, please contact either:

Dr Rionach Casey on 0114 225 2987 or e-mail r.casey@shu.ac.uk

Professor John Flint on 0114 225 4680 or e-mail j.f.flint@shu.ac.uk

ABOUT YOU

Q1. Gender:

Male	1
Female	2

Q2. Date of birth (dd/mm/yy) ..... **OR Age:** .....

Q3. Where were you born? (circle **one** option only):

England	1
Republic of Ireland	2
Northern Ireland	3
Other (please state):	4

.....

Q4. Would you define yourself as (circle **one** option only):

Irish	1
Second-generation Irish	2
Third-generation Irish	3
Other (please state):	4

.....

Q5. What year did you come to Britain (if first generation Irish)?

Year ☐

Q6. What type of accommodation are you currently living in? (circle **one** option only)

Renting from the Council	1
Renting from a Housing Association	2
Renting from a Private Landlord	3
Owner Occupied	4
Living with friend or relative as a lodger	5
Supported/specialist accommodation	6
Staying with friend or relative as a guest	7
Homeless	8
Other (please state):	9

.....

Q7. Do you have access to a car? (circle **one** option only)

Yes	1
No	2

HEALTH PROFILE

Q8. **Tick the statement that best describes you** (circle **one** option only):

I am very healthy	1
I am reasonably healthy	2
I am not very healthy	3
I am definitely ill	4

Q9. **How many (if any) cigarettes do you smoke per day?** (circle **one** option only)

1-10	1
11-20	2
21-30	3
31-40	4
41+	5
None	6

Q10. **How many units of alcohol do you consume in one week** (note: a glass of beer/wine/small spirits is one unit)? (circle **one** option only)

1-10	1
11-20	2
21-30	3
31-40	4
41+	5
None	6

Q11. **Do you have health concerns about your own health, or the health of a family member, in relation to any of the following?** (circle all that apply):

a	Diabetes	1
b	Cancer	1
c	Heart Disease	1
d	High Blood Pressure	1
e	High Cholesterol	1
f	Asthma	1
g	Smoking	1
h	Alcohol Use	1
i	Healthy Eating	1
j	Weight Loss/Management	1
k	Mental Health (including depression, stress and/or anxiety)	1
l	Substance Misuse (i.e. drugs)	1
m	Not Applicable	1
n	Other (please state):	1

.....

Q12. Are you currently having any treatment for illness (mental or physical)?

Yes	1	
No	2	**Go to Q14**

Q13. If yes, please identify the illness/illnesses:

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Q14. What do you do to keep healthy and stop yourself becoming ill? (circle all that apply):

a	Exercise	1
b	Healthy diet	1
c	Leisure activities	1
d	Voluntary work	1
e	Social activities	1
f	Church/religious activities	1
g	Other (please state):	1

Q15. What sort of things do you do to deal with fairly minor illnesses? (Please list up to 3 - for example consult pharmacist, self-mediation, seek advice from family or friends):

1. .....

2. .....

3. .....

Q16. What sort of things would make you go to the doctor? (Please list up to 3)

1. .....

2. .....

3. .....

OPINIONS ON HEALTH

The following statements suggest some key aspects of health.

Q17. Can you please indicate how strongly you agree or disagree with the following descriptions of a healthy person?

		Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
a	A healthy person is physically and mentally fit	1	2	3	4	5
b	A healthy person takes regular exercise	1	2	3	4	5
c	A healthy person has social connections	1	2	3	4	5
d	A healthy person has a balanced diet	1	2	3	4	5
e	A healthy person is spiritually and emotionally fulfilled	1	2	3	4	5

Q18. Can you be healthy and still have some kind of illness?

Yes	1
No	2
Don't know	3

Q19. Do you think that Irish people are particularly prone to poor health?

Yes	1	**Continue**
No	2	**Go to Q21**
Don't know	3	**Go to Q21**

Q20. If yes, why do you think that is?

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AWARENESS AND ACCESS TO LOCAL HEALTH SERVICES

Type of service:

Q21. Are you aware of where the following health services are available in Calderdale? (circle all that apply):

a	GP	1
b	Dentist	1
c	Pharmacy	1
d	Physiotherapy	1
e	Chiropodist	1
f	Optician	1
g	Counselling	1
h	Other (please state):	1

.....

Q22. Do you use the following health services? (circle all that apply):

a	GP	1
b	Dentist	1
c	Pharmacy	1
d	Physiotherapy	1
e	Chiropodist	1
f	Optician	1
g	Counselling	1
h	Other (please state):	1

.....

Q23. Please rate the quality of any health service you regularly use:

		Very good	Fairly good	Average	Fairly poor	Not applicable
a	GP	1	2	3	4	5
b	Dentist	1	2	3	4	5
c	Pharmacy	1	2	3	4	5
d	Physiotherapy	1	2	3	4	5
e	Chiropodist	1	2	3	4	5
f	Optician	1	2	3	4	5
g	Counselling	1	2	3	4	5
h	Other (please state)	1	2	3	4	5

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BARRIERS TO ACCESSING SERVICES

Q24. Do any of the following prevent you from accessing health services? (circle all that apply):

a	Cost	1
b	Appointment times	1
c	Lack of information	1
d	Family/work commitments	1
e	Lack of transport	1
f	Location of services	1
g	Language/communication difficulties	1
h	Racism	1
i	Not Applicable	1
j	Other (please state):	1

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Q25. Please indicate which of the following would improve health services (circle all that apply):

a	Reduction in waiting list	1
b	More suitable appointment times	1
c	More accessible by public transport	1
d	More accessible location for consultations	1
e	More time given in consultations	1
f	More information	1
g	More cultural awareness regarding Irish people	1
h	No change	1
i	Don't know	1
j	Not Applicable	1
k	Other (please state):	1
	.....	

Q26. To what extent do you want to be involved in changing health services in Calderdale (circle **one** option only)**?**

Very involved	1
Fairly involved	2
Not involved at all	3
Don't know	4

Q27. Have you experienced negative discrimination in health services on any of the following grounds? (circle all that apply)

a	Accent	1
b	Colour	1
c	Sex	1
d	Sexual orientation	1
e	Ethnicity	1
f	Disability	1
g	Nationality	1
h	Age	1
i	Religion/Faith/Belief	1
j	None	1
k	Other (please state):	1
	.....	

FURTHER RESEARCH

As part of the research, we would like to talk in more depth to some people about their experiences of health and well being and their use of health-related services.

Anything you say will be treated in the strictest of confidence by the research team, who are independent of the PCT

Please indicate by ticking the boxes if you would be willing to take part in further research about Irish people in Calderdale, and provide us with your contact details:

☐ **Take part in a focus group** (small group discussion about health and well being issues affecting Irish people in Calderdale)

☐ **Take part in a one-to-one interview** (with a researcher from Sheffield Hallam University)

CONTACT DETAILS

These will only be used to contact you about further research if you give permission for this to happen.

Name: .....

Address: .....

.....

.....

Postcode:.....

Tel: ..... **Email**: .....

Please indicate by ticking the box whether you are willing to have your contact details only (i.e. name, address and telephone number) on a database held by Calderdale NHS, and be contacted by them in the future

☐ I **agree** to have my contact details included in a database held by Calderdale NHS and be contacted by them in the future

☐ I **do not** agree to have my contact details included in a database held by Calderdale NHS and be contacted by them in the future

Please turn over

PLEASE USE THIS SPACE IF YOU NEED TO CONTINUE ANY OF YOUR ANSWERS OR IF THERE IS ANYTHING ELSE YOU WOULD LIKE TO SAY THAT YOU HAVEN'T BEEN ASKED ABOUT

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THANK YOU FOR TAKING THE TIME TO HELP THE IRISH COMMUNITY IN CALDERDALE