Better
Health
Briefing

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Dementia and cancer in the Irish community in Britain

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Key messages

1 Because of the tendency to only view ethnicity in terms of skin colour, health inequalities experienced by the Irish community and persisting into the third generation in Britain are largely invisible. As such, preventive health strategies are neglected and the specific cultural needs of Irish people are rarely considered. The health of Irish Travellers is among the worst in Britain.

2 As with other black and minority ethnic communities, the Irish lack knowledge about cancer and dementia. Fears about being diagnosed with either make them reluctant to seek help, leading to late access to treatment, often only when a crisis occurs. Cultural beliefs and stigma related to these disorders are among the factors which delay help-seeking. Past experiences of anti-Irish racism and discrimination in health services can be more significant in the unwillingness of older people and their carers to access mainstream services.

3 Understanding social and lifestyle factors, cultural and religious beliefs, experiences of and fears about cancer in the Irish community and partnerships with the Irish third sector could help increase uptake of screening, encourage early diagnosis, improve recovery rates and reduce mortality.

4 Providing culturally sensitive care for Irish people with dementia and their carers could improve access to health and social services and reduce late diagnosis. An understanding of Irish culture, migration and settlement, childhood in Ireland, access to Irish music, arts and literature should underpin efforts to develop dementia friendly environments and activities.

Introduction

Increasing longevity has contributed to growing numbers of people living with cancer and dementia in the UK and elsewhere. While dementia and cancer can occur in younger people, the risks of both increase with age. In the UK, there is a considerable policy focus through the *National Dementia Strategy* (DH, 2009), the *NHS Cancer Plan* 2000 (DH, 2000) and the *Improving Outcomes: A Strategy for Cancer* (DH, 2011).

Although there is clear evidence that people from black and minority ethnic groups have poorer health and problems accessing services, major national initiatives frequently pay limited attention to their needs (Tilki *et al.*, 2015). There is a growing recognition that people from black and minority ethnic groups with dementia and cancer have needs which are not being met by mainstream services (Truswell, 2013; Tilki *et al.*, 2015).

A tendency to define ethnicity in terms of skin colour means that the Irish community (who are predominantly white and English speaking) are not considered (Hickman and Walter, 1997). The propensity to aggregate Irish ethnicity data into the overall white category presumes they have the same problems and needs as English people, and renders the health inequalities they experience invisible. It also denies the evidence that self-reports of poor health and limiting long term illness continue into the second and third generation rather than assimilating to the patterns of the host society (Harding and Balarajan, 1996; 2001; Clucas 2009).

The absence of up to date evidence about the Irish community is occasionally noted, but policy makers and commissioners generally fail to commission contemporary research or consult with Irish community organisations (Irish in Britain, 2014). This information deficit limits public health data and impacts seriously on Joint Strategic Needs Assessments and subsequently on Health and Wellbeing Strategies (Salway *et al.*, 2013a; 2013b). In the absence of up to date information it is unclear how or whether inequalities can be levelled and improvements made to health or treatment outcomes. Although there are many health inequalities in the Irish community in England, cancer and dementia care are priorities now. However, targeting information and health promotion interventions around these conditions could go a long way to improving diagnosis and treatment for these and other preventable illnesses.

1   The Irish community in England

The Irish population comprises 1% of the population in England, although the percentage varies from 2.2% in London to 0.2% in the North East (Ryan *et al.*, 2014). Irish people (from both the Republic and Northern Ireland) are concentrated in London and surrounding regions, with significant populations in the South East, North West, East and West Midlands. There are also sizeable populations in the Southwest, Yorkshire and Humber.

The 2011 census shows that the age profile of the Irish community is distinctive, with a higher proportion of people above 55 and particularly beyond pension age than in the general or minority ethnic populations (Ryan *et al.*, 2014). This reflects the period of their migration to England, with 38% of the Irish community arriving before 1961 and a further 18% between 1961-71 (Ryan *et al.*, 2014). Although the Irish community have high levels of employment, especially in the upper occupational categories, a large proportion of the community is economically inactive due to retirement (Ryan *et al.*, 2014). In addition, a significant number of Irish people aged from about 50 upwards and Irish Travellers of working age are economically inactive, because of long term sickness or disability (Ryan *et al.*, 2014). Reflecting the demographic profile of the community, Irish people are more likely to be homeowners, living in single person households than any other group in England. This has implications for care and support in old age and illness (Tilki *et al.*, 2009).

Analysis of the 2011 census provides robust evidence of high levels of Limiting Long Term Illness (LLTI) and self-reported poor health among Irish people over 50 (Ryan *et al.*, 2014). Gypsy and Irish Travellers aged 50 and over have the highest levels of limiting long term illness and "bad" or "very bad" health in England. Levels of LLTI among White Irish people over 50 is lower than Bangladeshi, Pakistani and Caribbean groups but worse than the White British population. Research by Irish community organisations suggests that mobility problems, cardiovascular disease, pain, depression and anxiety are common causes of LLTI (Moore *et al.*, 2012). A quarter of Irish people and over forty percent of Gypsy and Irish Travellers provide fifty or more hours of unpaid care each week (Ryan *et al.*, 2014). Although the research is somewhat dated, there is robust evidence to show that Irish people have disproportionately high rates of cancer, heart disease, hypertension, and stroke particularly in older age bands (Wild *et al.*, 2006; Harding *et al.*, 2009).

The incidence of mental illness amongst Irish communities are high, with high levels of Common Mental Disorders (Weich *et al* 2004), excessive rates of depression, anxiety and psychological-ill health (Ryan *et al.*, 2006) suicide and attempted suicide (De Ponte, 2005; Maynard *et al.*, 2012). In-patient admission rates among Irish people over 50 are also higher than in the general population. The Count Me In Census (a count of in-patients on a specified day) repeatedly demonstrated Irish people above 65 were disproportionately represented in mental establishment admission figures (CQC/NMHDU, 2010).

2   Common factors relating to cancer and dementia

Although at a superficial level there would appear to be few links between cancer and dementia, a further examination suggests that there are similarities which are pertinent to the Irish community in Britain. Indeed many of the problems faced by Irish people are shared with people from other minority ethnic groups. Cancer and dementia are more common in older people and they both instil fear and have taboos about them which prevent dialogue and discussion (Waller *et al.*, 2009; Truswell, 2013). Apart from delaying help-seeking, the failure to discuss fears and anxieties with family and friends limits opportunities for information, sources of advice and encouragement to take the first step towards diagnosis. There is evidence that being older, people are not always referred for investigation or prioritised for treatment as younger people might be (DH, 2012; RCS, 2012). General practitioners are reluctant to diagnose dementia for a range of reasons (Downs *et al.*, 2006). Language, literacy, culture and the insensitivity of assessment tools exacerbate the problem for people from minority ethnic groups (Mukadam *et al.*, 2013). Older people often have lower expectations of health services, are reluctant to make a fuss and, especially when ill, lack the confidence or energy to challenge health professionals. This often reflects how their life history has shaped their health and attitudes towards health services (Bowers *et al.*, 2009).

Smoking, obesity, and alcohol consumption are important factors in the genesis of cancer and dementia and, although behaviour is changing in the wider community, it is changing more slowly in the Irish community in Britain (Tilki *et al.*, 2009). There are few focussed attempts to address this by public health authorities and dissatisfaction with mainstream services and stigma prevent the older generation in particular from engaging with preventive interventions.

3   The Irish migratory experience

Irish people have migrated to Britain for centuries and, because of its proximity, emigration was often unplanned. Like other minority ethnic groups, few Irish people expected to settle (Tilki, 2003). Poverty and unemployment were the main reasons for leaving Ireland, but many sought to escape a claustrophobic, unfair society. Significant numbers were escaping abuse in institutions or families. This and the impact of childhood poverty meant many migrated with physical or mental health problems which were compounded by the difficulties they faced in Britain (Tilki, 2003; Delaney *et al.*, 2013,). Arriving in England afforded employment, income, access to better healthcare and, for many, freedom. However, this was often coupled with displacement, loneliness and homesickness (Tilki, 2003), with ongoing evidence of the impact of migration on mental health (Bhugra, 2004).

While most Irish immigrants found the English polite and respectful, they invariably felt like outsiders with little in common with the host society. When attempting to find work or somewhere to live, they were faced with "No blacks, no dogs, no Irish" signs (Tilki, 2003). Although Irish people worked in farms and factories alongside the English during World War II, they were seen a threat to national security and persistently taunted about Ireland's neutrality (Tilki *et al.*, 2010). However, from the late 1960s, the "troubles" in Northern Ireland legitimated very public expressions of anti-Irish racism and draconian police powers though the Prevention of Terrorism Act 1974 (Hickman and Walter, 1997). Survival for Irish people meant keeping a low profile and expressing their Irishness only in the privacy of home, the Catholic Church, dancing school or local Irish centre. While anti-Irish sentiment has mostly disappeared, experiences of the past have taken their toll on mental and physical health and may still be vivid for the older generation (Moore *et al.*, 2012).

4   Cancer and the Irish in Britain

There is an urgent need for contemporary evidence, but robust research since the 1990s has shown high levels of mortality from cancer among the Irish community in Britain (Harding and Balarajan, 1996, 2001; Harding and Rosato, 1999; Wild *et al.*, 2006). Irish community organisations such as Irish Community Services in South East London today report high levels of cancer morbidity and untimely deaths from cancer among their customers. Standard mortality ratios for all cancers have significantly increased for Irish people of all ages and this persists into the second and third generations (Harding *et al.*, 2001). This contrasts with mortality rates for other migrant groups who have generally lower cancer levels albeit converging towards host population figures (Harding *et al.*, 2009). Compared with a general reduction in mortality for the population of England and Wales, cancer mortality either remained the same or in some cases increased for the Irish from 1979-2003 (Harding *et al.*, 2009). Longitudinal data from 1979-2003 demonstrated that men born in Ireland had higher mortality rates for all cancers compared to English and Welsh populations (Harding *et al.*, 2009). Although patterns vary at different times and between people from Northern Ireland and Republic of Ireland, consistently high rates of cancer of the oro-pharynx, rectum, liver, larynx, stomach cancer and pancreas persist and, in some cases, increased among Irish men. Although the research is somewhat dated, evidence demonstrated that lung and colorectal cancer remain the main cases of mortality among Irish men. Lung cancer was around 50% higher than for men from England and Wales and 30% higher than Bangladeshi men. Colorectal cancer was around 30% higher than for English/Welsh men but lower than in Bangladeshi men (Wild *et al.*, 2006).

Among women, colon, stomach, cervical and ovarian cancer continued to be high with no evidence of the decline in mortality seen in other populations (Harding *et al.*, 2009). Conversely, all cancer mortality rates for Republic of Ireland born women increased between 1989-1993, and 1999-2003. Unlike women from most other migrant groups, lung and breast cancer remain the main causes of mortality among Irish women (Harding *et al.*, 2009). Breast cancer mortality between 2001-2006 was broadly similar to women in England and Wales but lung cancer mortality was almost 40% higher (Wild *et al.*, 2006).

Analyses of Proportional Admission Ratios (expected admissions for size of population) for London residents between 2003-2006 demonstrate excessive hospital admissions for various cancers (and other illnesses, LHO, 2006). However there is no data on screening, referral for investigation, cancer staging or treatment outcome, leaving major information deficits about the Irish community (Irish in Britain, 2014).

5   Cancer risk and Irish people

There is no single explanation for high rates of cancer among Irish people, but socio-economic status, lifestyle and late access to services play a part (Harding, 1998; Harding and Balarajan, 2001). Research shows that knowledge of cancer symptoms is poorer among the Irish than White British population (Scanlon *et al.*, 2006, Genetic Alliance, 2012). Irish people fear cancer more, are more likely to keep it hidden and are less optimistic about the effectiveness of treatment (Scanlon *et al.*, 2006). This partly explains delay in seeking help, leading to diagnosis at advanced stages which significantly influence mortality rates (Foot and Harrison, 2011). It is easy to suggest that late diagnosis is a culturally shaped choice. However, this ignores the reality that a significant proportion of the older Irish population in Britain live in areas of multiple deprivation with poorer access to services and, arguably, poorer services to access (Tilki *et al.*, 2009). It also ignores insensitivity and racism experienced within the NHS by some Irish people, especially those who are older or marginalised (Tilki *et al.*, 2010).

6 Understanding attitudes to cancer in the Irish community

There is a lot of work to be done to raise awareness of the signs of cancer, the value of screening and the importance of early diagnosis in the Irish community (Irish in Britain, 2014). Although the success of cancer treatment is widely known in English society, the experience of Irish people is often different. Communications with Irish voluntary organisations such as Irish Community Services in South East London highlight that because of taboos around the topic, many older people may have first known about a relative having cancer when they were terminally ill. Irish literature is littered with factual and fictional accounts of painful death and children orphaned by cancer such as John McGahern's *Amongst Women* (1990) and Colm Tóibín's *Nora Webster* (2014). It is not uncommon for bereaved Irish families to find leaflets about cancer among the belongings of their deceased relative: high mortality rates from cancer are real for the Irish community as they see people around them die from cancer, often very soon after diagnosis (Tilki, 2003). While this mostly reflects late diagnosis and lifestyles, it does little to inspire confidence in seeking help. Equally, experiences of not being listened to by doctors or symptoms being blamed on alcohol do little to encourage help until a crisis occurs (Tilki, 2003).

The reluctance to talk about cancer or even use the term, limits opportunities to hear the benefits of early diagnosis or the success of modern treatments. Despite the high numbers of Irish people experiencing cancer, it has been very difficult to establish self-help groups because the issue is so painful within the community. This mirrors the experiences of other minority ethnic groups (Avis *et al.*, 2008). While younger Irish people are comfortable to talk about cancer in mainstream support/ self-help groups, the older population need encouragement to talk even within their own community. Organisations such as Irish Community Services have found that guilt around smoking, unhealthy diets, alcohol consumption or other factors play a part in delaying help seeking. Faith is a sensitive issue and prayer is a form of support and a way of coping for many. However, prayer as an alternative to professional help can delay diagnosis and make treatment more difficult and less successful (Tilki, 2003). Irish organisations understand and respect this but sensitively remind people that their religion requires them to take measures to protect and care for their own health, using resources as necessary to enable this.

Unfortunately, despite policies to reduce cancer inequality by enhancing awareness and improving access to services by minority ethnic groups, there is no mention of the disproportionate mortality from most cancers among the Irish in Britain. Even the National Cancer Action Team, *Cancer Does Not Discriminate* (NCAT, 2012a), ignores the Irish except to publicise plans to produce a health supplement in 2012 (NCAT, 2012b).

7 Preventing cancer

Given the persistence of cancer (and health) disadvantage into second and third generation Irish people in England, there is considerable scope for health promotion. Although the evidence base for many health promotion activities is limited (Asthana and Halliday, 2006), Public Health England objectives emphasise the importance of involving the community and voluntary sector in tackling health inequalities (PHE, 2014). As with other minority ethnic communities, the Irish third sector is ideally situated to raise awareness of cancer, promote screening, early diagnosis and provide information in partnership with public health or NHS authorities (Tilki *et al.*, 2015). Messages must convey information about improved survival rates, but also highlight the genetic cancers which may affect children and grandchildren. While younger people will engage with mainstream campaigns, there are opportunities for focused smoking cessation or alcohol reduction programmes for older people (DH, 2010).

The anecdotal experience of Irish organisations suggests that a non-judgemental approach, understanding the role of smoking and alcohol in Irish peoples' lives will be more effective than a hectoring one. The Irish third sector believes that campaigns focused around Lent or St Patricks Day could capture the Irish custom of abstaining during Lent. Gaelic Sports events throughout England provide opportunities for men (especially) to exercise and afford an ideal space for campaigns around health matters. Given the popularity of dance for health we suspect that céilí or step dancing could be promoted for fitness and weight loss and modified appropriately for older people.

Irish organisations should be supported to develop cancer self-help groups. Having a common illness will not necessarily generate the trust needed to share painful experiences, and fears (Avis *et al.*, 2006). Although there is a long history of self-help in the Irish community (Tilki, 2003), our experience is that people question how sharing with others who have cancer will be of any benefit to them. Therefore, the value of mutual support and sharing ways of coping with everyday problems must be promoted. Although some may reject an Irish-only group, the majority would feel safer with other Irish people who understand experiences of racism and share similar beliefs about cancer and treatment (Moore *et al.*, 2013).

8 Dementia and the Irish community

As identified, the median age of the Irish community in England (53) is higher than other ethnic groups , including the White British population (42), Black Caribbean population (41),Indian (32) and Pakistani populations (26) (CPA, 2013). However, because the Irish are not always considered as a minority ethnic group distinct from the British majority, their needs are frequently overlooked by policy-makers, commissioners and service providers (APPG, 2013). The Royal College of Psychiatrists identified the Irish as a minority ethnic group with an older population more than twice the size of the next largest (Caribbean) group, yet no commentary or recommendations were made regarding their health or health outreach programmes (RCP, 2009). Similarly, the Policy and Research Institute on Ageing and Ethnicity (PRIAE, 2005) demonstrated that whilst the Irish population aged between 60-79 was double that of the Caribbean population, for those aged over 80, the Irish population was more than three times greater than the older Caribbean population. Again, no recommendations were made.

Evidence from Irish community organisations has highlighted a growing incidence of dementia for almost a decade now (Mulligan, 2007; FIS, 2010, 2012). Using the Alzheimer's Society estimations of prevalence, Truswell (2013) calculates that around 10,000 Irish people in England might experience dementia. This is consistent with reports of increasing numbers seeking help from Irish community organisations because of memory problems, diagnosed dementia or difficulty accessing services (Tilki *et al.*, 2009; FIS, 2010). Evidence from community organisations also reports that Irish Travellers appear to experience unusually high levels of early onset dementia and have particular difficulties associated with nomadic traditions and the provision of care on inadequate Traveller sites (LeedsGATE, 2013).

9 **Dementia risk and Irish people**

The risk of dementia is reflected in the older age profile of the Irish community, particularly the proportion in the very oldest category where dementia is more prevalent (Ryan *et al.*, 2014). It is also possible that excess levels of cardiovascular disease among the Irish population compound the risk (Tilki *et al.*, 2010). High levels of psychological ill-health and common mental disorders such as depression and anxiety may also exacerbate the risk (Tilki *et al.*, 2009; CQC, 2010) and are magnified for Irish Travellers (Parry *et al.*, 2007) Although Irish elders are mostly concentrated within larger Irish communities, areas with smaller populations risk of isolation and limited access to support for older people (Tilki *et al.*, 2009).

The high proportion of people living alone predisposes the older Irish population to social isolation and is exacerbated by ill- health, poverty, unreliable transport or fear of crime in deprived areas (Tilki *et al.*, 2010). As in other communities, embarrassment about poor memory, language, sensory problems or altered behaviour makes people with dementia and their carers reluctant to leave the home (Mukadam *et al.*, 2011). Isolation itself contributes to dementia, but practically, also increases the risk of increasing cognitive impairment, unusual behaviour, neglect or carer stress going unnoticed (APPG, 2012; 2013). It can also limit access to information about resources and services or the likelihood of friends and family encouraging the person to seek help (APPG, 2013). Past experiences of racism, insensitivity and hostility are more likely than stigma to compound the reluctance of Irish people to seek help (Tilki *et al.*, 2010).

10 **Culturally appropriate dementia services for Irish people**

Although age is a major risk for dementia in the Irish community, measures to prevent cancer and cardiovascular disease can also have a positive effect on dementia diagnosis and treatment if instituted early (APPG, 2012). Reducing isolation through luncheon clubs or social events can help prevent or delay the progress of dementia and afford opportunities for information and psychosocial support (Tilki *et al.*, 2010). Older Irish people are reluctant to use mainstream services and when they do, they are often dissatisfied (Tilki, 2003; FIS, 2010). The Irish third sector is well placed to provide specific services which enable Irish people adapt and adjust practically and emotionally and live well with dementia. Family carers can be supported and helped to adapt to and cope with the change in their loved one, and afforded some respite in a safe environment (Tilki *et al.*, 2010).

Good Practice - Cancer and the Irish in England

While younger Irish people are comfortable to talk about cancer in mainstream support/ self-help groups, the older population need encouragement to talk even within their own community. Simple matters such as accents not being understood, pronunciation of Irish names and cultural taboos prevent people accessing mainstream services (Tilki, 2003). Organisations such as Irish Community Services have found that guilt around smoking, unhealthy diets, alcohol consumption or other factors play a part in delaying help seeking. Faith is a sensitive issue and prayer is a form of support and a way of coping for many. However, prayer as an alternative to professional help can delay diagnosis and make treatment more difficult and less successful. Irish organisations understand and respect this but sensitively remind people that their religion requires them to take measures to protect and care for their own health, using resources as necessary to enable this.

Good Practice -Dementia and the Irish in England

As with other minority ethnic groups, the Irish in England have distinct traditions and cultural practices that have a profound bearing on the needs of people with dementia (APPG, 2013). Although Irish people speak English, accents and dialects may not be understood and native Irish speakers who lose their ability to speak English, may have nobody to communicate with when dementia strikes. Despite having much in common with the English, the biographies and experiences of Irish people are very different.

For example, as memory "peels back", hostilities experienced by Irish people in England during World War II, the troubles in Northern Ireland and IRA bombings during the 70s may become real again, creating anxiety, agitation or behaviour change. Travellers can relive experiences of forced eviction, harsh treatment by police and generally being harassed by the public. Childhood experiences in Ireland can provide happy opportunities to reminisce and recall happier times. However, those who experienced institutional abuse, or were raised in difficult families may recover painful memories repressed for decades. Reminiscence or disinhibition associated with dementia might resurrect "taboos" such as babies given up for adoption, abortion, miscarriage, sexual orientation. This will not be an issue for everybody, but such "secrets" need to be understood in an Irish context and handled sensitively.

Most Irish organisations provide services for older people and many are becoming dementia friendly and developing provision for Irish people with dementia. The services vary but most offer social activities for cognitive stimulation such as reviewing Irish newspapers, television, art and literature. Culturally informed staff or volunteers undertake reminiscence drawing upon the rich Irish tradition of storytelling and the wealth of music, poetry and art in Irish culture. Several groups address fitness in the form of keep-fit, yoga, chair exercises. Tea dances are popular events, providing social interaction, exercise and continuity with the past through Irish dancing and music.

Some Irish organisations facilitate groups where carers share experiences with other carers, learning from each other and sharing ways of coping with their relative. Advice and information about benefits and services care provided by staff and experts on different issues are invited to speak. Social events or memory cafes provide a small degree of respite from their responsibilities and the chance for carers to "let off steam" in an empathetic environment.

Conclusion

Cancer and dementia will continue to be major health issues for the foreseeable future. There is a dearth of research about dementia in black and minority ethnic and Traveller communities and this is compounded by poor ethnic monitoring in primary and secondary services (Botsford and Harrison Dening, 2015). There is a growing interest in cancer in minority ethnic communities but more research is needed (NCAT, 2012a). Mainstream research campaigns must do more to recruit participants from minority ethnic communities, who are now reaching the age where cancer and dementia are more prevalent.

 However, there is also an urgent need for data about the Irish community, so that public health interventions can be planned through Joint Strategic Needs Assessments (JSNAs) and Health and Wellbeing Boards (HWBs) (Salway *et al.*, 2013a, 2013b). The aim to increase cancer survival rates by improving early detection (Foot and Harrison, 2011) is highly appropriate for the Irish community, but without targeted action is unlikely to succeed (Irish in Britain, 2013, 2014). The ambition to increase the number of dementia diagnoses by improving information and awareness especially in minority ethnic groups cannot be monitored unless better data on diagnosis rates is available (Truswell, 2013). Addressing smoking, alcohol, obesity and exercise will have a positive impact on dementia as well as a

range of other disorders (WHO, 2014). Public health authorities, GPs, NHS and other health professionals have a very important role to play in promoting a healthy lifestyle across the Irish community in England. Many Irish people will engage with mainstream campaigns but channelling them through Irish organisations, sports or cultural events, using Irish media or sports stars could widen their reach.

The Irish are a resourceful resilient community with a long history of self-sufficiency and there are extensive assets already with the Irish third sector in England (Tilki *et al.*, 2010). Like the black and minority ethnic sector, Irish community organisations emerged to address the failings of mainstream services. They understand their constituents, are trusted by them and reach into sections of the community labelled "hard-to-reach" (Tilki *et al.*, 2015). Larger organisations like Leeds Irish Health and Homes, Irish Community Care Merseyside, Brent Irish Advisory Services provide professional accessible services and have considerable scope to expand through commissions or partnerships. Low threshold services such as the luncheon club provided by Irish Network Stevenage are an economical and effective way of reducing social isolation but with a moderate increase in resources could do much more to improve health. Irish people are part of the fabric of English society and as citizens and taxpayers, deserve equitable services.

Resources

Cancer

Irish Community Services
www.irishcommunityservices.org/projectsservices/cancer-self-help-group

Irish Community Services in South East London has set up the first self-help group for people affected by cancer within the Irish community. The aim is to create a safe, confidential, friendly and relaxed environment for people to share experiences and support each other throughout this challenging illness. The group is held at the same time as Irish Community Services lunch club so a good home cooked meal can also be enjoyed.

Dementia

Cuimhne
www.irishinbritain.org/campaigns/cuimhne-irish-memory-loss-alliance

Cuimhne (the Irish word for memory, pronounced "*queevna*") is an Irish in Britain (http://www.irishinbritain.org/) national campaign to address the needs of Irish people in Britain who experience all forms of memory loss. The Cuimhne initiative aims to build a community alliance of individuals, organisations and businesses which are knowledgeable, sensitive to and inclusive of people with memory loss and their carers. Training in dementia awareness and cultural sensitivity is a central tenet of the Cuimhne strategy.

Resources

Community Action on Dementia Brent
[Website should be ready soon]

Community Action on Dementia Brent is a recently formed charity initiated and led by Irish in Britain. It comprises a number of charities, voluntary organisations, black and minority ethnic community groups, faith communities, fire and police services Brent Council, Health and Wellbeing Board and Clinical Commissioning Group. People living with dementia and family carers are involved in advising the group and representing the needs of their peers. The aim of the social movement is to improve the lives of people with memory loss, help them maintain independence and keep and their carers them engaged in their local communities.

Brent Irish Advisory Service
http://biasbrent.co.uk/what-we-do/respite-and-day-care-service

Brent Irish Advisory Service provides a respite and day care service for older members of the community with care needs who may otherwise be unable to get out and about to enjoy social activities. The day involves a range of activities including light chair exercise, singing, storytelling, live music, arts and crafts, bingo, card games, quizzes as well as a freshly cooked lunch. This is a safe, friendly environment which promises a warm Irish welcome to all members of the community. Staff and volunteers are culturally sensitive and are about to undergo dementia awareness training through the Cuimhne programme.

Irish Community Care Merseyside
http://iccm.org.uk/about-iccm/our-projects

Irish Community Care Merseyside runs several support groups for older people in different venues. The aim is to reduce isolation, empower older people to make decisions about what best meets their needs. Staff and volunteers are dementia aware and culturally sensitive having undergone training through the Cuimhne programme.

Irish Network Stevenage
http://irishnetworkstevenage.org.uk

Irish Network Stevenage was formed in 2007 to respond to the support needs of an ageing Irish population. The aims are to enable older people live independently in their own homes and combat social isolation. Social activities such as a film club, tea dances, flower arranging, IT courses and exercise are offered to keep members socially interactive and mentally stimulated. Information and advice is provided during most social events. There is also a volunteer outreach service to older, vulnerable isolated members of the community. INS volunteers and staff are dementia aware and culturally sensitive having undertaken Cuimhne training.

Leeds Irish Health and Homes
www.lihh.org/support-services/dementia-services

Leeds Irish Health and Homes runs a weekly social group for people who have dementia. This group is by referral only and it is primarily for individuals who have been diagnosed with dementia or have memory problems. Referrals can be by the person concerned, a friend, family member or health care professional. Staff and volunteers have received Cuimhne training.

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