Report on

Community Health Research

in the

North East Inner City

Using a

Participatory Research Action Programme

October 2010

Acknowledgements

CAN would like to extend very sincere thanks to *all* those who took part in the Participatory Research Action programme in North East Inner City Dublin especially those who participated in the course and facilitated focus groups and one to one interviews; those who attended focus groups and generously gave their opinions and views, time and trust; and those who attended public meetings and contributed to the search for solutions.

Particular thanks are extended to ICON Staff for their on-going support to the programme in so many ways.

Working for Change Through
Community Development

Contents

Structure of the report

This report is presented as follows:

Part 1 provides an introduction to the report and its structure. It provides the background to and rationale for the action research programme in the North East Inner City (NEIC). It also provides a resource of other health research that has been conducted in the NEIC and that has been drawn from in the production of this report.

Part 2 looks at health inequalities at a wider level and also locally in the North East Inner City.

Part 3 introduces the participatory action research process undertaken and outlines the training methodology employed during the research process.

Part 4 presents the findings of the research in relation to a broad range of population groups. It includes additional research findings from a number of other reports that dealt with the health needs of some of the groups that we met.

Part 1: Introduction

This report presents the background, process and findings from a participatory action research programme undertaken within the North East Inner City (NEIC), Dublin on behalf of the Inner City Organisation Network (ICON) Health Action Forum. It begun in January 2010 and was completed in October 2010. This Participatory Research and Action programme (PRA) was initiated by ICON Health Action Forum. This Forum is supported by the Inner City Organisations Network (ICON), a network of community based projects, organisations and individuals living and working in the North East Inner City. The key focus of the network is to create a forum for debate and local policy making on issues identified within the community and to initiate the development of relevant service responses. Inherent in the aims of the organisation is a commitment to pursuing a partnership approach between statutory and non statutory sectors as well as actively encouraging the participation of local tenants and residents.

Rationale for the Research

It is envisaged that the research process will support the expansion of the ICON Health Action Forum that will work to

- support local participation in the improvement of health services
- achieve greater access to decision making regarding health issues
- support participation the Primary Health Care team in the Summerhill Area.

A first step in involving the local community in doing this was to train a team of local people and locally based community workers to research what impacts on people's health through Participatory Research and Action (PRA). This research training was delivered by Community Action Network (CAN).

The Health Action Forum:

'*The ICON Health Action Forum is comprised of local community organisations and individuals living and working in the North East Inner City, who are exercising their right to participate in health and service development*'. [1]It is envisaged that through the process of this research more local people from a variety of backgrounds will engage and become more involved with the Health Forum.

Aims of the Health Action Forum:

- To help the community to improve their own health and services through raising awareness and creating dialogue on health matters among community groups and with health services.
- To positively influence the health of the population through gathering of relevant data and information.

[1] ICON documentation, 2008

- To enable the community to make informed choices through access to appropriate health information and intelligence.
- To work with the statutory agencies in developing strategies to improve access to health services.
- To ensure the rights of the community to be consulted at local level regarding their health needs through representative community groups.
- To ensure that services for the community are appropriate, responsive to local needs, accessible and delivered in a manner that respects their privacy, dignity and individuality.
- To facilitate the most appropriate delivery of the Primary Health Care Strategy for the ICON area.

The Participatory Research and Action programme (PRA) initiated in 2010 was one part of the process which seeks to address community participation on health needs in Dublin North East Inner City area. This programme is based on the premise that the most meaningful solutions result from understandings shared between people who experience health inequalities and those who are involved in the delivery of a variety of services which exist to address them.

Part 2: Health Inequalities at the wider and local levels

Poverty and health inequalities

There is considerable research regarding health inequalities that show that lower socio-economic groups experience poorer health and a greater prevalence of health problems than those in higher socioeconomic groups. Such inequalities are considered to be unnecessary, unfair and avoidable[2]. For example, the all-cause mortality rate, on the island of Ireland, in the lowest occupational class is 100-200% higher than in the highest occupational group[3]. Over recent years, considerable progress has been made at international, national and regional level in terms of identifying the significance of the broader social and environmental factors and inequalities impacting on health. These factors have been central to the way in which Irish health related policies and strategies have developed. Specifically these include the National Health Strategy[4] and the Primary Health Care Strategy[5], both launched in 2001, the Traveler Health Strategy (2002-2006)[6] and the National Anti-Poverty Strategy and Health (2002-2007)[7].

The National Health Strategy sets out a vision that aims to provide -
"A health system that supports and empowers you, your family and community to achieve your full health potential. A health system that is there when you need it, that is fair, and that you can trust. A health system that encourages you to have your say, listens to you, and ensures that your views are taken into account."

Additionally, much has been researched and written in relation to the links between poverty and ill health and many of the wider influences on our lives.

'The social conditions in which people live and work can help create or destroy their health. Lack of income, inappropriate housing, unsafe workplaces and lack of access to health care systems are some of the social determinants of health leading to inequalities'.8

These 'social determinants of health' include 'the person's wider socio-economic position, inequality, poverty, social exclusion, socio-economic position, income, public policies, health services, employment, education, housing, transport, the built environment, health

[2] Combat Poverty Agency, 2005.
[3] Balanda and Wilde 2001
[4] Dept. of health & Children. A Health System for You: A Health Strategy 2001
[5] Dept. of Health & Children. Primary Care: A New Direction 2001
[6] Dept. of Health & Children. Traveler Health : A National Strategy 2002-2005
[7] Combat Poverty Agency. Health Services & the National Anti-Poverty Strategy. 2002
[8] World Health Organization [WHO], 2004

behaviours or lifestyles, social and community support networks and stress.' [9] The model recognises that the circumstances and conditions within which people live and work affects their health status and their access to health services.[10] They are represented in the following diagram[11] that shows all of the determinants and their relationship to the individual.

[9] Farrell C., McAvoy H., Wilde J and Combat Poverty Agency. Tackling Health Inequalities - an All Ireland approach to Social Determinants: Combat Poverty Agency/Institute of Public Health in Ireland. 2008

[10] Marmot 2005:3

[11] Dahlgren, G. & Whitehead, M. Policies and Strategies to Promote Social Equity in health. Stockholm: Institute for Future Studies 1991

Health Inequalities in NEIC: A Snapshot

Please note that most of this information is taken directly from the Community Consultation Process to assess the needs of the community in relation to Mountain View Court Health Care Facility, Summerhill and the services to be provided there. (Louise Monaghan and Siobhan McGrory. 2008.)

Geographic area covered by ICON

> 'The North East Inner city comprises ten electoral divisions in the centre of Dublin….. The area is bounded to the south by the River Liffey, to the east by the sea, to the north by the River Tolka and Clonliffe Road, and to the west by Dorset Street and East Arran Street' [12]Essentially the area is Dublin 1, the southerly part of Dublin 3 (Ballybough and Northstrand), and very small parts of Dublin 7.

Inequality is also researched by the SARHU index, a nationally accepted indicator of deprivation, combining unemployment, low social class, car ownership, rental accommodation and overcrowding. This index allocates its highest (i.e. worst) rating of 10 to all but one of the electoral divisions within the North East Inner City.

District Electoral Division	1966	1971	1981	1991	1996	2002	2006	% de/ increase from 02-06
Ballybough A	6,039	5,145	4,969	3,581	3,570	3,368	3624	**7.6%**[13]
Ballybough B	3,926	3,380	2,460	2,466	2,571	3,009	3215	**6.8%**
Mountjoy A	7,957	6,442	3,690	2,983	3,108	3,242	3760	**15.9%**
Mountjoy B	3,345	2,902	2,102	1,657	1,994	2,725	3446	**26.5%**
North City	2,966	2,311	927	819	2,391	3,942	3867	**-1.9%**
North Dock A	2,237	2,032	1,593	1,222	1,188	1,287	1200	**-6.7%**
North Dock B	6,244	5,637	4,258	3,503	3,655	3,628	3690	**1.7%**
North Dock C	5,067	4,366	2,659	2,324	2,411	3,568	4179	**17%**
Rotunda A	4,982	4,172	2,597	1,837	2,522	4,199	4672	**11.3%**
Rotunda B	1,775	1,886	1,273	896	1,122	1,752	2137	**21.9%**
Total NEIC	**44,538**	**38,273**	**26,528**	**21,288**	**24,532**	**30,720**	**33790**	**10%**

Source: Census of Population, Small Area Population Statistics.

The following statistics, highlight the significance of the deprivation in the NEIC. On a range of indicators, including health and deprivation, the North East Inner City contains some of

[12] Integrated Services Initiative. , Common *Goals Unmet Needs*. 1997

[13] All percentages have been rounded off to the nearest decimal point or nearest percentage therefore there will be small errors if culmatives are calculated.

the most deprived localities in the country. It has been recognised, however, that electoral division level statistics mask the true deprivation in some areas. Practically all local authority housing estates are in the most disadvantaged categories.

Mortality:
13 deaths from all causes are 'geo-coded' so that they can be given per electoral division. The most recent data on mortality by electoral division is almost 10 years old. The NEIC contains the highest standardised mortality rates (SMR's) or death rates. Mountjoy A has the highest SMR, almost twice the rate of the Eastern Regional Health Authority(ERHA), followed by Rotunda A and North Dock C, both over 70% higher than the ERHA as a whole.

Medical Cards:
The highest density of medical card ownership in the North City is also in the NEIC with over 40% ownership in some electoral divisions.

GP's:
Generally, in Ireland there are 68 GPs for every 100,000 people. Based on these figures there should be approximately 25 GPs serving the ICON geographical area. Up to July 2008 there were only 14 in the ICON area. However this situation has improved over the past 2 years. Based on a mapping of the GMS population in the Summerhill, North Strand and East Wall area, the number of GPs with a minimum patient population of 50 patients is currently 24 GPs (across 16 practices). The HSE also confirms that a number of other GPs would also have GMS patients in the area but these are not included in the above figure as they have less than 50 GMS patients in the Dublin North Central Area. Furthermore, it should be noted that some people living in this geographical area may be listed with GPs outside of the immediate area.[14]

Family profile
In the NEIC RAPID area (of 5 DEDS) there are 1,881 family units with children, in a population of just fewer than 20,000. Of these 1,881 family units with children, 1,324 are lone parent families representing 70.39%.
In the ICON area there are 3,642 family units with children, 2,000 of these are lone parent families. Across the North Inner City Drug Task Force (NICDTF) area there are 5,973 family units with children, 4472 of these are lone parent families, representing 75%.
These statistics are in stark contrast with those relating to Dublin City where 38% (27,804 of 73,628) of family units with children are lone parent families. Furthermore, in Dublin City & County, 29% (59,594 of 199,368) of family units with children are lone parent families. Finally, in Ireland as a whole 25% (189240 of 749626) of family units are lone parent families.

[14] Source: HSE Local Health Office, Dublin North Central, July, 2008

Older People

There has been a substantial decrease in the number of older people living in the North East Inner City in the period from 1991 to 2006. In this 15 year period the overall population of the North East Inner City has increased from 14,848 people in 1991 to 22,896 in 2006 – this represents a remarkable increase of 54% in the local population between 1991 and 2006. In a 15 year period, that has seen an increase in the overall population of the NEIC from 14,848 people in 1991 to 22,896 in 2006 however; the number of older people has decreased from 1,969 to 1,495 (a fall of 24.1%). In 1991 older people in the North East Inner City accounted for 13.3% of the local population – by 2006 this percentage was less than half representing 6.5%. In overall terms, there are 474 fewer older people living in the North East Inner City in 2006 than there were in 1991. In certain Electoral Divisions the difference in the population of older people is particularly stark. This situation makes living in the NEIC much more isolating and lonely for the older people who continue to live within these communities.

In addition it is estimated that 65.2% of older people living in the NEIC are single, separated divorced or widowed and that 34.8% are living with their husband/wife. This serves to further re-enforce the importance of addressing issues relating to loneliness and social isolation.[15]

NEIC Household Types

There are just fewer than 7,300 households in the NEIC RAPID area (5 DEDs). Of these, nearly 66.5% are apartments, flats and bed-sits. In the ICON area (of 11 DEDs) apartments, flats and bed-sits make up 57.5% of all households. Across NICDTF area (of 19 DEDs) apartments, flats and bed-sits represent 55% of all household types. In contrast, 31% of households in Dublin City comprise of apartments, flats and bed-sits while the figure is 10% for Ireland as a whole.

Indicators of Drug Use

In Ireland over 9,000 people are treated with methadone for heroin use, over 80% of methadone service patients reside in the greater Dublin area. In the NEIC Rapid Area (5 DEDs) there are approximately 460 people attending for methadone treatment. In the ICON Area (11 DEDs) there are over 600 attending methadone treatment services. In NICDTF (19DEDs) area as a whole there are now estimated at over 1,000 people receiving methadone treatment. In the DED known as Mountjoy A, 6% of the population aged less than 15 years is on methadone. Of the GP's referred to above, only 2 offer methadone treatment. [16]

[15] Rourke, S. 2008. Changing Times – Changing Needs - Needs Analysis Project of Older People in the North East Inner City of Dublin

[16] O' Reilly. F. 2005. "We're people too" Views of drug users on health services

In DED's Mountjoy A & Ballybough A between 1 in 20 and 1 in 25 adults between 18 & 64 attend methadone treatment services. These figures are estimates for 2006 and are indicative of drug use prevalence for heroin and other drugs. The National Advisory Committee on Drugs conservatively put prevalence estimates of active drug users for NICDTF area at between 1,500 to 2,000 in 2005.

NEIC Foreign National Population

In NEIC RAPID Area 6,435 individuals, representing 35% of the population, are of foreign national or ethnic origin (non-white Irish). In 3 other NIC DEDs this rises to over 50% of the resident population (4,292 of 8,271) of foreign nationals. This contrasts with a figure of 15% for Dublin City and a figure of 10% for Ireland as a whole.[17] According to Dublin Inner City Partnership analysis this population is made up of over 50 nationalities.

Primary Health Care in the NEIC

Despite extreme poverty and social disadvantage, the NEIC has yet to be provided with a comprehensive Primary Health Care Facility. It was proposed that a new health care facility be built on the Mountainview Court site in Summerhill. This site, and proposed building, is the property of the Dublin City Council and it was envisaged that the HSE, as tenants, would buy space in this building, primarily with a view to relocating the existing primary care services from the North Strand and Summerhill health centres to this new site. This development has now been abandoned, with no indication of when it might proceed as a result of government reduction in spending. The promise of the centre did provide an opportunity for the NEIC community to identify their health needs and to name the range of services that should be provided within this new facility.[18]

[18] Monaghan, L. & McGrory S. 2008. Community Consultation Process to assess the needs of the community in relation to Mountain View Court Health Care Facility, Summerhill and the services to be provided there.

PART 3: Health Research Training Programme

ICON Health Action Forum contracted CAN to train local people in the methods and techniques of participatory research and action (PRA). To begin the process CAN met with the health forum and used some of the exercises and methods of PRA. The process was repeated during two information meetings for individuals and groups in the local area. One meeting was held in the morning and one in the evening. As a result of these meetings a total of 14 participants signed up to do the training in PRA as community researchers.

Participatory Research and Action (PRA)

PRA, as it is known, is a participatory research approach which ensures that 'participants' are central to the research process and are actively involved in all stages of it. It works with communities to identify their issues and using creative approaches, the information, or 'data', is gathered on the issues that impact most on communities. It assumes that everyone involved has valuable insights and perspectives to share. PRA can be used on a wide range of issues but in this case the focus is on health.

In relation to community health planning, PRA is based on the philosophy that communities are the experts in their own lives when defining their health issues, and that the most meaningful solutions come about as a result of understandings shared in partnership between people who experience health inequalities and those who are involved in the delivery of a variety of services related to health. This is the approach used by CAN and the researchers.

The PRA training

PRA training is based on the belief that health is determined by a wide range of factors including social determinants, and that health is not only the absence of illness or disease. The training commenced in Feb 2010 and was held in CAN for once weekly sessions until the end of April 2010. The research training group consisted of 14 participants living and working in different organisations in the local area. They included men and women of different ages and ethnic backgrounds, all with an interest and commitment to tackling the health inequalities in the area. The organisations that supported participants to attend the training were:

- Hill St FRC
- Dublin Aids Alliance
- ICON
- Act of Compassion
- Cairde
- Community Policing Forum
- Liberty Belles (local women's group)
- HSE - Public Health Nurses

The course content covered a wide range of topics which included:

The participants on the course were brought through a variety of exercises and techniques of participatory action research that they themselves would be using in the research with focus groups. Participatory learning methodologies were used during the training including small and large group work, mapping, and role play, group research techniques as in pie charts, matrices and questionnaires.

Example of Mapping during the training course

Mapping captures the broader community in a creative way drawing in and using symbols that represent the services and organisations that are connected to health.

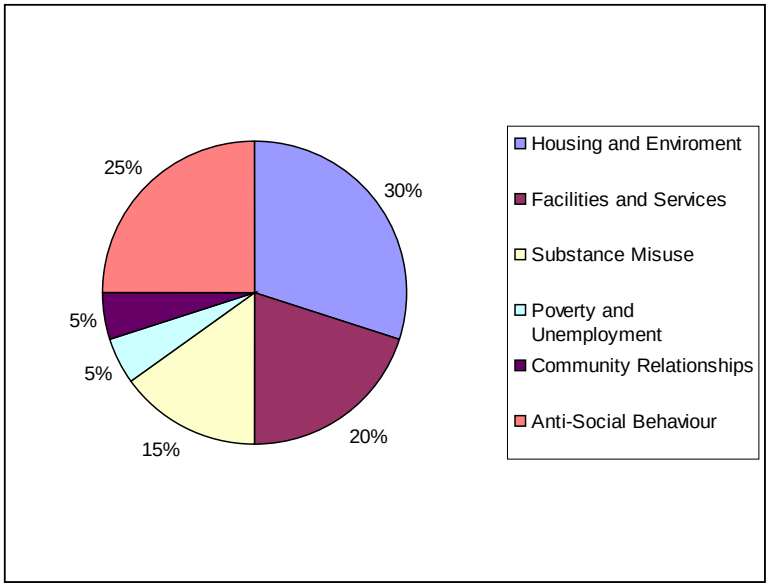
CAN training Course 2010

Pie charts

Another technique used in the research was creating Pie Charts. A pie chart is a diagram that can be used to illustrate *relative sizes* or *relative importance* of things. It is named for its resemblance to a pie which has been sliced. Pie charts are an effective way of displaying information visually.

The group discussed the 'social determinants' model, and began to identify a wide range of social factors which determine their own health. These are represented in the pie chart under the headings below.

Sample of Pie Chart from the training course



A Pie Chart is used so that

- people can see the large diagram more easily
- it can be rubbed out, moved around and changed.
- people feel free to do it themselves
- people can participate spontaneously and can be drawn into the process

Matrices

A matrix is probably the most common diagram form used in participatory approaches. It takes one issue identified in the pie chart and lists the problems associated with it down left hand side and the causes on the top of page. This continues into further matrices of listing the causes and then the solutions. Issues are prioritised by the use of stickers.

Here is an example of MATRIX from pie chart already completed taking the following issue identified

Housing and Environment

Causes → / Problems ↓	**Bad local government planning by DCC**	**Developers pulled out**	**Dept of environment has no money**	**No system of housing for extended families within DCC**	**No 4/5 bedrooms social housing built or available**	**Children not seen as important members of family**	**Play not seen as essential to good health**
Not enough social housing	●●●●●●	●●●●●	●●●●●		●●●		
Overcrowding	●		●●●●●	●●●●●●	●●●●●●		
No facilities for children to play	●●●●●		●●●			●●●●●	●●●
No Water							
Lack of Security							

Dots are the stickers represented

Focus groups

It was planned that the Community Researchers would convene and facilitate a range of focus groups in the North East Inner city area in order to gain an understanding of their perception with regard to what impacts on their health. Many of the focus groups were conducted in pairs, and were carefully planned in advance.

The focus groups were mainly conducted in the spring months of 2010. In each of the focus groups the Community Researchers role was to encourage and build safety in the group. There followed questions to the group on what impacts on people's health and the causes and solutions to the health problems. The Community Researchers ranked the answers using pie charts and matrices in order to discriminate between the answers and establish the most important factors impacting on people's health.

A total of 10 community groups took part in the focus groups, which added up to 71 local people participating. The focus groups were as follows;

- Hill St. Parent & Toddler group
- Acts of Compassion group
- Liberty House Women's Group
- Liberty House Senior Citizen's group
- Community Workers in the NEIC
- Senior Citizens from St Agatha's Hall
- Residents from Portland Row
- Sheriff St. Women's group
- Women from the Saol Project
- The PRA Training group

Individual Interviews

In addition the group identified a range of people through their own roles and contacts that they knew to have specific health needs but were not linked to any groups. It was considered important that their experience be represented and the Community Researchers conducted individual interviews with them, following a similar format to that of the focus groups. These interviews included migrant families in private rented accommodation, people with no official status in Ireland, people seeking asylum in Ireland and homeless people. 13 people were interviewed using this format.

In May two of the community researchers organised and ran a successful Health Day for residents/workers of the NEIC. Those attending were asked to take part in a questionnaire interview where they were asked questions similar to those that had been asked in group settings, 27 individuals took part in this process.

It was not possible to conduct a focus group with men or people with disabilities but individual questionnaires were completed. However other recent research reports were drawn on to consider the health needs of these groups.

Open Forum Meeting

Each of the Community Researchers encouraged those who had participated in the research to come to a second open forum meeting in September 2010 in Ballybough Community Centre to hear the results of the research and to discuss ways of addressing the health issues, and who needs to take responsibility for them. This meeting included local residents, community/health workers and statutory agencies. The community researchers facilitated small group workshops on each of the themes identified in the research. The findings from this meeting are recorded in the main findings of the research.

Primary Health Care

During the course the HSE kept in communication with ICON and encouraged representation from the area. While the Forum was in its early stages of formation it was considered an opportunity to have some of community researchers attend the Primary Health Care meeting. Three people did attend a meeting, two from the course group and one additional from a sponsoring organisation. They found this meeting very informative and were of the view that it was important to build on this as soon and as solidly as possible. While this will require the formation of a body from which people can be drawn it is CAN's view that every opportunity should be availed of to build relationships and take a place on the team.

On finalisation of this document in February 2011, key HSE staff, with responsibility for the development of the Primary Health Care team, have resigned. There is no indication that they will be replaced and it is not now known how the work will proceed.

PART 4: Outcomes of Research

The community researchers collated the views and research data from the focus groups and individuals and an outline of the issues arising are presented in this chapter. In some instances additional data is provided from other related research that was conducted in the ICON area.

Summary of Main Issues

- **Health Services and Facilities**
- **Lack of Community/Social Networks**
- **Drug and Alcohol Misuse**
- **Housing and the Environment**
- **Anti Social Behaviour**
- **Unemployment & Poverty**

While these headings were chosen to best summarise the research findings there is considerable overlap between them, thus emphasising the very close relationship between all the social determinants of health.

Health Facilities and Services

Problems associated with the lack of Health Services and Facilities

Overall access to decent health care particularly:

- difficulty in getting a medical card, either through being on the income borderline as a result of language/literacy difficulties, immigrant status, cultural barriers and/or lack of information
- lack of public health nurses & social workers
- lack of easy information regarding appropriate services or their location
- judgemental attitudes by health personnel to some client groups, particularly expressed by drug users and foreign nationals
- Some frontline staff and management in health services are not trained in multi-culturalism/racial awareness, sometimes resulting in misunderstandings and a breakdown in communication which, in turn, can result in barriers to accessing health services
- Current migrant status is directly related to one's ability to access health services. This is a particular problem for undocumented migrants some of whom were interviewed and found to be living in situations that severely endangers their health.
- Shortage of GP's
- Long waiting lists for outpatient and other services

Stress & all its associated problems

Stress arises from many of the difficult living conditions that people experience. Many of these are outlined under the other main headings that follow.

Causes of problems

- Lack of accessible information about available services and allowances
- Government cuts in all services particularly experienced through reduction in the numbers of public health nurses, home helps, social workers, family support workers, longer waiting lists for medical appointments, cancellation of hospital appointments
- Doctors reluctant to make house calls patients
- Worry about recession and financial commitments
- Burglaries
- Embarrassed by moaning about illness

Solutions to these problems

- Provision of adequate locally based health services, that would include an adequate number of community based health staff
- Provision for the specific health needs of some groups, particularly older people, asylum seekers, immigrants, homeless people and drug users
- Easy information on health services
- Training for staff in asylum seeker hostels on the issues facing them
- Better management & monitoring of government funding

Who is responsible for meeting these needs?

Information was a recurring theme for many of the groups interviewed. This was addressed at the follow up meeting on September 29th 2010.

Who is responsible?

Everyone with a role to play in provision of services was named as responsible for improving the current situation;

- All government departments were named as being responsible for producing information leaflets and forms that are easy to read.
- Community organisations have a responsibility to make such forms/information easier to understand as part of their dealings with the public
- Potential Health Forum needs to explore and devise an information strategy on getting health information in and out to local people, out of which it could initiate action to form a local information network among existing projects, GP's, other medical services, pharmacies and Community Information Centres. A newsletter was also proposed here as a possible solution
- Literacy agencies and schools could provide assistance with internet access and training on how to use computers for individuals/groups who either do not have easy access to a computer or are not computer literate.

With regard to provision of adequate locally based health services, particularly the reinstatement of previous levels of funding for health care staff. The HSE was named as responsible through the establishment of the proposed Primary Health Care team and facility in the Mountainview Court Health Centre.

With regard to provision of day care centre's for older people DCC was named as having responsibility to provide venues and some staff.

With regard to more access to GP's for medical card holders and non holders the HSE was named with responsibility for increasing employment of GP's in the NEIC. In addition there needed to be greater awareness of Dub Doc as an alternative, GP s and the HSE were named as having responsibility for generating this awareness.

With regard to transport for older people to bring older people to hospitals, GP's and day care centres the HSE was named as having responsibility for the direct or other provision of such transport to people so that they could avail of their medical appointments.

With regard to provision for the specific health needs of some groups the HSE, DCC, Homeless Agencies, Interagency groups, Cairde and Age Action were all named as having responsibility for responding to the health needs of different groups.

With regard to training for staff in asylum seeker hostels on the issues facing them, the HSE, privately operated hostels, the RIA, Dept. of Justice and Law Reform, Cairde were all named as having responsibility for responding to this need.

With regard to better management and monitoring of government funding, HIQA and the HSE were named as having responsibility for this. It was also proposed that a Health Forum could monitor this at a local level.

The 2 priorities for a Health Forum, in conjunction with a Primary Health Care team, to work on in this area, both were considered equally as important were,

1. Provision of easily accessible information
2. Lobby for improved health service, at least to the standard that was in place before the health cuts of the last 2 years.

Lack of Community and Social Networks

Problems associated with the lack of community and social networks

This was mostly expressed as a problem by 3 groups; older people, migrant and asylum seeker families and homeless people. Others also referred to it in conversations when they talked about lack of neighbourliness and young people not having enough to do.

Older people

Problems for older people associated with lack of community and social networks

- Fears of anti social behaviour
- Loneliness
- Lack of easy transport supports
- Pressures of caring for grandchildren without supports

Causes of problems experienced by older people

- Increased anti social behaviour and as population ages fears increase
- Withdrawal or lack of transport services that allow them to go out with peace of mind
- Lack of flexible supports for grandparents caring for their grandchildren

Solutions to problems experienced by older people

- Transport service be made available so that they are not afraid to go out
- Activities/community events where they can meet others
- Befriending and counselling services[i19]
- Supports for full time grandparents that are not threatening. Most said that they were nervous of the HSE, in case children would be removed from their care

Migrant/asylum seeker families

Problems for migrant and asylum seeker families associated with lack of community and social networks

- Extreme loneliness and in some instances mental health difficulties due to long delays in family reunification[20] and few opportunities to get to know local people due to language and cultural barriers
- Experience of stigma and racism
- Physical and mental ill health

Causes of problems experienced by Migrant/asylum seeker families

- Isolation – people, particularly women are alone so much with children.
- Difficulty in finding community play/education.
- Difficulty in meeting with others.
- Language barrier presents obstacles to getting good information.
- Lack on information on child benefit and other possible income supports.

Solutions to problems experienced by migrant and asylum seeker families

- Support groups for parents
- Childcare support to allow parents to socialise

[19] O'Rourke. S op cit.

[20] Cairde Ethnic Minority Health Forum (EMHF)2006

- English classes with childcare provided

Homeless people

Problems for homeless people associated with lack of community and social networks

- Acute loneliness and loss of family
- All day to wander streets & meet trouble
- Mental health and addiction issues

Causes of problems experienced by homeless people

- High incidence of alcohol and drug addiction amongst homeless community.
- Lack of appropriate services to assist people to overcome alcohol and drug problems.
- Ease of availability of drugs and alcohol on the street and in hostels.

Solutions to problems experienced by homeless people

- better supports in hostels or outreach from hostels that would help people address their drug and alcohol problems
- more support to get own accommodation and live independently

Who is responsible for meeting these needs?

At the meeting on September 29th where this question was addressed, in small working groups, there were no homeless people or immigrant or asylum seeker families in the group who looked at this issue. Therefore further work needs to be done on this question and could be addressed by a health forum.

Some of the concerns of older people were addressed and the following was prioritised:

Transport is considered a priority for older people and Dublin Bus is responsible for this. The reinstatement of the 51 bus route to Clonliffe Rd. was considered a priority for those discussing this matter as was better provision of facilities for the visually impaired and other disabilities.

Dublin Bus to provide facilities for the visibly impaired and those with a disability.

Activities/Community Events for Older People was also given high priority and a number of agencies and organisations were attributed with responsibility for this.

The VEC, DCC and HSE were named as bodies with responsibility for funding community projects that are active in this area of work and making venues available for activities. They also have a key role to play in making referrals to existing services and the provision of transport.

Supports for Full Time grandparents

The grandparents themselves are considered responsible for coming together and providing mutual support. This could be done in conjunction with support from local community groups and DCC to provide a venue and insurance.

The discussion on the 29th did not allow for a full discussion regarding priorities for a health forum as the group was not representative of those who had taken part in the initial research. It was decided on the day that it would be better for the Forum to take this matter forward by another means.

Drug and Alcohol Misuse

Problems associated with drug and alcohol misuse

- increase in different substances through 'headshop' activity
- poor quality cocaine and heroin available that often leads to bad reactions and sometimes death
- increased dealing on the street
- Gardai ignoring dealing or not having resources to deal with it adequately
- intimidation for late payment for illicit drugs, leading to violence
- residents not taking responsibility for problem and ignoring the problem either through fear or acceptance
- Anti Social Behaviour in the community
- family life is neglected, when money is spent on alcohol or drugs rather than food or other necessities

Causes of problems experienced by people, who misuse alcohol and drugs, these were categorised into why people misuse and why it is so difficult for them to stop:

Why do people misuse drugs & alcohol?

- Peer pressure through example and culture
- Cultural acceptability of drug use makes it easier for young people to experiment
- People seeking to escape from the pressure of living in difficult environment and with other problems
- Drugs & alcohol are very easily accessible and becoming cheaper
- 'Headshops' have found new ways of selling products
- Head shops causing addiction to young people - under 12 and upwards
- Hereditary addiction
- Lack of education on outcomes of drug & alcohol misuse

Why is it so difficult for people to stop?

- Lack of services and information to help them deal with addictions
- Drug users selling to maintain own habit
- Not enough work done to reduce dependency on Methadone
- Not enough Garda resources to police sale
- Cheaper tablets available e.g. paritan
- Headshops closed but still dealing under the counter

Solutions to problems as experienced by those who misuse alcohol and drugs

To prevent people misusing in the first instance

- Education to focus on vocational as well as academic so that all young people can find an education appropriate to their strengths
- Increase opportunities and choices for people so that they do not resort to alcohol and/or drugs to cope with life's challenges
- Alcohol and drug education work in schools

To prevent sale of illicit drugs

- have more Gardai on the streets dedicated to policing sale of drugs
- allow money from CAB to go into the community for more effective policing
- implement legislation regarding mandatory sentences for supply of drugs
- harsher sentences following conviction

Care and treatment of alcohol and drug users

- More community based addiction services provided by community and HSE
- More respect for the client in delivery of services, this is dealt with in greater detail in Uisce's report, We're People Too[21]
- More dispensing of methadone in appropriate pharmacies
- Outreach supports to those who are stable and/or who are living in hostels
- Develop simpler forms for accessing assistance and one stop shops for information & support
- Drug free hostel accommodation so that those with addiction problems can maintain efforts to stay dry
- City Clinic to ban loitering & impose sanctions where necessary

In a general sense people talked about the need for more resources for Gardai and for treatment services and those gains from the Criminal Assets Bureau should be targeted for areas such as the NEIC that are most affected by drug misuse in particular.

Who is responsible for meeting these needs?
At the meeting on September 29th this question was addressed in a smaller working groups, Therefore further work needs to be done on this question and could be addressed by a health forum.

Care/Treatment of drug/alcohol users

With regard to providing more community based addiction services, it was agreed that the HSE and community were responsible

With regard to being more respectful to people who misused alcohol and drugs it was agreed that there is a general attitude in society that supports so everyone has a responsibility to change that and those who work in the health services have a particular responsibility as it is part of their professional duty to treat people with respect.

With regard to more dispensing of methadone in appropriate pharmacies it was agreed that GP's and HSE are responsible

[21] O'Reilly. 2005 op cit. *Major problems with services were attitudes of staff, lack of confidentiality and inadequate treatment of the person as a whole (sent different places to get different health issues catered for). Respect was shown by some services and participants acknowledged this (i.e. James's and Merchants Quay).*

With regard to outreach supports to those who are stable and/or who are living in hostels it was agreed that the HSE and wider Community are responsible

With regard to developing simpler forms for accessing assistance and one stop shops for information & support it was agreed that Community Groups, NALA and Health Forum are responsible

With regard to maintaining drug and alcohol free hostel accommodation it was agreed that DCC, HSE and voluntary providers all have responsibility to either maintain a drug and alcohol environment or provide both types of accommodation.

With regard to the City Clinic banning loitering and imposing sanctions where necessary it was agreed that while City Clinic has a responsibility to ban loitering it was agreed by those present that there should not be sanctions imposed on those who do.

There was not enough time to discuss prevention during the session.

Priorities for Health Forum to work on:

1. Explore ways and work with the Primary Health Care Team on developing more respect for the client in delivery of services
2. Develop simpler forms for accessing assistance and one stop shops for information & support for alcohol and drug misusers
3. Work with City Clinic to develop greater awareness about the importance of not having people loitering

Housing and the Environment

Housing emerged as a very strong influence on people's health or lack of it. People interviewed lived in 3 different types of accommodation, public, private and hostel. Findings are presented under these headings

Public housing and associated problems

Maintenance

- Problems to do with deterioration of internal conditions, stairwells, & balconies
- External problems to do with lighting & communal areas
- Accommodation is often unsuitable for gender mix of teenagers

Availability

- long waiting list for allocation of housing
- lack of clarity about allocation system
- people waiting on flats to be allocated
- government policy to slow up/halt house building

Causes of problems related to public housing.

- DCC do not respond quickly and sometimes not all to requests for maintenance
- DCC don't maintain external & communal areas
- There is a lack of clear information on systems & procedures for allocation of housing
- Homeless unit ignores the issues of homeless accommodation with no coordinated response from different agencies according to the needs of different types of homelessness
- Government Policy to slow up/stop building programmes

Solutions

- Ensure prompt maintenance by DCC so that further disrepair cannot occur
- Install gated doors and lighting on stairwells and maintain on a regular basis
- Improve physical conditions for older people and those with disabilities
- DCC and tenants have at least 2 annual meetings to build relationship
- DCC provide clear and transparent information on allocations
- DCC to implement policies re communal spaces
- Community protest against living conditions

Private Rental and associated problems

- flats are not maintained and are often unsafe on the first letting
- communal areas are dirty
- there are no safe play facilities
- landlord's demand for large deposits make it difficult to leave

Causes of problems related to private rented accommodation

- Dependency on private landlords due to long waiting lists for public housing and in this environment landlords will take advantage of tenants
- Private landlords are often biased against drug users & migrants
- Gated apartment complexes often isolate residents and work against good community relations

Hostel Accommodation and associated problems

- There is easy access to alcohol and drugs due to large number of homeless people with addiction problems making it very difficult for residents to abstain if they are trying to
- Having to leave early in the morning and have no day time activity
- Uncertainty from day to day with regard to whether one will get a bed

Solutions

- Set and enforce rules for hostel living so that people can address their difficulties
- Provide different types of hostels so that those who do not want exposure to alcohol or drugs are free from them
- Provide support services within hostels to assist resident to address their addiction issues
- Allow residents to stay later in the day and/or come in earlier at night

Direct Provision/Asylum Seeker Accommodation and associated problems

- Entire living arrangement works against maintaining good health – no choice regarding food, no facilities to cook for oneself and family, overcrowded sleeping arrangements and living in generally overcrowded conditions with people who are suffering with stress and ill health.

Solutions

- As a matter of urgency it was proposed that medical services be improved within the hostels
- Second to that the asylum process should be speeded up so that people do not have to live in such a setting for so long. Those interviewed had no confidence that conditions would change.

Who is responsible for meeting these needs?

There was a very strong theme regarding communication in the discussion group that worked further on this issue on September 29th. They talked again about a very poor quality of relationship between DCC and tenants and until this improved it was difficult to envisage change. People wanted to work on two issues, maintenance and transparency regarding allocations.

With regard to ensuring prompt maintenance by DCC, and better communication it was agreed that the DCC is responsible and that strong tenant/resident associations are needed in order to work on this.

With regard to improved conditions for older people and people with disabilities it was agreed that DCC and HSE are responsible.

Another related aspect to allocations that arose on the day has to do with allocations of vacant flats. Tenants are very dissatisfied that flats are boarded up for long periods when they know people who are waiting on accommodation.

DCC to implement policies re communal spaces

Priorities:
It was agreed that it could be difficult for a health forum to take on all of the work associated with addressing housing but that it should work where possible to point out the relationship between housing and health and where possible address the following 3 priorities.

1. Ensure prompt maintenance by DCC
2. Provision of clear information on allocations
3. Develop/work at a much better relationship between DCC & public

Anti Social Behaviour

Problems associated with anti social behaviour were named as

- Substance abuse on stairwells & in communal areas
- Intimidation of people for a variety or reasons, some direct and some indirect
- Family feuding
- Racism
- Youth being beaten up, some random instances and some targeted
- Knife attacks & snatching personal belongings
- Crime – robbery of homes and cars
- Lack of respect towards others
- Graffiti on stairwells and in other communal spaces
- Public fighting
- Cars speeding
- Dumping rubbish

Causes of anti social behaviour

- Lack of meaningful activity for young people, either education, work or leisure
- Lack of community action to provide for young people and/or to address issues
- Influence of drugs and alcohol
- Peer pressure to engage in such activities
- Lack of parental guidance and control of young people
- Lack of Ethics education in other places
- Anti social behaviour is accepted locally
- Disrespect for others, society, law and police
- Environmental factors, where the environment is already so run down that there is no incentive to maintain it or keep it rubbish or graffiti free.

The solutions posed can best be categorised in 2 responses, through a community and social service response and through statutory services.

A range of community and social service responses were proposed:

- More and improved family support services, including peer family support
- Increased parental involvement in children's education through outreach by the schools
- Parents and Garda taking action together
- More clubs and facilities for young people
- Build community awareness about the problem and develop a joint response to tackle problem
- Challenge the fear of vandalism & intimidation through community awareness & adult education
- Encourage more volunteerism in communities
- Foster expectations, hopes & dreams in young people so that they do not resort to anti social behavior.

A further range of statutory responses were proposed:

- Increase the number of community Gardai
- Introduce a confidential helpline

- Introduce a curfew for children under 10 years
- Reduce the number of alcohol sale outlets
- Dublin City Council implement its policies regarding Anti Social Behaviour
- Dublin City Council improve open space planning
- Increase & improve family support services
- Schools develop awareness from young age

Who is responsible for meeting these needs?
With regard to developing more and improved family support services, to include peer support groups, it was agreed that the HSE should provide more resources to community groups and provide services directly also.

With regard to increased parental involvement in children's education it was agreed that the Dept. of Education is responsible, to provide better outreach to parents from the schools.

With regard to parents and Garda taking action together it was agreed that
The Dept. of Justice and Law Reform should provide for the setting up of more Community Policing Forums and in doing so to have the same Gardai attend regularly and to have consistency of personnel for as long as possible.

With regard to more clubs and facilities for young people it was agreed that parents they need to get involved in this.

With regard to building community awareness about the problem and develop a joint response to tackling it, it was agreed that ICON should address this.

With regard to challenging the fear of vandalism and intimidation it was agreed that this will only happen through community awareness & adult education. In addition the Gardai need to tackle this, with the Probation service and the implementation of restorative justice.

With regard to encouraging more volunteerism in communities it was agreed that the Dept. of Social Welfare should support this through payments/allowances for work done.

With regard to fostering expectations, hopes and dreams it was agreed that everyone is responsible for this in that we need to encourage our young people to reach their full potential.

With regard to increasing the number of community Gardai it was agreed that this was the responsibility of the Dept. of Justice and Law Reform and Senior Gardai.

With regard to the introduction of a confidential helpline it was acknowledged that this is already in operation, but that people must not be aware of it or afraid to use it. It would appear that there needs to be more information available about it and people is encouraged to use it.

With regard to the introduction of a curfew for children under 10 years it was agreed that this was an individual family responsibility and everyone must take responsibility for their own children.

With regard to the reduction of the number of alcohol sale outlets it was agreed that it is necessary to take local action and protest as government has provided for all of these licenses.

With regard to Dublin City Council implementing its policies regarding Anti Social Behaviour it was agreed that it needed to be stricter and more consistent with tenants and that there is clear guidelines for all staff of the Council.

With regard to the improvement of open space planning by Dublin City Council it was agreed that it is necessary for the Council to commit to better consultation with communities and keep them involved in local planning.

With regard to schools developing awareness in children from a young age
about respect and care for others it was agreed that the HSE should develop programmes for schools and create awareness through local organisations.

Unemployment

Problems associated with Unemployment

- low levels of income and in many cases poverty
- accumulated debt, often from illegal money lenders
- lack of opportunity
- *social isolation*

Causes of Unemployment

- *Recession*
- *Lack of Education*
- Lack of Planning for employment from a variety of sources
- Lack of opportunity from Government and employers
- Poor funding from Government for training and employment initiatives
- Migrant status can have a significant impact on one's ability to secure meaningful employment relevant to one's background and skills. This results in reduced quality of life and isolation.
- Little or no provision of allotments to help people grow food

Solutions

- increase in state funding for work training schemes
- national strategy to increase employment
- state assistance for individuals to set up enterprises
- allow asylum seekers to work
- speed up amnesty processes for asylum seekers

Priorities for action

1. Increase state funding for work training schemes
   Who is responsible? - State bodies – FAS & IDA 2) private funding

2. National strategy to increase employment
   Who is responsible? - State bodies – FAS & IDA

3. Freedom for asylum seekers to work
   Who is responsible? – Department of Justice and Law Reform and the Government

Summary of Priority Areas for A Community Health Forum to address

Description of Actions		Who
Health Services and Facilities Provision of easily accessible information Lobby for improved health service, at least to the standard that was in place before the health cuts of the last 2 years. With regard to better management and monitoring of government funding it was also proposed that a Health Forum could monitor this at a local level.		HSE Primary Care Team Community Health Forum HIQA
Housing and the Environment It was agreed that it could be difficult for a health forum to take on all of the work associated with addressing housing but that it should work where possible to point out the relationship between housing and health and where possible address the following 3 priorities. Ensure prompt maintenance by DCC – follow protocol Provision of clear information on allocations Develop/work at a much better relationship between DCC & public		DCC – maintenance division Community Health Forum
Anti Social Behaviour All needs are priorities With regard to building community awareness about the problem and develop a joint response to tackling it, it was agreed that ICON should address this.		DCC Garda Policing Forum ICON Dept of Justice and aw Reform
Unemployment Increase state funding for work training schemes National strategy to increase employment Freedom for asylum seekers to work		FAS IDA Dept of Justice and law Reform
Lack of Community and Social Networks The reinstatement of the 51 bus route to Clonliffe Rd. More Activities/Community Events for Older People The VEC, DCC and		Dublin Bus VEC DCC HSE Community Health Forum

Drug and Alcohol Abuse Explore ways and work with the Primary Health Care Team on developing more respect for the client in delivery of services Develop simpler forms for accessing assistance and one stop shops for information & support for alcohol and drug misusers Work with City Clinic to develop greater awareness about the importance of not having people loitering		HSE Primary Care team Community Health Forum

Conclusions

It is clear from the variety of meetings, discussions and conversations on "what impacts on people's health" in the North East Inner City Area, that there is a much interest and concern for addressing the health inequalities identified in this report. This participatory process has enhanced the capacity of a group of local people to identify issues, analyse data, and create solutions in a collaborative way. To continue to be true to the development of participatory processes, the Community Health Forum has a resource of local people to draw on who wish to become more involved in tackling health inequalities that affect the daily lives of those living in the NEIC. The identified solutions in this report can be used to inform the basis of a Health Action Plan working collaboratively with ICON, the Community Health Forum and Primary Care Team.

APPENDIX 1.
QUESTIONNAIRES USED AT HEALTH EVENT

ICON Community Consultation
to assess the health needs of the community

For administration at the Health Forum event

Prompt questions: Please note that some of the questions are supported by **optional prompt questions/boxes for tick** to help the interviewer prompt those being interviewed if required. These prompt questions need only be used in the event that those being interviewed are unable to come up with answers to the questions.

To be completed by interviewer:

Male ☐ **Female** ☐ **Age** ☐

Perceptions of health:

1a. What does health and being healthy mean to you?

1b. What helps to keep you healthy?

1c. What affects your health in a negative way?

Lack of health services, any particular service?

- o
- o
- o

1d. What affects the health of your community/area you live in?

PROMPTS BASED ON OTHER RESPONSES

- No leisure facilities
_ Bad landlord
_ Anti social behaviour
_ Alcohol abuse
_ Drug Abuse
_ Lack of community spirit
_ Isolation
_ No job
_ Low pay
_ Expensive rent
_ Insecure accommodation/homeless

1. e

Of all the things that you have mentioned which 1 has the greatest impact?

1.

2. What are the problems associated with it?

2.1

2.2

2.3

2.4

2. A. What do you think is the cause of these problems?

2. A.1

2. A.2

2. a.3

2. a.4

2. b

What solution(s) would you suggest to these problems?

2. b.1

2. b.2

2. b.3

2. b.4

QUESTIONNAIRE USED WITH INDIVIDUAL INTERVIEWS

ICON PRA RESEARCH FORMAT FOR ONE TO ONE

What does Health mean to you? – To stay healthy what do you think you need?

What impacts on your health?

What impacts on the health of your community or neighbourhood?

Of the impacts named ask what would be the 3 main impacts?

Choose 1 main impact and ask what are the problems associated with this?

What are the likely causes? – Do you have any suggestions for solutions to these causes?

References

CAN wishes to acknowledge all of the other health related research and its authors that has been drawn on to make this report as comprehensive as possible.

O' Reilly. F, Reaper . Emily and Redmond, Tom. 2005. "We're people too" Views of drug users on health services. UISCE

Rourke, S. 2008. Changing Times – Changing Needs - Needs Analysis Project of Older People in the North East Inner City of Dublin

Men Alone – study on the experiences of socially excluded men. Men Alone in No-Man's Land (MAIN), a study into urban male isolation in Dublin's Inner City

ICON -2008: Experience of grandparents caring for grandchildren

Louise Monaghan and Siobhan McGrory. 2008. Community Consultation Process to assess the needs of the community in relation to Mountain View Court Health Care Facility, Summerhill and the services to be provided there.

CTA - Youth Participation Project : 2010