

Dublin City University  
Ollscoil Chathair Bhaile Átha Cliath



*Cairde*  
Challenging ethnic minority health inequalities

New Communities and  
Mental Health in Ireland:  
A Needs Analysis



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To the community leaders and focus group participants

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## PREFACE

This project was established within the Science Shop framework as developed and promoted by the International Network of Science Shops. Science shops are part of an established European network that provides support, training and information. They are a practical way of improving public confidence in science because they can help to solve problems for the community. The shops provide a two-way benefit in that they allow researchers to gain a clearer understanding of the needs of society while citizens see measurable effects from the research.

Science shops provide a tried and tested way for universities to develop links with and contribute to civic society by making the research facilities of university available to community organisations. With the increasing globalisation of society, issues are no longer just local so research outcomes can be publicised to benefit other researchers and other communities. They seek to fulfil EU objectives of bringing together policy-makers, researchers and citizens.

The first requirement of a science shop project is that the research should focus on an issue of concern to society leading to clear outcomes that would be of benefit to society. The NewCom project dealt with two issues of major concern to Irish society that are generally under-researched and under-funded. These issues are mental health and the welfare of new communities. It is hoped that this report will help to inform and guide policymakers and others working in these areas.

The project was mentored by the partner organisation, the Science Shop, Queen's University, Belfast. Dr. Eileen Martin and Dr. Emma McKenna put their experience of running their well established science shop and of mentoring others through their work with TRAMS (Training and Mentoring of Science Shops) initiative at the disposal of the NewCom project in the initial stages and at regular intervals throughout the duration of the research.

The research was client-centred in that it was set up in association with the other partner organisation, Cairde. Representatives of Cairde were involved in developing the proposal and research was carried out in conjunction with Cairde staff who facilitated workshops and provided contacts and introductions. Regular meetings were held between Cairde and DCU on the progress of the research with the aim of making the research process transparent.

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## 1 EXECUTIVE SUMMARY

This project brings together a university (DCU) and an NGO (Cairde) to address the mental health needs of immigrants in Ireland. Focus groups were convened from groups and organisations affiliated with Cairde under the Ethnic Minority Health Forum. Ten community leaders participated in training relating to facilitating and moderating focus groups and community research and development. Focus group questions were generated by community leaders during the training and asked about the meaning of good and bad mental health; the important things affecting mental health; how discrimination affects mental health; contact with health professionals; and from whom people seek help when they are distressed; what could be done to improve mental health.

Ten focus group discussions took place between November 2007 and February 2008 involving 71 participants (44 females and 31 males) from 24 countries (Sudan, the Congo, Angola, Ghana, Somalia, Eritrea, Mauritius, Morocco, Egypt, Algeria, Iraq, Syria, Saudi Arabia, Iran, Romania, Moldova, Ukraine, Latvia, Lithuania, Russia, Estonia, Belarus, Indonesia, and Turkey). Transcripts were made of all focus groups and these were imported into the software package QSR N-Vivo (version 9) and data were analysed thematically.

### Key findings

The components of **good mental health** were found to be: having good relationships with families, friends, community members, being occupied, by work or other activities, feeling happy and optimistic and perceiving oneself as respected, having security, freedom from war and torture and also security of resources and status.

The conceptions of **mental ill-health** that were described were: external factors such as experience of war, torture and other trauma, feeling out of control or uncertain about the future; 'direct provision', threat of deportation, uncertain immigration status, discrimination, being prevented from working, learning or enjoying citizen rights led to and confirmed feelings of being out of control and fuelled stress and worry. Negative emotions such as anxiety, depression, unhappiness, apathy, anger and absence of hope were described. Mental ill-health was associated with aspects of cognition such as the content, form and flow of thoughts; excessive worry, uncertainty and negativity; being 'unable to let go' of negative emotions or intrusive recollections of trauma (as in nightmares); excessively 'personalising' events, unpredictable or unusual behaviour – excessive aggression, difficulty sleeping and problems with expressing oneself or communicating needs.

#### The most important things affecting mental health:

- Immigration policies and status and their effects of their daily lives- in terms of ability to work, study, and also to feel secure,
- Fitting in and being part of society

#### Ways of dealing with anxiety, stress or unhappiness:

- Support seeking- ringing home, talking to a spouse, family member or friend to obtain comfort, care and instrumental aid; meeting as a group
- Emotional regulation and expression, such as screaming or crying in response to distress or frustration.
- Distraction or sublimation – activities which serve to distract, relax or soothe people, including writing, bathing or showering, walking, playing sport or going to the gym, shopping, listening to or composing music, eating and cleaning.

## Discrimination and mental health:

- It was widely agreed that language, accent and immigration status could make a profound difference in how people are treated. Group members varied in their perceptions of the extent of the problem- Europeans on working visas recounted different experiences to asylum seekers and non-European people.
- Some people perceived that skin colour marked people out as different. Stereotypes and perceptions- many people believed that they were perceived as inferior by Irish people or were viewed in stereotypical fashion by some people. The news media as being largely responsible for the promulgation of stereotypical images.
- **Discriminatory experiences** were recounted relating to many areas of everyday life- in employment, on the streets, on public transport, by public officials, by private rented accommodation providers, within direct provision (which was viewed as discriminatory in total).

## Experiences with health professionals in Ireland

- Most people had sought assistance for a range of health related issues and most found the services uncaring, of poor quality, involving considerable waiting and delays. No respondents acknowledged seeing specialist mental health services.
- Most respondents recounted numerous negative encounters and experiences with the health and welfare system, resulting in a lack of trust of health services or health professionals in Ireland.

## What could be changed to improve mental health in your community?

- Structural changes: securing access to housing, education, employment and childcare, which were all affected by immigration policies.

- Increased information about services- mental health services and all health services; language support services.
- Enhanced integration and belongingness: a desire for enhanced integration and a feeling of belongingness was, linked with a sense of contributing to society, being respected and being treated well. Participants wished for the opportunity to be independent and to practice their talents and contribute to society:

## Key points

The findings of this study are all inter-linked and in an overall sense highlight the structural difficulties and barriers which affect daily life quite significantly. Particular groups have particular difficulties and needs; what connects them is stress, socio-economic disadvantage and a feeling of a lack of belonging. This is most acutely seen for asylum-seekers (in direct provision), based on explicit government policy. However those who can work and study also convey a sense of isolation and separateness.

The participants in this study specifically identified what changes could improve mental health for them and their communities:

- structural changes such as access to education, housing and employment which were all fundamentally linked to immigration and legal status.
- increased information about mental health services, health services in general and other social services.
- Increased opportunities for integration, independence and a chance to contribute to society and be understood and respected.

Based on these and all of the findings of this study, **key recommendations** are made which will have the potential to:

- Enhance the **social capital** of people within the new communities in Ireland
- Protect fundamental **human rights** of people within the new communities in Ireland
- Contribute to a more responsive and socially **cohesive society** with long-term benefits for all, particularly urgent in constrained economic times.

### Health professionals

- There is a need for health professionals who come into contact with people from ethnic minority groups to actively develop trust and demonstrate their trustworthiness- based on a model encompassing Values Based Practice and cultural safety outlined above. Values Based Practice involves professionals understanding how diverse values interact, relate and impact within the experiences, actions and care relationships in mental health care. This may require additional training for such professionals, including general practitioners, nurses, midwives. In particular, General Practitioners need to be able to respond to the levels of emotional distress described by participants in this study. Their preventative input will have long-term benefits for their patients and for communities more widely. This needs to build on existing initiatives and the effectiveness of training needs to be robustly evaluated, from health service users' perspectives.
- Language support may also be required by health professionals in order to respond appropriately and in a culturally safe way.
- This is the responsibility of the professional bodies (Irish Medical Council, An Bord Altranais [Irish Nursing Board], Irish College of General Practitioners etc). It will be measurable by service user led research.

### Health service planners and providers

- There is a need for a range of services to respond to the needs identified in this study and a need to implement the approaches to culturally safe community-based care outlined in a Vision for Change and other mental health policy documents. The HSE intercultural strategy is promising in its intent and needs to be implemented and evaluated. This is particularly critical for vulnerable groups. In particular there is a need for low level/non-specialist psychological support and care, primarily preventative services, especially in the form of outreach services.
- Counselling and psychological services are also required in some cases and there is a need to provide accessible and affordable services. Since it is evident that those who participated in this study rarely adopt solution-focused approaches to their stresses, this is a particular need to provide services within this approach.
- Those who have experienced trauma require accessible and affordable specialist and specific trauma counselling.
- Those with severe difficulties or mental illnesses require access to timely and appropriate specialist mental health services, again outreach services are also required. Crisis intervention services are required to deal with emergency situations that arise, and where Garda involvement is particularly perceived as threatening. Following the independent assessment of need, the power to access appropriate and timely services must be with that assessor. Case management of people with complex needs can respond more effectively than the currently fragmented sets of services; this requires the empowerment of the case manager to access the required services.

## Immigration policy makers

- Because of the profound affects of direct provision on the mental health of those within that system, there is a need to examine the fundamental principles and practices of direct provision- and to urgently consider more humane and just alternatives to it. The findings of this study support the calls of other groups (e.g. the Irish Refugee Council) for direct provision to be discontinued. Until this happens, the needs of asylum-seekers who are in direct provision are manifold and most critically require the following reforms:
  - Additional financial support specifically to facilitate travel and social interaction. The current cash allowance of €19 per week is totally inadequate to allow even the most basic participation in society.
  - The accommodation standards in both reception centres and hostels for those in direct provision must be independently and regularly inspected and upheld in a binding way. The management and interpersonal relations with those in such accommodation also needs monitoring and improvement.
  - Opportunities to work and study need to be made available as these have been found to be the major sources of stress and distress in this study.

## Social policy-makers

- For those not in direct provision affordable and secure rented accommodation is required.
- Community groups fulfil the need for social interaction and support and need to be facilitated, with resources and facilities, to promote the strengthening of social capital of members of new communities. In particular there is a need to support community leadership and health promotion training within groups. Those who commit considerable time to such community work need to be recognised and financially and psychologically supported, as there is a natural movement of people to paid work when this is allowable for them, in order to make ends meet. This training and support should be bottom-up, with the needs identified in this and other studies of Cairde and others met.
- There are issues around childcare and school support that are about integration and affordability. Lack of access to affordable childcare significantly affects participation in education and work- where this is allowed, dependent on legal status. For those without the permission to work and study, childcare and school accessibility is also critical for social integration and well-being.

These recommendations address the key findings of this study and aim to address the stark needs identified for a sustainable, integrated and fair society in Ireland.



## 2 INTRODUCTION

This project brings together a university (DCU) and an NGO (Cairde) to address an important issue in civil society. It brings together academic specialists in mental health and migration with a community organisation concerned with the connection between those two issues. The project was aimed at producing a needs analysis of immigrants in a particular aspect of social services and, in so doing, to develop a framework for social needs analysis that can be applied in other circumstances.

The specific objectives of the project were as follows:

- To provide access to independent, affordable scientific advice and research results for a local community organisation.
- To deliver a systematic study of migrant health issues based on knowledge of local conditions and reflecting the needs of migrant subpopulations.
- To provide migrant communities in DCU's hinterland with the knowledge they require about health inequality risks and to increase their capacity to define their needs and to design strategies to bring about change to meet those needs.
- To provide an intercultural context to underpin the formulation and delivery of mental health services for migrant communities.
- To provide students and researchers engaged in the project with a real world research experience which encompasses both regionally initiated research and knowledge sharing.

Although migration has been a ubiquitous feature of the Irish social and cultural experience for over 150 years, it is only in recent years that inward migration has occurred in any significant manner. Apart from a brief period of returning migration in the late 1960s and early 1970s and an ongoing and steady inflow of Irish elders mainly from Britain

during the 1980s and 1990s, it is only in the past decade that Ireland has become a destination of choice for migrants from other parts of the world. Therefore, recent years have seen the transformation of Irish society from a homogeneous monoculture, with a population which was 95 percent white and Roman Catholic to a significantly more heterogeneous, multicultural society in which non-native born people made up nearly 12 percent of the population at the last Census. Issues of concern to immigrants are a matter of urgency in Ireland to which sustained immigration is new and whose responding social provision needs updating as its economy develops rapidly. Among the many social concerns that need to be addressed for immigrants is that of health provision. This issue has been identified for research in discussion with a non-governmental ethnic minorities' community development and health organisation, Cairde.

Cairde is a non-government organisation working to reduce health inequalities amongst ethnic minorities. Cairde's aim is to tackle health inequality experienced by minority ethnic communities and individuals, by working through community development to build the capacity of minority ethnic communities and individuals to realise their rights by engaging directly with and influencing the policy system. Cairde aims to develop an understanding at community level that health inequality is a direct consequence of wider societal inequalities.

Cairde's objectives are:

- To build the capacity of minority ethnic community organisations to identify their own needs and develop an awareness of the policy context within which services are planned and delivered;
- To build the capacity of minority ethnic groups to act collectively in identifying the health and wellbeing concerns of their communities and engaging with statutory service providers and planners so that genuine processes of consultation and participation are initiated between ethnic minorities and the policy system;

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- To target at risk or disadvantaged minority ethnic groups and provide tailored supports to build their capacity i.e women, people living with HIV, Roma etc.;
- To advocate on behalf of individuals with statutory and other service providers;
- To provide information and other resources to community groups and individuals and/or groups working with ethnic minorities.

Cairde facilitates an Ethnic Minority Health Forum. The Forum was established in 2002 with an aim to make a positive impact on the health and wellbeing of ethnic minority communities. It is comprised of individuals and groups from many countries (Romania, Algeria, Congo, Nigeria, Afghanistan, Ghana, Morocco, Russia and other) interested in health. Ethnic Minority Health Forum members were coming together for a number of years to discuss issues affecting health of their communities, share information and look at the strategies and possible actions to address these issues and barriers. At present, there are 35 groups/ organisations represented in Forum. It is also open to any ethnic minority individual who is interested in participation in the Forum's activities, interested in health or need information about health and health services.

## 3 Background

### 3.1 The European Context

Though migration into Europe is not a recent phenomenon, considerable societal concerns have been raised about the increase in the rates of migration in recent years. It is estimated that 56 million of the world's 175 million migrants live in Europe (1) and this has raised associated concerns with regard to the impact of these numbers on patterns of demographic change, labour market structure, and the provision of health and welfare services (2).

The integration of migrant populations into European societies has become an important priority in social policy on both the local and pan-European levels. It is recognised that in the long term migrants will form an important component of the social, economic and demographic structure of these societies in the coming years. Without proper structures and policies in place to facilitate the social inclusion and prevent the marginalisation of migrant groups, social problems will be an inevitable outcome (3).

More recently still, it has been recognised that the health of migrants is an issue of some importance, in part because of fears that migrants bring into receiving societies their own health issues, both mental and physical, which may have important implications for the provision and development of health services, but also because, as Ingleby et al (3) note,

*...migrants' integration in the area of health could be measured using the same types of concepts used to measure structural and cultural integration (classically defined as equality of access, allocation of resources and participation). In this way, migrants' state of health and migrant health care policies might be used as an indicator of integration and integration policies (3).*

In parallel with these developments is the simultaneous recognition that mental ill health presents a significant challenge to the attainment of policy objectives in social, economic, educational and criminal justice areas while remaining, until recently, a relatively neglected area of community wide research or intervention. Since 1996 it has been acknowledged part of EU policy that mental health is an indivisible part of public health in general and that there is a need to foster initiatives promoting mental health and research into mental illness within and between member states (4).

Under the auspices of Article 152 of the Amsterdam Treaty, the Key Concepts Project identified priority areas for research and intervention. One of the significant outcomes of this initiative was the publication of the 2004 report *The State of Mental Health in the European Union* (5). Noting that studies of the mental health of migrants in Europe were relatively rare, its authors nonetheless draw attention to the growing incidence of a number of common symptoms in migrants referred to as Chronic and Multiple Stress Syndrome, which appears to be associated with a deterioration in the mental health of newcomers.

They note

*The growing incidence of this syndrome in many psychological and psychiatric services across Europe have alerted a group of social scientists and health care professionals from different countries to address the European Parliament to highlight the situation. (5), p.53*

The same authors also conclude

*Immigration has also been considered as carrying a special risk relating to mental health. ....There is little data available with regard to the level of psychological and physical problems among those who are culturally different, owing to inadequate systems of registration. (5), p.65*

Other authors note that the special risk connected with migrant mental health is a highly complex and poorly understood phenomenon.

## 3.2 Health of Immigrants

A recent major Public Policy Office report from the United States reflects the general international trend with regard to migrants and health showing the critical lack of quality culturally and linguistically appropriate mental health services: 'Immigrants have less access to, and lower utilisation of, mental health services' (6). The conclusion drawn is the urgent need for the development of culturally and linguistically competent programs and services for immigrants and cultural competence training for service providers.

The 2007 EU conference on Health and Migration held in Lisbon was premised on the notion that 'addressing the health of migrants was also seen from the very beginning not only as a humanitarian cause, but moreover as a need for attainment of the best level of health and well-being for everybody in the EU' (7). Migrants face increased health crises, similar to those of EU disadvantaged groups in general. These risks are seen to be the product largely of social and environmental factors including poor housing and working conditions, personal security, family situation, poor integration, linguistic barriers and discrimination. This conference concluded also that: 'due to the particular circumstances of migration and settlement, migrants may be particularly vulnerable to mental health problems'. The promotion of high quality and culturally sensitive mental health care is seen as a priority. There is also, a very relevant to this study call, to encourage migrants to actively participate in the definition of their own needs.

The following areas have been identified as priorities in migrant health care took up the development since the 2005 European Green Paper on Improving the mental health of the population' which had shown migrants were particularly vulnerable

to mental health issues linked to low social and economic status. They recommended, given that the issue was still very much to the fore, that:

- Migrants should have access to mental health services;
- The services offered should be integrated and appropriate to the needs of migrants;
- Mental health services should be sensitive of and responsive to the cultures of the migrants;
- Mental health services should encourage the active participation of migrants in defining needs.

The international experience and policy development suggest that we need to address as urgent priorities:

- Migrants' state of health, how it can be monitored, and what factors influence it;
- Migrants' rights and access to health care;
- Care delivery – the nature of 'good practice' in this area, measures taken to improve the quality of care for migrants.

To date there are no significant, established programmes in Ireland within either the governmental or non-governmental sectors to monitor or facilitate progress in these areas. Where concerns have been identified they have been primarily focussed upon groups such as refugees and asylum seekers who constitute only a declining minority of the immigrant population in Ireland in recent years.

Furthermore, despite the persisting myth of the 'healthy migrant', there is significant evidence that certain groups of migrants because of their position in the labour market and barriers to accessing health services are likely to suffer disproportionately worse health in the long term than their native born counterparts.

### 3.3 Migration and Mental Health

Migrants to any society do not constitute a homogenous group with regard to risk factors for mental illness. Issues such as reason for migration, distance from home, the ability to develop social structures and communities which might mediate the stressors involved in migration and adaptation to the receiving society, cultural differences in health seeking behaviour and the attitudes of the receiving society towards particular migrant groups have all been shown to have a bearing on the psychological well-being of migrants.

Any programme of research needs to be sensitive to this lack of homogeneity amongst migrant groups and seek to identify the factors that may under any given set of conditions increase the risk of psychological distress requiring intervention. Some recent studies support the long standing, but not uncontested, findings that migration itself is detrimental to the psychological well-being of migrant groups. In addition, research from Britain suggests that the situation for migrant and ethnic minority groups is further compounded by a lack of cultural sensitivity and awareness amongst mental health providers which can lead to misdiagnosis on the one hand and poor uptake and use of services on the other.

Both contemporary and historical research on migration and mental health, therefore, suggest that the mental health needs and circumstances of migrants need to be considered seriously in the development of health services in any society in which migrants constitute significant numbers. In Europe, models of good practice for both migrant and settled minority groups have gradually emerged over the past 30 years. But the situation in Ireland, for historical reasons, lags far behind. The issues of long term settlement and the establishment of large and viable non-native communities seem to have been almost completely neglected in the discussions surrounding the provision of services in or to the wider community. In fact psychological

services for migrants and ethnic minorities, such as the Refugee Psychological Service and the Centre for the care of survivors of torture, seem to operate on an almost ad hoc basis.

Most importantly, no data is available for the monitoring use of psychiatric services in Ireland by migrants/ethnic minorities and there appear to be at present no plans to incorporate such monitoring into the system. Under the present ethos, with its focus on refugees and asylum seekers, it is likely that the mental health needs and experiences of migrant groups of significant and growing size, such as groups from eastern Europe and those born in Britain will go unrecorded and, as a consequence, be neglected for the foreseeable future.

### 3.4 Migration and Multiculturalism in Ireland

Lacking a history of in-migration, Ireland is unlike other Western European societies, most which have experienced in-migration of non-nationals since the 1950s. The rapidity of migration in-flows and the characteristics of its recent migrants relative to the host population are also markedly different from the pattern experienced elsewhere in Europe. From the point of view of health provision, the most numerically significant flows of immigration into other European states took place during a period of post-war reconstruction and economic boom where populations were expected to rise and services in health and social welfare were being developed accordingly.

In Ireland, where the population had fallen almost annually throughout most of the 20th Century, such services were geared to serving a population amongst whom high out-migration was the norm. They are currently struggling to cope, not only with in-flows of migrants but also with the fact that long term out-migration amongst the native born has largely ceased to be a significant demographic factor.

Furthermore, it has recently been acknowledged that immigration to Ireland is unlikely to be a short-term phenomenon and that migrants will form a significant proportion (i.e. possibly up to 20 percent) of the population by the year 2020. In a society unused to the presence of large numbers of resident non-natives, it is anticipated that this will result in significant social transformation and possible upheaval in the transition from a mono-cultural to a multicultural community.

The Irish experience of immigration has been dramatic, as the country shifted from a traditionally emigrant culture and became a substantial zone of immigration from the late 1990s on. People from 188 different countries were living in the State at the time of the last census in 2006. Of the 420,000 non-Irish people residing here on census day in April 2006, the largest group was UK nationals, who numbered 112,000. Poles were the second-largest group, followed by Lithuanians, Nigerians and Latvians (8).

## 3.5 Migration and Mental Health in Ireland

A significant shift from institutional based care to a 'care in the community' model together with an increased involvement of NGO and voluntary organisations in the provision of social care services to the mentally ill and other vulnerable groups, seems to have been instituted without meaningful reference to the considerable numbers of new migrants who are likely to settle in Ireland in the coming years.

There is a strong case made for the social causation of mental illness. According to this theory people belonging to migrant groups are among the highest at risk of developing major mental health problems (9). Poverty, racism, isolation and alienation are inextricably linked to poor levels of mental health all of which are experienced by a significant number from ethnic minorities, particularly among migrant populations. Suicide risk has been shown to be

significantly higher among ethnic minority groups when compared to the general population of host nations (10). Low socio-economic status experienced by migrant populations is strongly related to this high suicide rate. In Ireland migrant workers are experiencing 'a system of near-serfdom that perpetuates social, economic and cultural exclusion on a large scale' (11). This inevitably impacts on the mental wellbeing of the current migrant community and is likely to have a negative effect on the mental health of future generations of migrants that settle in Ireland.

Recent Irish mental health policy and strategy documents fall short in appreciating and addressing the specific mental health needs of ethnic minorities and migrant groups in Ireland. However, there is reference to community, diversity and culture that broadly relate to facilitating the needs of such groups. Vision for Change (12) as a government health policy document provides direction to develop mental health services in Ireland for at least the next decade. It is recognised that the majority of mental health difficulties experienced will be resolved in the community through informal care, with support from friends and family, or in primary care where treatment is provided by GPs. Vision for Change encourages mental health services to take cognizance of the mental health needs of the local population in which they operate and recommends that the community becomes a partner in shaping such services. Primary care services and mental health promotion strategies should be developed with emphasis on prevention and early intervention. Vision for Change also identifies community as a resource; that is able to support people through times of emotional distress, reducing the risk of developing long term mental health problems. Social inclusion, strengthening individuals and communities are crucial elements attached to these strategies.

The Mental Health Commission (13) in setting out a Quality Framework for Mental Health Services in Ireland, state that services need to be 'equitable and accessible', and that information should be

provided 'in ways that are accessible to people from minority groups'. As part of mental health promotion a 'Designated health promotion officer with formal links to the mental health service works with local voluntary and community groups' should be employed. This, one would assume, includes linking up with organisations that represent ethnic minorities. The Commission also states that: 'Service providers respond sensitively to the beliefs, value systems and experiences of the service user during service delivery, and provide appropriate privacy for service users to practice their cultural, religious and spiritual beliefs'. The importance of addressing cultural differences is acknowledged in these documents but the extent and nature of mental ill health among migrant groups and subsequent recommendations to meet their needs is noticeably absent. This is important as migrants can be mistrustful of state services and as a consequence be cautious in seeking medical help (14). Furthermore, there may be tentative links made between community and mental health, but there is no specific recommendation made to understand the nature of communities (in particular those that are becoming increasingly transient) and the impact on the mental wellbeing of migrant groups.

Where explicit policy and practice related to mental health of migrant groups have been implemented, the focus has tended to be placed upon groups deemed to be in extreme need, such as refugees and asylum seekers and there is a danger that the mental health needs of larger, but ideologically less visible, groups will be overlooked. Migrant populations tend not to be homogenous and the mental health needs of different groups may vary widely (15). There is an abundance of evidence to suggest that migration per se may present additional risk factors for an individual's mental health status, irrespective of the factors provoking migration in the first place (15).

Bhugra (16) highlights the need to look at the different stages of migration in order to understand how individuals and groups will respond to the

different stressors associated with migration. Four stages of migration – pre-migration, initial stage, middle stage and final stage, all have different stresses and therefore very likely to respond differently to other stressors. Preparation to migrate, he argues, is a significant factor in the outcome of migration. Those who are migrating for higher education or economic betterment will have different types of stresses compared with political exiles. It is likely that professional's and those with a high level of education may experience further stress when they are unable to acquire employment commensurate with their status and aspirations.

Post Traumatic Stress Disorder (PTSD) is the most common mental health problem among refugees and asylum seekers, followed by mood disorders: the range of psychological problems experienced by torture survivors can include: nightmares, hallucinations, panic attacks, sexual problems, phobias, difficulty in trusting others and forming relationships and depressive illness or anxiety (15). PTSD is more likely to affect those fleeing from political or religious persecution.

Psychiatrists from the Psycho-pathological and Psychosocial Assistance Service (SAPPIR) team in Barcelona have described the common symptoms that migrants present with as The Chronic and Multiple Stress Syndrome (Ulysses syndrome). Immigrants affected by this syndrome present depressive symptoms with atypical characteristics, where depressive symptoms are mixed with anxious, somatoform and dissociative symptoms (15). This condition develops over time as the immigrant faces the obstacles that take place during the migration process: dangerous journey, distance from their own environment and family, difficulties to find a job, food, housing and in obtaining documents, and the racism suffered in the host country. The team suggest that there is a growing incidence of this syndrome in many services dealing with migrants across Europe and argue that it has worsened during the last five years.

# NEW COMMUNITIES AND MENTAL HEALTH IN IRELAND

Because of the long history of out-migration from Ireland, there are no systematic intra-national studies of migrant mental health and only a handful of small community based surveys of mental health needs of immigrants. This raises possibility that the development of policy and practice in the short term may be based on inadequate knowledge of local conditions and geared to the needs of potentially unrepresentative migrant sub-populations.

There has been a recent response to the emerging issues and needs, in the form of the National Intercultural Health Strategy 2007 – 2012 which was developed by the HSE on foot of the National Action Plan against Racism. The strategy was launched on 21st February 2008, following a wide-ranging consultation process involving members of ethnic minority and Traveller groups, HSE staff, service users, and community and voluntary organisations working with minority ethnic communities. The primary objective of the strategy is to provide a framework through which service users and service providers are “...supported to participate actively and meaningfully in designing, delivering, and evaluating provision of health care to minority ethnic service users in Ireland.” The strategy is also aiming to reduce the social exclusion experienced by ethnic minorities, enhancing their access to health services (including mental health services), and promoting positive health outcomes and social gain. Deemed central to the development of the Intercultural Health Strategy, the consultation process identified four priority areas:

- Information, Language and Communication.
- Service Delivery and Access to Services.
- Changing the Organisation (HSE).
- Working in Partnership with Minority Communities.

The document proposes the establishment of a National Advisory Body to oversee the implementation of recommendations of the strategy. This representative, multi-sectoral group will link closely with appropriate HSE structures and mechanisms, which may include the National Working Group on Travellers and Ethnic Minorities and the anticipated Expert Advisory Group on Social Inclusion. Its task would be to develop an action plan for implementing the recommendations of the strategy.



## 4 METHOD

Focus groups are a qualitative research method that is an alternative to individual interviews. The focus group method enables participants to comment, explain, disagree, and share attitudes and experiences (17). Focus groups are concerned with the interactions between members as well as what they say. Focus groups are particularly useful for exploration of complex social phenomena (18).

### 4.1 Focus Group Sample

Focus groups were convened from groups and organisations affiliated with Cairde under the Ethnic Minority Health Forum. At an Ethnic Minority Health Forum meeting in May 2007, the broad mental health needs of communities involved in the Forum were discussed and community leaders endorsed in principle the idea of being involved in leading focus groups to systematically examine perceptions of need within their communities. Ten community leaders participated in training relating to facilitating and moderating focus groups and community research and development. Focus group questions were generated by community leaders during the training. Tonya Sanders negotiated with each community leader to convene focus groups at a location of convenience to participants. Community leaders provided verbal explanations regarding the purpose of the focus groups, and obtained verbal consent for participants to contribute. Copies of the questions to be discussed in the focus groups (see table 2) were provided to potential participants who were given considerable time to consider whether or not they wished to be involved (at least a month in most instances) copies of the questions (in their first language when needed).

Details of country of origin, languages spoke, gender composition, and religion of participants is described in table 1.

*Algerian Community of Ireland* – This group consisted of Algerian people drawn from an independent voluntary membership organisation called ‘Algerian

Community of Ireland’ committed to supporting Algerians living in Ireland through practical support, advice and community development activities. Participants of this focus group mostly knew each other and all had ‘Stamp 4’<sup>1</sup> status.

*Congo Lisanga* – Members of this group were mainly asylum seekers<sup>2</sup> living in a direct provision accommodation centre. Two members had IBC<sup>3</sup> residency. English proficiency was mixed within the group.

*Eritrean Community* – All participants in this group were men, asylum seekers and residents of a direct provision hostel. All were of the Muslim faith and Arabic speakers. Two members came from Eritrea, two from Iraq and another from Sudan.

*Romanian Community (Men and Women)* – All participants of these groups had EU citizenship but most had been granted ‘Stamp 4’ status prior to Romania joining the EU (enabling them to work). The men’s group consisted of people who were actively organised as community leaders and advocates for the Romanian community.

*Russian speaking men and women* – This group came from a range of former Soviet Union states including Moldova, Ukraine, Latvia, Lithuania, Estonia, Belarus and Russia. Two individuals had refugee status (‘Stamp 4’) and the remaining had either IBC or New EU residency status. Most people within the group knew each other and the focus group was conducted entirely in Russian.

1 Stamp 4 indicates that the person is entitled to work without a work permit. It is issued to people on work visas/work authorisations, and also to, e.g., spouses of Irish and EU citizens, refugees, people with Irish Born Child residency, people with long term residency status.

2 Asylum seekers must remain within the ‘Direct Provision’ scheme until they are granted refugee status, leave to remain or, if their application for refugee status is unsuccessful, until they are deported. See: [http://www.ria.gov.ie/coming\\_to\\_ireland\\_as\\_an\\_asylum\\_seeker/](http://www.ria.gov.ie/coming_to_ireland_as_an_asylum_seeker/) Focus group members reported this process taking 5 to 6 years.

3 Application for renewal of permission to remain in the State on the basis of parentage of an Irish Born Child born in the State before 1 January 2005

# NEW COMMUNITIES AND MENTAL HEALTH IN IRELAND

*Somali Community* – All participants of the Somali community group were Asylum seekers, from Somalia and of the Muslim faith.

*West African Network (Men)* – This was a group of young males (age < 22 years) who shared attendance at a church youth group and participated in worship, music, poetry and debate etc. Some came to Ireland as unaccompanied minors and were fluent in English. Their resident status was as migrant workers (stamp 2) or asylum seekers.

*West African Network (Women)* – This was the largest and most diverse group. The session was conducted in Mosque by an active member of West African Network. Most were between the ages of 25 and 45 years, married, were Muslim and attended English language classes together. These women came from a range of countries. Nine were on a stamp 3<sup>4</sup> visa, 3 on visitors' visas and the remainder had stamp 4 residency status.

<sup>4</sup> Stamp 3 is a limited stamp which indicates that the person cannot work or study full time in Ireland. This is usually given to visitors or spouse dependants

**Table 1: Composition of focus groups**

Group Name	Country	Language	Religion	Sex	Number
Congo Lisanga	Congo	French, Lingala	Christian	F – 6 M – 2	8
Algerian Community of Ireland	Algeria	Arabic, French	Islam	F – 3 M – 3	6
Russian Speaking Women 'Slavianka'	Ukraine, Estonia, Russia, Estonia, Latvian, Belarus, Moldova	Russian, Ukrainian, Latvian, Belarusian, Moldovan	Russian Orthodox: 4 N/A: 4	F	8
Russian Speaking Men	Moldova, Ukraine, Latvia, Lithuania, Russia	Moldovan, Russian, Ukrainian, Latvian, Lithuanian	Orthodox: 2 N/A: 4	M	6
WANET (West African Network)	Angola, Ghana	Portuguese, Twi	Christian	M	7
WANET (West African Network)	Morocco, Algeria, Sudan, Syria, Mauritius, Egypt, Saudi Arabia, Indonesia, Iran, Algeria, Turkey	Arabic, Creole, Indonesian, Persian, Turkish	Islam	F	18
Eritrean Community	Eritrea, Iraq, Sudan	Arabic	Islam	M	6
Somali Community	Somalia	Somali, Swahili, Arabic	Islam	F – 3 M – 3	6
Romanian Community	Romania	Romanian	Orthodox	F	6
Romanian Community	Romania	Romanian	Orthodox	M	4

## 4.2 Focus Group Process

Community group leaders negotiated a time and place of convenience to participants to hold the focus groups. Most were held at Cairde and others were held at a Mosque or community centre. Focus groups followed an agreed structure and protocol agreed during training (see table two). Consent was revisited at the beginning, all participants agreed that the session could be taped and transcribed. In most groups there was an agreed facilitator/leader and a second person who was able to provide support if needed e.g. the transcriber sat in as an observer and took notes in most of the groups. The transcriber was known to many people as a trusted staff member of Cairde. The length of time of focus groups varied from 75 minutes to 120 minutes. Where there were groups with mixed proficiency with English or there were multiple first languages the groups took longer as the facilitator translated or clarified questions and responses.

## 4.3 Method of Analysis

The aim of the analysis was to provide a comprehensive and parsimonious representation of the perceptions and viewpoints of focus group participants. Transcripts were made of all focus groups and these were imported into the software package QSR N-Vivo (version 9). Three project members (Tonya Sanders, Richard Lakeman and Anne Matthews) reviewed all data and met to commence coding. Using the first level headings as starting points each line of each transcript was allocated one or more codes representing a perception, opinion, assertion or example of a concept. When a sufficient number of codes were generated and a unifying concept appeared to emerge, elected codes were aggregated under that concept. Thus a tree like structure grew with the central concept (or top level category) being the question or concept (e.g. components of good mental health) from which various branches emerged (e.g. Having good relationships, occupation etc) which in turn were populated by exemplars and connected back to the transcribed text. Further

coding was completed independently by group members. The group met to review and completed the coding structure by looking at the whole and apprehending any distinctive conceptual patterns. Codes were rearranged to ensure 'best fit'. The group also read the transcripts and coded data with a view to discerning differences between groups. Finally the narrative account that follows was written (by RL and AM) ensuring that all content elements were included and higher level categories were illustrated with verbatim examples from the transcribed text.

**Table 2: Focus group questions**

### Introductory questions:

What is good mental health?

What is poor or bad mental health?

1. What do you think are the most important things affecting a person's mental health here in Ireland?
2. If you could change anything to improve mental health in your community, what would it be?
3. Do you think discrimination and prejudice affects a person's mental health and wellbeing?

PROBES: How does it do this?

Can you give any examples?

How do you feel \_\_\_\_\_ people are treated in Ireland?

PROBES: What effects do you think this has on them?

4. Think of the last time you had contact with a doctor, health worker or social worker... How did you feel about the way they treated you?

PROBES: If it was good what made it good

If it was bad what made it bad

5. If you feel anxious, stressed or unhappy what do you do?

PROBE: Would you ever look for help from Irish health or social worker when you feel like this?

PROBE: If no, why is that?

## 5 RESULTS

### 5.1 Components of Good Mental Health

The most discussed elements of good mental health related to family functioning and security. Elements of family functioning were mentioned in all focus groups whereas security was most often cited by refugees and asylum seekers.

#### 5.1.1 Having good relationships

Having good relationships with friends, family and the wider community were cited as important for personal happiness and mental health. This included being around understanding people and particularly being with family:

*When all your family and children are with you... no worry about them being far away with the strangers* [‘Slavianka’ Russian speaking women]

Being able to provide for family, enjoying leisure activities together and establishing the routines and rhythms of everyday life were construed as important for personal mental health as was being able to communicate with others easily.

#### 5.1.2 Having opportunities

Mental health and happiness was tied to having opportunities to work, to learn and to help others. Some cited recognition by others of skills, qualifications and experience as pivotal to realising these opportunities. Others stressed independence and opportunities to direct ones own life (particularly those who had spent time in direct provision centres) e.g.

*Being active, being able to care for myself and solve my own problems. I used to do this at home, but here after years in the camp [accommodation centre]... they strip away your confidence that you can do anything for yourself or for your family.*

*Now, I am trying to get back to the same level I was at home, but it is hard...* [‘Slavianka’ Russian speaking women]

*When you can change your situation, when you are depending on yourself, not on decisions of others* [Somali Community]

Others described the importance of opportunities to do things that made them happy or realise their potential.

#### 5.1.3 Occupation

Work and activity were frequently cited as a facet of mental health. A West African woman stated that ‘work makes us happy’ and particularly opportunities to work outside the home. Having a normal routine of work, school, and leisure time was mentioned by others who also felt that enjoying such normalcy was contingent on immigration status being resolved. Others spoke of satisfying activities, art and creativity and worship.

*Having a good job and in general living in a good environment. Basically to have no daily worries like having something to eat, having a place to live etc.* [Romanian – Women]

#### 5.1.4 Feeling and perceiving

Respondents variously described mental health as feeling happy, relaxed, contented and optimistic about the future. Feeling respected by others was important to some as was being and feeling physically healthy.

*When you have a hope that tomorrow day is good, not waiting for bad things to happen, when you are not waiting – just living.* [‘Slavianka’ Russian speaking women]

A Romanian man stated ‘Mens sana in corpore sano’, or loosely translated from Latin ‘A healthy mind in a healthy body’. This led to a lively discussion in which participants agreed mental health was more than that – encompassing rationality, discernment and ‘normal functioning’ of the brain.

### 5.1.5 Security

Being safe and secure was considered by many to be an essential component of mental health. Some stated that good mental health was not being exposed to war and violence or ongoing conflict in countries of origin. More generally good mental health was associated with having sufficient and secure resources to meet basic needs, having a sense of security in relation to ones citizenship/immigration status and being able to build and maintain a home.

*When I have the necessities in life, like shelter, food, water. To be able to go outside and feel safe, having a home. [West African Network – Women]*

## 5.2 Conceptions of Mental Ill-Health

Some groups (e.g. Romanian – Women) stated that mental ill-health was the opposite of mental health and did not elaborate much further. In some focus groups people made reference to other people who manifested extremes of distress or unusual behaviour that they considered ‘crazy’ or ill. However, in the brief discussion of mental ill-health held in each focus group emphasis was on the unremarkable, everyday manifestations of distress and psychosocial ill-health, particularly as related to the experiences of migration to Ireland.

### 5.2.1 External factors

Numerous factors external to the individual were cited as being implicated in mental ill-health. Experience of war, torture and other trauma were mentioned. Examples were proffered of both manifestations of and causes of mental ill-health. For example, feeling out of control or uncertain about the future was considered a manifestation of ill-health. However, ‘direct provision’, threat of deportation, uncertain immigration status, discrimination, being prevented from working, learning or enjoying citizen rights led to and confirmed feelings of being out of control and fuelled stress and worry.

### 5.2.2 Feelings and affects

There was some agreement that stress and anxiety were manifestations of mental ill-health and these were frequently tied to external factors.

*I think that anxiety is the best defining concept. That constant fear... that you are not going to get home safe, that you are taking a flight and you are afraid, that tomorrow you will be out of the job, that you won't find any work. You know how it is in Ireland, you work for 7 days and then next week there's no work. And this fear that you may be out of the job, and then the landlord comes and kicks you out of the house. [Romanian Community – Women]*

Yearning for family and friends was a distressing experience. For some refugees this was compounded by uncertainty about the welfare of family and friends left behind. For others the distress and yearning associated with separation from children was acutely felt.

*[I feel distressed]... when I call home and talk to my other children who are not here. When I have to tell them that I can't bring them here. ['Slavianka' Russian speaking women]*

Depression, unhappiness, a-motivation, anger and loss of hope were cited as other examples of mental ill-health.

### 5.2.3 Cognition

Aspects of cognition such as the content, form and flow of thoughts were described. Excessive worry, uncertainty and negativity in ruminations were described as ill-health. Being ‘unable to let go’ of negative emotions or intrusive recollections of trauma (as in nightmares) was described as was excessively ‘personalising’ events.

### 5.2.4 Behaviour

Unpredictable or unusual behaviour was seen to be a potential sign of mental ill-health. Behavioural

manifestations of ill-health were often construed to arise within family relationships. Excessive aggression, difficulty sleeping and problems with expressing oneself or communicating needs were construed as being potential manifestations of mental ill-health.

## 5.3 The most Important Things Affecting Mental Health

*It is hard to deal with disappointment and crushing of your dreams and aspirations on psychological level. I feel sometimes that you have made wrong decisions in your life and lives of other people in your family [Russian speaking men].*

The most important things affecting mental health were linked to immigration policies and status. Fitting in with Irish society was also a related factor identified by participants. Throughout their discussions, participants vividly described the effects of these various factors in emotive and expressive terms. They described feelings of frustration, worry, feeling “not together”, incompleteness, anger, wanting to scream, sadness, isolation, unhappiness, anxiety, stress, disappointment, disempowerment, depression, rejection and worthlessness.

### 5.3.1 Immigration policies and status

The effects of immigration policies on the lives of the participants were directly discussed in all groups.

*... being treated differently, not like a human being. This causes hurt, anger, upset. 'I was treated badly at Dublin Airport, I was asked questions for over an hour although I had passport and everything was ok. [West African Network – Women]*

Respondents made reference to dealing with officials in accommodation or immigration and provided accounts of not being believed, treated well or given adequate explanations. Some of the participants within African groups described their perceptions that officials and health professionals

did not acknowledge or accept their distress, because they appeared stoic and still smiled throughout hardship.

Immigration status and the consequences of immigration policies in terms of ability to work, study, and also to feel secure, were raised. Participants expressed their frustration at the waiting and uncertainty about the future which is involved in immigration processes.

*When you have a hope that tomorrow day is good, not waiting for bad things to happen, when you are not waiting – just living [Russian speaking women]*

*Immigration is also important issue. Talking to Department of Justice about my citizenship is very frustrating. I have been here for a long time, applied for naturalization and now waiting – again. Half of your life spent in waiting for responses from Justice [Algerian Community].*

Those in direct provision described the restrictions and lack of freedoms associated with that, as well as the restriction on working while in the asylum process.

*Once you arrive in Ireland, you are sent to a Direct Provision hostel. It makes you want to scream, it's not easy [Congo Lisanga].*

*I have no job, no nothing, the asylum process makes me unhappy because it prevents me from living normal life like other people [Eritrean Community]*

There were several references by those in direct provision to feelings that they were being treated like animals and that this reflected people's views of them. The experience was also described as isolating and prison-like. People stated that they just wanted to be treated normally, like everyone else. They also stated that they wanted to be independent and look after themselves but were prevented from doing so by policies. They did not feel cared for by those with whom they interacted in direct provision. Others described feeling belittled or treated like a child by the process of direct provision.

*In my country is not like here... You have a responsibility to look after yourself, there is no social welfare. If you have a job – you eat, you do things. If you don't – you'll die. Here they treat you like a child, taking control over your life if you an asylum seeker. They tell you when to eat and what to eat, they do not allow you to work or study – you lose respect for your own abilities [Congo Lisanga]*

Others stated that they were unhappy at being perceived as wanting benefits when they did not have any opportunity to work. Those who could work expressed their frustration at getting jobs that did not fit their qualifications. Sources of stress at work were working below your skill level. Work was described as a means to financial security but also providing a routine and structure as well as fulfilling family roles, for both men and women, based on expectation in their own countries and cultures.

Participants referred to having difficulties making ends meet, getting into debt, not having choices, the pressure of high bills for accommodation, heating, fuel and childcare. Poverty therefore was strongly linked to immigration status- whether in direct provision or in lowly-paid jobs due to discrimination or a lack of recognition of qualifications and skills.

*...Because if you are poor and you don't have any work, you've got no money; and if you've got no money, you cannot take care of your family, you don't have anything to eat, you become anaemic, and then your brain no longer functions properly [Romanian Community – Men]*

Private rented accommodation causes problems for those not in 'direct provision' but with access only to low-paid jobs, paying high rents and poor security.

*The other big problem is housing. It's not easy to get a council house; and when you are renting, you don't know what is going to happen next. No security in the place you are living in; you could move at any time. Also the rents are too much for what you are getting [Algerian Community].*

### 5.3.2 Fitting in and being part of society

The importance of integration and acceptance was highlighted, especially in terms of the isolation described when these are absent. Those in direct provision felt particularly isolated and apart from other people. Experiencing racism also affected the extent to which people felt part of a wider community:

*You feel like an outsider, discrimination gives you a lack of confidence. Once you have a negative experience, you don't have any hope that you can be a part of the society [West African Network – Men]*

A language barrier was stated to make it more difficult to be a part of Irish society and this affected adults and children. A need for unity and solidarity within ethnic communities was liked with integrating with Irish society. The role of the media in highlighting difference was also given as a factor affecting integration. This sense of isolation seemed heightened when there were family difficulties, more specifically the absence of family causing difficulties:

*I also frequently have headaches, because I think about home and family – that's hard. You always have this feeling that you are not together, not complete if you worry about your family (when they are not here but somewhere else) [Algerian Community]*

*I think it's to do with why you leave your country. Where I come from affects my situation here, I'd been living with my family now I'm on my own. You can find yourself depressed [West African Network – Men].*

People who suffered in their own countries because of their religion or who had been imprisoned also described suffering further trauma within this isolating environment.

Some participants described gambling and alcohol as ways of coping with isolation whilst acknowledging that gambling made the financial situation worse for them. Using alcohol was also identified as affecting mental health and a way of alleviating distress.

People's immigration status forced roles to change within families and for some men not being able to provide for their family and inactivity caused additional stress beyond that associated with poverty.

*When men where in their home country they work and are out all the time, but when they come here they are in hostel; they are here all the time doing nothing, and the children wonder what's going on. He wants to work but he can't (not allowed). [Congo Lisanga]*

Financial stressors were identified as causing family break-ups, and also challenging women to adopt new roles within the family.

## 5.4 Dealing with Anxiety, Stress or Unhappiness

Participants in the focus groups were asked how they dealt with anxiety, stress or unhappiness. A range of general methods of coping were shared. Support seeking followed by emotional expression or regulation, and helplessness were the most dominant themes. Most respondents described a range of responses.

### 5.4.1 Support seeking

People described ringing home, talking to a spouse, family member or friend to obtain comfort, care and instrumental aid. Several commented that it was useful to meet as a group

*Also if you can talk to some individuals, have a group talk as well... Like we came here to talk to someone, have a cup of tea, share your worries [Eritrean Community]*

Prayer was used as a method of coping for some, and as a means to make sense of and deal with hardship. Church or faith communities were also a source of social and emotional support.

*What alternative we have? For a lot of us, mental health is an inner peace. So if can strive to achieve it – good, this means that we are dealing with our mental health issues... And we sometimes get strength in community, family, church – if you are not alone and have somebody to talk to – half of the problem is gone! Obviously, this “some one” is not my GP! [Russian speaking men]*

Whilst there was a general distrust of health professionals, those that had previously described good experiences said they would seek support from professionals, such as social workers, psychologists or other mental health professionals.

*In the first stage, nobody goes to a specialist. Everybody tries to make sense of the situation first by themselves and then they talk to friends... and only then I may ask for specialised help. [Romanian – Women]*

Some people acknowledged that there were times (such as during domestic disputes) when it was more effective to receive support and advice from outside of the family or friendship group.

### 5.4.2 Emotional regulation and expression

Women in most focused groups described either screaming or crying in response to distress or frustration. Some stated that crying helped but others were ambivalent. Drinking alcohol or using natural therapies were other means of regulating emotions.

*I scream sometimes because I am frustrated with everything. Children can trigger that and then I am shouting at them for a very small reason. I take valerian root sometimes to calm down. [‘Slavianka’ Russian speaking women]*

Over the course of the focus groups people described feeling frustrated, angry and greatly distressed and were challenged to find ways to contain or express these emotions.



### 5.4.3 Distraction or sublimation

Various activities were described which served to distract, relax or soothe people. These included writing, bathing or showering, walking, playing sport or going to the gym, shopping, listening to or composing music, eating and cleaning.

### 5.4.4 Isolation

Respondents described isolating themselves from others either physically or psychologically.

*I sit at home on my own, close the door and don't go out* [Algerian Community]

### 5.4.5 Accommodation or helplessness

Some people described being resigned to stress or accepting adversity. Some had hope that pain would pass or that their situation would improve.

*Sometimes I feel that I don't have energy to do anything, I feel very lethargic and nothing interests me. The situation around me could be not bad at all, but I still feel very empty. When this happens, I just wait until it passes...* ['Slavianka' Russian speaking women]

Others described a bleaker outlook that tended towards helplessness or hopelessness stating that it was pointless doing anything or seeking help.

*I don't believe in anything or in anybody, including the health system. I thought about suicide once, when situation was very bad for me, but my religion would not forgive me for that. So I did not do anything to myself. I hope that my story or my experience that I have shared here will serve a good purpose, will show to everybody how hard the life is here for us [visibly shaking].* [Algerian Community]

## 5.5 Discrimination and Mental Health

People in the focus groups were asked directly about their experience of discrimination and their views about the impact that discrimination had on mental health and well-being. Group members varied in their perceptions of the extent of the problem.

*I think discrimination is minor in Ireland, not major. The doors are open for all people, generally...* [Algerian Community]

*Not everyone is racist. But sometimes it is very bad.* [Eritrean Community]

*Anywhere here, we are not respected; in any situation – in police, health service, society – we are nothing, we are not respected.* [Congo Lisanga]

Europeans on working visas recounted different experiences to asylum seekers and non-European people.

*We are immigrants, foreigners and new to here – what would you expect? In any country people are very wary of newcomers... That's why they give us low jobs – who else will do them for that money?* [Russian speaking men]

Some people perceived that skin colour marked people out as different.

*I also think that a woman from Algeria, who is also African, but she's white and I'm black, I think she has more chance than me.* [Algerian Community]

It was widely agreed that language, accent and immigration status could make a profound difference in how people are treated by Irish Nationals.

*We are discriminated by us being here. If your immigration status is not clear – then you have less rights, if you are speaking with a strong accent – you are also discriminated.* [Russian Speaking – Women]

## 5.5.1 Stereotypes and perceptions

Many people believed that they were perceived as inferior by Irish people or were viewed in stereotypical fashion by some people. Respondents identified the news media as being largely responsible for the promulgation of stereotypical images.

*I think it also a media (fault). If you are from Russia or Soviet Union country and you are a woman – means that you are looking for a rich husband or you are mail order bride or came to work in lap dancing club. That's where discrimination starts – when people look at you through their own lenses and see what they want to see. It doesn't bother me any more. Sometimes I am saying I am not from Moldova but from Italy – the language is similar. [‘Slavianka’ Russian speaking women]*

People described being perceived as terrorists, bad or inferior...

*‘People have a wrong idea about us; they look at you as you are inferior’. This creates a feeling of unhappiness. ‘They think we are poor and are bad people’. ‘They think we take money from the government’. This is stereotyping. ‘I am a political refugee with a good education’. [West African Network – Women]*

Respondents pointed out that Irish people had much less experience than others in dealing with and responding to migrants. They therefore, often formed stereotypical views based on limited first hand experience of people. For example, people may think an Eastern European person is a construction worker or driver because those are the occupations they may have seen Eastern European working in.

*The Irish society they haven't seen foreigners or had experience of dealing with people coming to the country for long... Where it is different in the UK, we are the first generation of immigrants that have come here, in UK there are generations of people... This means a lot to be learned from this experience... [Somali Community]*

## 5.5.2 Examples of discrimination

Discriminatory experiences were recounted relating to many areas of everyday life. One person described it as a systemic problem

*It is a problem with a whole system here, with the lack of support for the new communities... This means that anything that you do or want to do is a problem: finding a job, getting out of social welfare, being discriminated and abused, having problems with housing and landlords, not having opportunities to study or get educated – it is all parts of the same big problem... [Algerian Community]*

### Employment

The most frequently cited examples of discrimination occurred around employment. Some migrants groups were perceived to have difficulty obtaining employment even with a good grasp of English and having excellent qualifications. People reported being employed in menial jobs and being unable to practice in their chosen profession.

*When I called for the job, when they heard my accent they said – oh no...the job is gone. I saw it advertised after – again. But you can't prove anything – it was a one-to-one conversation. This makes me feel – like why trying? What can I do? I can speak English, but not as a person who lived here all their life. [Russian Speaking – Women]*

Respondents recounted examples of people not being interviewed or employed because of their names and when employed being treated differently to other workers. Some described subtle differences e.g.

*I tell my boss that I have an emergency to take care on Monday and he acts annoyed because I am asking him a favour. But if somebody else doesn't come to work because he's been drinking all weekend, the boss says: ‘Ooo [in an admiration tone], X's not coming to work because he had a party on Saturday and Sunday. [Romanian – Men]*

Others spoke of racist taunts or being 'set up' by other employees. One woman who attempted to start her own business confronted more overt racism:

*I wanted to open a shop, start my own business to make my and my family life better in Ireland. I had a lot of problems; people were screaming at me to close shop down, people insulted me on the daily basis. Eventually, the shop went bankrupt; They (local people) made me close the shop down. [Algerian Community]*

For some people language was a difficulty that mitigated against employment or advancement. This was particularly so for women with dependent children. Lack of inexpensive and accessible English language classes and few childcare options confined women to the home and contributed to alienation from economic and community life.

### **On the streets**

People recounted examples of racism and abuse as they went about their day to day business. Some people had been taunted by strangers on the street e.g. 'Go back to your own country' or 'monkey show me your tail'. Others reported having doors slammed in their face or people ignoring greetings or spitting at them.

### **Transport**

People described incidents accessing public transport e.g.

*I wanted to get on the bus with my baby but I was told no the bus was full but it was not. The driver just didn't like the look of me... [Algerian Community]*

One young person perceived that other people did not sit next to him on the bus or sat on the edge of the seat rather than close to him. Another, was told by a taxi controller to learn English before ringing again.

### **Officials**

Participants described incidents dealing with officials or powerful people that caused great distress. One person stated that the local postman gives him the finger whenever he delivers mail to the house. Another described a General Practitioner telling her not to worry about getting a medical card because she wouldn't be in the country very long.

*Another time, someone called me a "Paki" and told me to "go back to your country". It was a police sergeant. Because I did not have identification with me, I was arrested, but I've done nothing wrong. I have been living in Ireland for 12 years, I have fluent English – I have citizenship here and I don't have to carry an identification... They let me go... I go to sleep every night and it stands in front of my eyes. [Algerian Community]*

### **Accommodation**

For some people accessing private rental accommodation even if they possess the means is exceptionally difficult due to discriminatory behaviour of private landlords and agents.

*Yes. I have been to an agency when we were looking for a house. And the person there looked at us and started to talk to us as if we were retarded. She said: [pronouncing the words slowly and one at a time] 'We-do-not-have-any-apartments-for-you. Do-you-understand-me? This was funny because I understand English perfectly. [Romanian – Women]*

'Direct provision', a discriminatory practice, was experienced as an indignity with negative consequences for people's mental health.

*Accommodation, no one can help you. We are stuck in Direct Provision; nothing will change their decision to segregate us. And keep us there like animals. The only thing they want is to deport us. We are not needed here... [Somali Community]*

## 5.5.3 Effects of discrimination

Respondents in all focus groups agreed that discrimination had negative effects. Discrimination had primary effects such as loss of opportunity, loss of income, insecure housing, and insecurity. At least as profound were the reported effects on self confidence, self-esteem and mood.

*Of course discrimination affects our health – mental and physical – very negatively. When people make you feel as a second class citizen it is very demeaning; and when it happens too many times – you start to believe in it yourself. It impacts on your confidence and ability to do normal things, like any other person. [‘Slavianka’ Russian speaking women]*

*...these insults reach deep inside your soul. Injustice is always frustrating and infuriating [Romanian Community – Women]*

People spoke of feeling stressed, anxious, worried and experiencing physical problems as a consequence of discriminatory or racist incidents, being unable to provide for themselves and facing an uncertain future. For some their enthusiasm for life diminished.

*The way professionals are treated is bad, skills are not recognised. Your gifts and your talents die, your interest dies down. Then you become frustrated and depressed. [West African Network – Men]*

Other respondents described feeling angry...

*...the aggressiveness grows in you and the psychological stability is affected. You snap out much quicker. You tend to take revenge on others because of what is happening to you, because you think it’s only fair that you ‘pay back in the same currency’ [Romanian Community – Men].*

However, more usually respondents reported feeling hopeless, despairing or suicidal...

*I had a lot of negative experiences in this country, which brought a lot of anger in me... My family*

*broke down and I only see my children occasionally. I am a young man but have very little hope that anything will be ever good for me here. [Algerian Community]*

## 5.6 Experiences with Health Professionals in Ireland

Most people had sought assistance for a range of health related issues. These included childbirth, diabetes, childhood illnesses, back-pain, acute illness, health screening and undisclosed problems. Several acknowledged seeing social workers or psychologists for counselling or seeking assistance from general practitioners for depressive symptoms. No respondents acknowledged seeing specialist mental health services.

### 5.6.1 Good experiences

Whilst most people recounted negative encounters with health services some people acknowledged finding particularly friendly or helpful practitioners. Some respondents (generally in response to hearing about the negative experiences of others) provided advice to others about how to access services e.g.

*I don’t think it’s a problem, but you need to make an appointment. There’s a lady doctor and you can go any time in the morning, just need an appointment after two. [Somali Community]*

People spoke of the difficulties finding good health professionals e.g.

*I have been trying to get diagnosis for my medical condition. Now I found a doctor who listens to me. He is a good doctor... Finally, after 3 years I found a good doctor to help me to get what I need... [Algerian Community]*

People spoke of particular health professionals who were helpful. For example a woman – participant of the focus group conducted by West African Network – spoke of the nurses being friendly at the clinic where she attended for treatment of diabetes.

People were particularly appreciative of health and welfare professionals being flexible in the assistance they provided e.g.

*I am happy with my GP, if I need things like letters – he will write it for me... Some doctors don't like to do that because they say that it is not their job. They don't like to write reports for Justice... My doctor wrote me a letter... [Algerian Community]*

Others reported receiving assistance obtaining employment, appreciated the friendliness or acknowledged that health professionals tried to assist e.g.

*My GP is ok and he talks to me and my children, but GP is not the only service I need. ['Slavianka' Russian speaking women]*

### 5.6.2 Bad experiences

Respondents recounted numerous negative encounters and experiences with the health and welfare system. The consequences of these encounters was that many respondents did not trust health services or health professionals in Ireland.

*I don't trust the system here; I don't trust anybody, including all health professionals and government [Algerian Community].*

People described accessing services and entitlements as a struggle.

#### **Waiting**

Waiting was a common complaint amongst respondents from most groups. People described waiting for long periods (6-15 hours in the emergency department) for emergency treatment and long waiting lists for referral to specialists or other services. One respondent claimed to have been waiting since 2001 (7 years) for a referral to a specialist to address unresolved and persistent headaches. A Romanian woman noted that it took

over 4 months to receive the results from a cervical smear test by mail, whereas in her home country results would be provided on the same day. A Romanian man recounted waiting with his wife at an emergency department after she became acutely ill from having a diaphragm inserted to be told 15 hours later that there was no gynaecologist at the hospital and to go to a general practitioner.

#### **Poor Quality Service**

There was a general perception that the quality of health services was poor;

*Sometimes the quality of the service is absolutely unacceptable. It's like going there with a stomach ache and then you come back home with a prescription for teeth pills. Treatment is usually very superficial... [Romanian – Men]*

These perceptions were often based on the experience of using health services in other countries e.g.

*I have had a bad back pain, I was told your ok just do exercise you be ok, two months later I went away to Eastern Europe they told me I'd problem with my kidneys. If someone was Irish it would have taken seriously and treated well, because of medical card I'm not taken seriously [Algerian Community]*

People were particularly critical of the quality of obstetric and maternity care in Ireland. Two groups described experiences of birth complications (one leading to death of the child). One group asserted that it was unacceptable to not see an obstetrician until into the fifth month of pregnancy (the experience of some women in the group).

*When I was pregnant I went to hospital, my water was broken and I was told to go back home, that my water isn't broken. I was scared and there was nobody to explain things to me. This happened because I'm black, it's not fair! [Congo Lisanga]*

*My experience of having a baby here was not good. I have a heart condition – nothing serious, but back home when I was pregnant doctors were monitoring me. Here, when I went into labour, I was trying to explain in the hospital that I have a problem with heart, nobody took any notes. The birth was difficult and the baby was pulled by forceps and I had a haematoma. They had to stitch me twice because of that. Nobody explained to me what went wrong and why this happened. After I was discharged home there was no follow up and I didn't see a gynaecologist for very long. I was in a lot of pain, but the nurses were nearly shouting at me: You've got your painkillers, you are not in pain. And I was – because of the internal bleeding. I was left there on my own for a very long time ['Slavianka' Russian speaking women]*

Respondents from every focus group spoke of attending a GP for a range of health problems and being prescribed either paracetamol or an antibiotic. This was not generally perceived as an adequate response to health care needs.

*She (the GP) gives you the same prescription, gives you the same thing and the same thing. It is only antibiotics she prescribes... [Somali Community]*

## **Absence of Care**

People spoke about not feeling cared for by health and welfare services.

*I had a miscarriage at home but the hospital did not care, they didn't give me anything to help with the pain, they just sent me home. [West African Network – Women]*

Another Congolese woman stated,

*They don't think about what you go through everyday. They don't care about me, what is the point?*

Some expressed concern about other residents in hostels whom they perceived were mentally unwell (in places described as people being “crazy”) or needed specialist care but service providers being unwilling to assist them.

## **Communication Problems**

Various problems with communication were cited by respondents in all focus groups. The most commonly cited problems related to accessing health related information, information regarding follow-up options and information about health status.

*I have a lot of health problems and was in the hospital for check ups and talking to the specialist doctors. My main problem was that it was difficult to explain that I had the diagnosis from home, and was on treatment before.... Here I had to start all the process again! The doctor was good, but nobody explained to me what is going on and when I have asked for a copy of my file, they said: why do need to have it? You are not a doctor... And I just wanted to know what is happened to my health. ['Slavianka' Russian speaking women]*

Other respondents who requested to see their files were also refused. People described what they perceived as condescending or patronising communication from health professionals. For example a Romanian woman was affronted by a doctor who asked “Did you really go to a gynaecologist in Romania?”.

Others who sought assistance for mental health problems were offered advice. For example a man who sought help from a general practitioner for depression reported being told ‘don't think about your-self too much’. Another person did not find feel listened to by a GP who said,

*...you are ok, you are not crying, you are calm and smiling. He said, you're a black person, you're strong. He didn't listen or believe me. [Congo Lisanga]*

The theme of being listened to (or believed) was common to many accounts and this was not always related to language barriers.

*I was treated in a bad way; social workers are supposed to support you. When I arrived to Ireland, I was interrogated by them. They were saying that they didn't believe my age or what I have been through. And I didn't have anybody to protect me, anybody who was on my side. [West African Network – Men]*

Language barriers were cited as a problem for some. Information brochures in various languages were said to be available in some health centres and some people said they would bring a fluent English speaker if they were to visit a doctor. Nevertheless, difficulties with language and understanding were a source of frustration for respondents and it would appear, health professionals.

*One doctor asked me a question I did not understand, she took her glasses off and slammed her book down, but I was good and then she rubbed my arm and said sorry. [West African Network – Women]*

### **Expense**

Health care was considered by some to be expensive, particularly for those who were receiving €19 per week while receiving 'Direct Provision' services. Whilst primary care was technically free, it was noted that the medical card did not cover the full cost of many prescription items. Transport to and from clinics was an additional expense and hardship for those on limited incomes. Some respondents stated that they travelled to Eastern Europe for dental treatment or stockpiled medications obtained from friends to defray expenses.

## **5.7 What Could be Changed to Improve Mental Health in Your Community?**

Participants identified a range of structural things that could be changed to improve the mental health of migrant groups. These included policy changes to secure access to essential services, increasing information about services, and enhancing integration so that they felt they belonged within Irish society.

### **5.7.1 Structural inequalities**

The structural inequalities that were most highlighted revolved around securing access to housing, education, employment and childcare, which were all affected by immigration policies. The affordability and accessibility of adequately sized homes was emphasised. Those who had been in Direct Provision still found that they had accommodation problems after they left that system.

*Housing; the housing system for newcomers is bad, the process you go through before one is accepted – very long. If you are single – you have to wait even longer. It is hard not to have a place of your own, a place that you can call home. First, there were years in Direct Provision and there is no end to it now... [West African Network – Men]*

Accessible and affordable childcare was judged to assist with finding work and accessing education.

*...when you do not have an opportunity to work. I feel disgusted with myself but I can't do anything. It is impossible to survive, too expensive to go to work. I can't even afford to go study – all the same problem – childcare. [Russian speaking women]*

Access to education related to both children's basic education and adults' continuing education.

*...give the chance for our children to go to school. Give our kids the right to go to school no matter what religion or immigration status they are. Also to give us the chance to study, to work to be like everyone else. We are not different than anyone.*  
[Congo Lisanga]

This was directly linked to the idea of being "happy" by participants.

Regarding work, being able to work and having an adequately paid job was highlighted.

*Yesterday I went for a job interview, what I was thinking! I didn't get it and it was not that I didn't pass the test, it was my passport and where I'm from.* [Congo Lisanga]

A need for mediated access to work contacts was also identified.

Since it is immigration policies and legal status which affect access to housing, employment and education, changing these would address the root of the problems described. Direct provision more directly reduces interaction and opportunities due to poverty. There was also a need identified for a faster and more transparent asylum-seeking system.

## 5.7.2 Increased information about services

There was little mention about the formal mental health services. However in some groups there was a need identified for information about mental health and mental health services, to prevent situations deteriorating.

*I think that information is the key. And prevention is important. There should be something done before it is too late as like with people who are suicidal. I think that's why there are so many suicides in Ireland – because unless they*

*save you half way through... nobody cares if you are showing symptoms of depression, no health professional will, on their own accord, do something about it. My partner had a depression... GP prescribed Prozac – that was it* [Russian speaking men]

*We also need to know that the solution is not putting people away in "crazy houses" or pump them with chemicals or drugs... Because this does not solve the problem... only manages the crises when somebody is already ill. Government should inform people as what mental health is and what mental illness is. And for us... we need to know what services are out there and what we can do ourselves as a community, group or church to respond to that.* [Russian speaking men]

This need for information about services also applied more broadly to all health services, where it was stated that access to information would assist in health promotion and community development.

*For ethnic minority communities more skills related to health needed. How to organize around health, having health information about services... We need training courses on how we can change health of our communities, how we can organize ourselves.* [Algerian Community]

Information about services generally was seen to need improvement:

*Yes, and to give information to immigrants how to go about the services... I don't know what to do if I feel not together or stressed... I drink and forget about every thing* [Russian speaking men]

Language support services which included the provision of essential information in a range of languages as well as opportunities to learn, improve and practice English were identified as important to enable access to services as well as to increase integration into Irish life.



*The language issue has to be addressed. In Ireland there is nothing written in Arabic... There should be more policies to encourage people to learn English. Providing free accessible English classes especially for women is essential, and in somewhere that is accessible and has a flexible timetable for women that are mothers. The government is trying to encourage people to learn English, but it is not enough: we do understand our personal responsibility to make an effort to learn English, but support is needed. Lack of English affects our understanding of how system works here in Ireland. Without that we can't work or do things that other people do [West African Network – Women].*

*If things – information, leaflets and forms – were in different languages, like in England they are more diverse than Irish society – it would be easier to cope. Also if interpreters were available when going places or accessing services.... [Somali Community]*

### 5.7.3 Enhanced integration and belongingness

The desire for enhanced integration and a feeling of belonging was described in many ways, linked with a sense of contributing to society, being respected and being treated well. Participants stated that they wished for the opportunity to be independent and to practice their talents and contribute to society:

*Also, more understanding about our situation from Justice and Social welfare – we don't want to be dependant on the state – we want to work, but also we want to eat and live in normal condition [Russian speaking men]*

*Some feel let down by the conditions they are living in, a lot of people have talents and want to contribute but they are let down by the system or community [Eritrean Community].*

Participants want to be heard- by the media and by Irish people; and that interaction would help increase mutual understanding.

*We do not get an opportunity to mix with other people, to understand people. We just locked up in direct provision centres and it is expensive for us even to come to the city centre. [Somali Community]*

There was a need identified for places to meet and interact, and this could include churches, social places, offices and internet access (to assist with employment seeking in particular; as well as a need to talk within communities and with Irish people). Strengthening communities was also seen as a way of helping involving trust, solidarity, patience with each other, commitment and participation by many. To achieve this enhanced integration there is a need to address racism and discrimination.

The need to shift the way ethnic minority groups are perceived by Irish people, the media and officials was also identified.

*The mentality of how Irish people see us. They think we sleep in the trees or in jungle. In the shops they follow us even if we are getting something for only 5 cent. They think we are animals. They have to take this out of their mind [Congo Lisanga]*

*The way the media talks about immigrants – this need to change, the television and on the radio. The way they were saying like all Polish people are coming to take their jobs. The media have to treat asylum seekers with respect [Congo Lisanga]*

## 6 DISCUSSION

### 6.1 Limitations

This report presents the findings of the ten focus group discussions conducted within this project. These findings might be described as ‘displays of perspective which are negotiated and developed between members’ (19). As a qualitative study it is not desired to find generalisable results, but to seek to gain subjective insights into the real and complex social worlds and experiences of participants. The participants of this study were self-selecting and may have more of an interest or concern in the issues being discussed than others within ethnic minority groups, as the questions for discussion were known in advance. The public nature of a focus group might also mean that personal sensitive experiences were not raised, for example, personal difficulties, experiences of trauma, abuse, violence, including domestic violence. Most focus group participants knew each other and this may lead to more inhibited comments (18). More personally sensitive issues may best be researched in future by using in-depth interviews.

The findings described in the last chapter are all inter-linked and in an overall sense highlight the structural inequalities and barriers which affect daily life quite significantly. Particular groups have particular difficulties and needs; what connects them is stress, socio-economic disadvantage and a feeling of a lack of belonging. This is most acutely seen for asylum-seekers (in direct provision), based on explicit government policy. However those who can work and study also convey a sense of isolation and separateness.

This study focused on mental health needs and the findings about **stress and coping** are discussed next. This is followed by a brief discussion of **social capital**, as a means to take account of the findings relating to isolation and lack of belongingness. Finally, linked with participants’ accounts of dealing with health professionals, and their mistrust of those professionals, the concept of **cultural safety** is discussed.

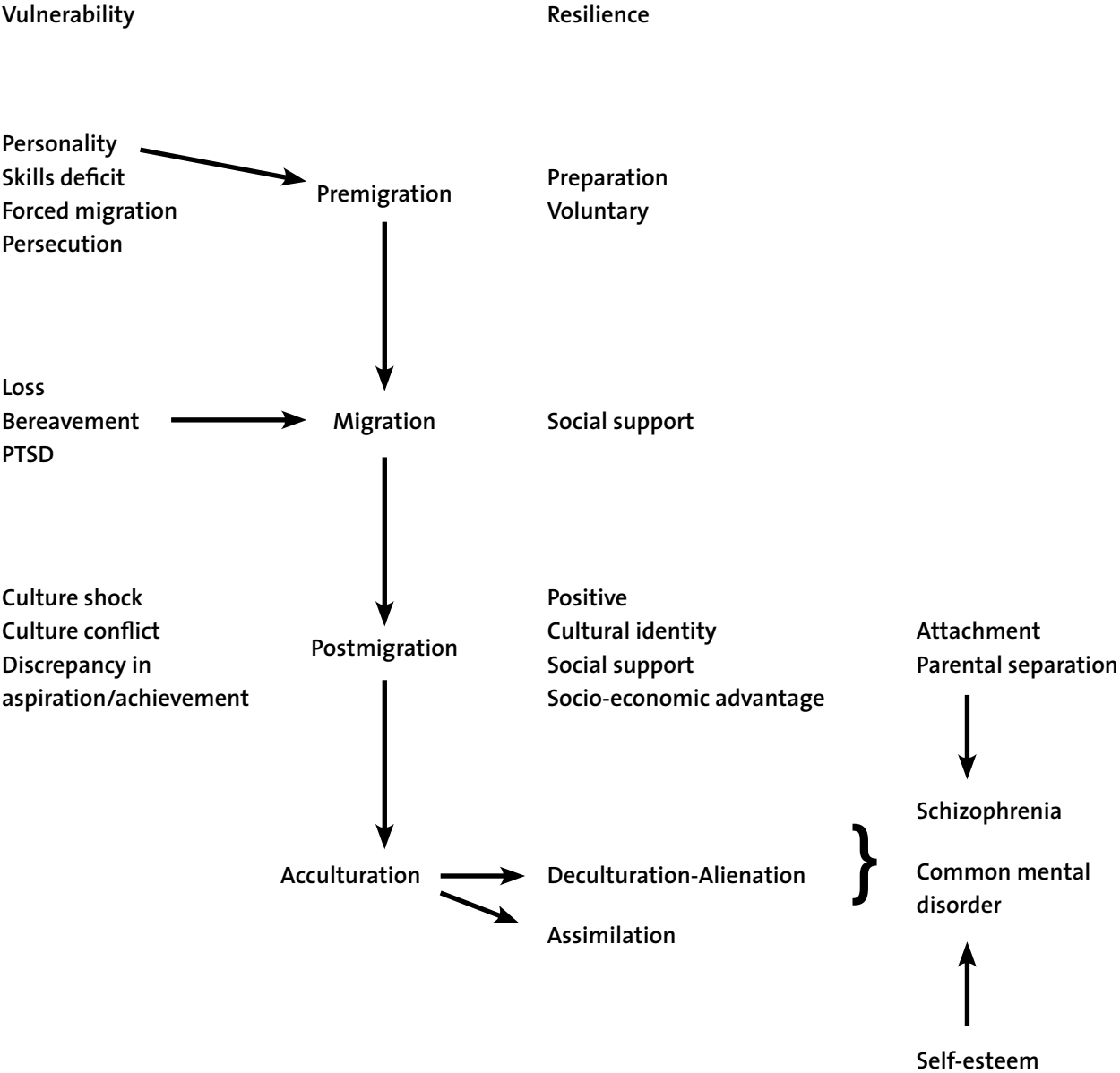
### 6.2 Stress and Coping

Migration is a heterogeneous experience and the relationship between migration and mental health is by no means clear. A strength of this study is that quite different groups of migrants are represented who collectively and as individuals face different issues at different points in time. Bhurga (16) described different stages of migration, and vulnerability and resilience factors that will have an impact on coping and mental health at each stage (see figure 1).

To understand the mental health status and needs of migrants one must pay particular attention to the kinds of stresses people are confronted with and how they adapt, cope or adjust. The majority of respondents in this research were immersed in the migration experience and many were in the uncertain circumstances of awaiting adjudication on application for refugee status. This uncertainty was clearly as stress for many who described their frustration and different methods of coping.

A common distinction which is made around stress and coping is that when confronted with a stressful or anxiety provoking event people’s ways of coping tend to cluster around solving the problem in some way or on dealing with or releasing emotion (20). Respondents in this research largely described emotion focused efforts to cope. In relation to dealing with the uncertainty of this phase of the migratory experience this may well be the most productive way to cope as there is little that individuals can do to solve the problem. For some the waiting took a considerable toll and some people described losing their sense of personal agency – wanting very much to be allowed to solve problems. The long term toll on mental health of being constrained from solving fundamental problems of living, of lacking personal resources, of being prevented from working and undertaking education, of living with the possible threat of deportation is not well articulated. People who move into a post-migration experience and status are unlikely to want to dwell on the previous phases of particular stress and uncertainty.

Figure 1: Migration and psychiatric disorders: a hypothetical model. Reproduced from Bhugra (2004)



People's pre-migratory experiences and the reasons for choosing or being forced to migrate will colour all other experiences. Some migrants carry the psychological scars of trauma, imprisonment, war and torture. These individuals require specialist and culturally safe post trauma interventions. Processes such as direct provision may re-traumatise or exacerbate post traumatic stress responses. Some respondents who were receiving specialist support stated that they found it helpful. Others who might have benefited were uncertain how to access such specialist support. For others culturally appropriate social support (being able to provide and access it) appears to be an important means of coping and adaptation during the new migration period.

During the post-migration period people may experience alienation or they may successfully integrate into local communities. Respondents in this phase most frequently identified some practices as unjust or discriminatory. Concerns mostly centred on "fitting in" and access to work, school, housing and opportunities. In this group poverty appeared to be a major contributor to adverse mental health.

## 6.3 Social Capital

Social capital has become an important concept in the world of sociological analysis. There is broad consensus that social capital consists of personal, group, community and organisational connections (networks) that can be utilised to meet certain productive ends. According to McKenzie (21) 'An important feature of social capital is that it is a property of groups rather than of individuals.' (p280). The constituents of social capital, which are also related to community are made up of social relationships built on trust, cooperation, reciprocity, and responsibility (22).

Immigrants are known to have few resources which predictably impacts on their ability to generate social capital, so returns are nominal. In this study this is further compounded by a lack of trust and cooperation between immigrants

and support services. Reciprocity is minimal because responsibility is neither shared nor allowed to cultivate during the early phases of the migration experience. The willingness and ability of immigrants to integrate and contribute to Irish society is underutilised and devalued. The prolonged waiting periods to have immigration status resolved, forced segregation from mainstream community and the accumulation of other negative experiences may diminish the capacity of people to generate social capital. The net effect of this systemic process of social exclusion is that isolation and alienation is experienced by immigrants (as reported by participants of this study). Ethnic groups in Ireland are probably best described as dispersed, further adding to a sense of isolation and alienation which has been shown to increase the incidence of mental ill health among this group.

For example in relation to mental health and social capital McKenzie (21) reference two studies providing evidence that: '...the incidence of psychotic disorders, suicide and psychiatric hospital admission rates in the UK is elevated among members of ethnic minority groups living in areas with lower proportions of ethnic minorities,' and that '...members of any minority group may feel excluded and stigmatised in areas where there is a high degree of cohesion among the majority group.' (p, 282). However Brettell (23) provides us with evidence that voluntary organisations are effective in helping dispersed ethnic minority groups maximise social capital gains by providing such things as support (counselling, training etc), information and building relationships between ethnic minority groups and/or the host society. Voluntary organisations can also be effective in mobilizing people economically and politically, all of which builds resources which can be used in the production of social capital, in turn can reducing incidences of mental ill health.

## Practice example – Sharing Voices Bradford

Sharing Voices Bradford (SVB) was set up as a Community Development project in 2002 with the aim to tackle mental health inequalities within Black and Minority Ethnic communities (BMEs) living in inner city Bradford (population approximately 155,000; 55% of which belong to the BME community). SVB was established on the premise that traditional psychiatric services is inadequately equipped to address the diverse mental health needs of BME communities. It was acknowledged that a significant number of people with mental health problems from BME communities mistrusted mental health professionals. SVB took the view that a community development project may be more effective in meeting the needs of BME communities and help reduce any fear and mistrust of mental health services. SVB also wanted to help Bradford BME communities develop their own mental health projects and strategies. SVB recognised that there was a causal link between mental distress, past and present social circumstances and that this had to be addressed: 'At the heart of its work is the view that poverty, racism, loneliness, relationship difficulties ... spiritual dilemmas are at the heart of most mental health crises' (24) (p267). Thomas and Yasmeen go on to describe two specific aims of SVB:

- Enabling people who experience distress, their families and others to develop sustainable solutions within the community.
- Liaison with statutory service providers to improve the range and quality of services.
- Stimulating a wider debate locally, nationally and internationally about the nature of distress, and the importance of diverse cultural perspectives' (p.267).

Helping communities establish peer support and self help groups is also a significant part of SVB work. Importantly, the SVB team consisted of five staff from the BME community. This includes two community development workers, one community engagement worker and a coordinator.

SVB was evaluated using participatory action research. Volunteers from BME communities received training to carry out essential parts of the work including facilitating focus groups, interview skills and questionnaire design. A total of 126 participants from the community took part. All had experienced mental distress. Findings revealed that participants valued the culturally and spiritually relevant support provided. Evidence was also provided that trust was now beginning to build between the community and statutory services, though a level of suspicion remained. Increased liaison with statutory services, training and employment opportunities and greater community awareness of the project was called for. A significant number of participants asked for increased representation and involvement from the BME community in managing the project.

A number of external stake holders were interviewed about SVB. They praised SVB for creating space where dialogue can take place between groups and organisations and helping improve relationships between services and community. SVB will continue to pursue alternative ways of working with people from ethnic minority groups on the basis that: 'participants wished to solve their problems in ways that are rarely available within mainstream services' (24) (p18). However the authors raise concerns that statutory service are often reluctant to promote and support what appears to some as radical practice based on democratic ideals.

## 6.4 Cultural Safety

Many focus group respondents in this survey were mistrustful of government services generally and their dealings with health professionals and health services. These perceptions were undoubtedly shaped and coloured by past traumatic experiences, their dealings with officials and for many people the experience of accessing or using health services. Some respondents provided accounts of encounters that were demeaning, belittling, unhelpful and at times unsafe. Notwithstanding that there are other dimensions of safety or quality of care that may have been wanting; in many instances the care received might be considered 'culturally unsafe'.

The term 'cultural safety' was coined in New Zealand in the late 1980s and became a requirement of nursing education in the early 1990s (25). It arose from the experience of New Zealand Maori and the way they perceived health care as infringing on their cultural wellbeing. The New Zealand constitutional document, 'The Treaty of Waitangi' guaranteed Maori protection, partnership and participation and cultural safety was developed as a means to deliver on these rights. Since then 'cultural safety' has gained currency as a useful concept for working with indigenous peoples in other countries such as Canada and Australia, and in thinking about safe practice in relation to minority groups in health care generally (25-27). The New Zealand Nursing Council (28), p.4 defines cultural safety as,

*The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.*

*The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.*

Whilst, the development and evolution of the concept of cultural safety in New Zealand can only be understood in terms of their particular cultural and historical context (25), the concept may have utility for thinking about good health and welfare provision in the context of migrant health generally. Culturally 'unsafe' practices contribute to the development of iatrogenic mental health problems related to accessing health and welfare services for all manner of problems. People who feel unsafe will not be able to take full advantage of available primary health care services, and may avoid services until dramatic and expensive secondary or tertiary intervention is required (25).

An important distinction between cultural safety and cultural awareness or sensitivity is that culturally safe practitioners do not need to necessarily research and understand the health beliefs and practices of others, but rather they reflect on their own culture so as not to impose their beliefs or stereotypical views on the minority (26). Cultural awareness or sensitivity may be beginning steps leading to the outcome of culturally safe care. Cultural safety for health and welfare professionals steps outside of ideological debates about integration or assimilation of minority cultures and emphasises that fundamentally health professionals share a common goal and ethical imperative to enhance wellbeing and to do no harm. What is a culturally safe service is defined by those who receive the service.

Some of the encounters described by respondents were blatantly racist. Reported experience of racism and institutional discrimination has been found to be related to poor physical and mental health (29, 30). A public health approach to addressing the mental health status of minority groups or communities must address personal and institutional racism. Whilst, most people would agree that racism by health or welfare professionals is deplorable and unacceptable, an emphasis on 'cultural safety' in the education, supervision and regulation of health professionals may provide a means to tackle institutional racism and directly promote positive mental health in the health and welfare sector. Such an approach would pay dividends beyond recent migrants or any one minority group.

## 7 RECOMMENDATIONS

The participants in this study specifically identified what changes could improve mental health for them and their communities: These were presented in the last chapter as:

- **Structural inequalities** in access to education, housing and employment which were all fundamentally linked to immigration and legal status
- **Increased information** about mental health services, health services in general and other social services.
- **Increased opportunities for integration**, independence and a chance to contribute to society and be understood and respected.

Based on these and all of the findings of this study, key recommendations are made which will have the potential to:

- Enhance the **social capital** of people within the new communities in Ireland
- Protect fundamental **human rights** of people within the new communities in Ireland
- Contribute to a more responsive and **socially cohesive society** with long-term benefits for all, particularly urgent in constrained economic times.

### 7.1 Health Professionals

There is a need for **health professionals** who come into contact with people from ethnic minority groups to actively develop **trust** and demonstrate their trustworthiness- based on a model encompassing Values Based Practice and **cultural safety** outlined above. **Values Based Practice** involves professionals understanding how diverse values interact, relate and impact within the experiences,

actions and care relationships in mental health care. This may require additional training for such professionals, including general practitioners, nurses, midwives. In particular, General Practitioners need to be able to respond to the levels of emotional distress described by participants in this study. Their preventative input will have long-term benefits for their patients and for communities more widely. This needs to build on existing initiatives and the effectiveness of training needs to be robustly evaluated, from health service users' perspectives.

**Language support** may also be required by health professionals in order to respond appropriately and in a culturally safe way.

This is the responsibility of the professional bodies (Irish Medical Council, An Bord Altranais [Irish Nursing Board], Irish College of General Practitioners etc). It will be measurable by service user led research.

### 7.2 Health Service Planners and Providers

There is a need for a range of services to respond to the needs identified in this study and a need to implement the approaches to culturally safe community-based care outlined in a Vision for Change and other mental health policy documents. The HSE National **Intercultural Strategy** is promising in its intent and needs to be implemented and evaluated. The strong hope is that the implementation of Intercultural Strategy, if it is to be successful in addressing the wider causes of inequalities in health, will provide mechanisms for community participation in planning actions, monitoring change and mainstreaming equality above and beyond the health service remit.

This is particularly critical for vulnerable groups. In particular there is a need for low level/non-specialist psychological support and care, primarily preventative services, especially in the form of **outreach services**.



**Counselling and psychological services** are also required in some cases and there is a need to provide accessible and affordable services. Since it is evident that those who participated in this study rarely adopt **solution-focused approaches** to their stresses, this is a particular need to provide services within this approach.

Those who have experienced trauma require accessible and affordable specialist and specific **trauma counselling**.

Those with severe difficulties or mental illnesses require access to timely and appropriate **specialist mental health services**, again outreach services are also required. Crisis intervention services are required to deal with emergency situations that arise, and where Garda involvement is particularly perceived as threatening. Following the independent assessment of need, the power to access appropriate and timely services must be with that assessor. Case management of people with complex needs can respond more effectively than the currently fragmented sets of services; this requires the empowerment of the case manager to access the required services.

### 7.3 Immigration Policies

Because of the profound affects of direct provision on the mental health of those within that system, there is a need to examine the fundamental principles and practices of direct provision- and to urgently consider more humane and just alternatives to it. The findings of this study support the calls of other groups (e.g. the Irish Refugee Council) for direct provision to be discontinued. Until this happens, the needs of asylum-seekers who are in direct provision are manifold and most critically require the following reforms:

- Additional **financial support** specifically to facilitate travel and social interaction. The current cash allowance of €19 per week is totally inadequate to allow even the most basic participation in society.

- The **accommodation standards** in both reception centres and hostels for those in direct provision must be independently and regularly inspected and upheld in a binding way. The management and interpersonal relations with those in such accommodation also needs monitoring and improvement.
- Opportunities to **work and study** need to be made available as these have been found to be the major sources of stress and distress in this study.

### 7.4 Social Policy-Makers

- For those not in direct provision, affordable and secure **rented accommodation** is required.
- **Community groups** fulfil the need for social interaction and support and need to be facilitated, with resources and facilities, to facilitate the strengthening of social capital of members of new communities. In particular there is a need to support community leadership and health promotion training within groups. Those who commit considerable time to such community work need to be recognised and financially and psychologically supported, as there is a natural movement of people to paid work when this is allowable for them, in order to make ends meet. This training and support should be bottom-up, with the needs identified in this and other studies of Cairde and others met.
- There are issues around **childcare and school support** that are about integration and affordability. Lack of access to affordable childcare significantly affects participation in education and work- where this is allowed, dependent on legal status. For those without the permission to work and study, childcare and school accessibility is also critical for social integration and well-being.

These recommendations address the key findings of this study and aim to address the stark needs identified for a sustainable, integrated and fair society in Ireland.

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## APPENDIX:

*This is an informal guide prepared by the Queen's University Belfast Science Shop purely for their own internal use. We are grateful to them for permission to reprint the guide here as it provides a practical understanding of the Science Shop approach to community knowledge exchange. For its part DCU is currently working on its own manual for the DCU Science Shop which we hope to release in the near future.*

## Queen's University Belfast Science Shop Operations Manual

### Introduction

This manual is a rough guide to the different aspects of running The Science Shop and is a guide rather than a rulebook. The aim is to indicate factors to be aware of before they happen rather than after they have happened. Most of it is based on experience.

The guide is in three parts; the first part refers to the initial meetings, whether it is with the community group or students. This is the most important element of the process as it lays the ground for later work. There follows a section on the development of the request, i.e. things to watch out for as the request progresses. The third section on completion looks at the loose ends that need tidied up.

### Groups

#### Initial Meetings – Find Out:

1. **Who wants to know?** This includes both the organisation/group concerned and the person representing the group. In the latter case it can be important to check diplomatically how representative the individual is of the group and it is important to realise therefore that the group may not share the individual's perspective on the question. Also if the person represents a committee it might be useful to check whether and when the committee changes personnel as new members may view the request differently.
2. **What is the question?** Try to agree a written statement of the question – after negotiation this can change.
3. **What are the time constraints?** When does the work need to be completed by? Must it start by a certain date? Does it need to take place at a certain time of the year? Why are these constraints being imposed? Sometimes constraints are set arbitrarily and may actually be negotiable.
4. **Why is this question being asked?** Answering this should include deriving a context for the request. This information is important both in terms of the basic Science Shop criteria and for later use. Being aware of the need for the request will help sell the request, particularly to students.
5. **How might the information be used?** This overlaps with the previous question. However, it is more specific. What will the group do with the results? Is it a possibility or a probability that they can act on the results? More importantly, is the person asking the question the same person who will act on the results? This information is important in terms of reporting to the student or academic what happened to their piece of work.
6. **What other assistance is being sought?** If other help is available will The Science Shop no longer be needed, or is The Science Shop input necessary to make things happen? The Science Shop worker needs to be careful that they don't take on the role of Community Development Officer – make your skills available and direct them to other resources when appropriate.
7. **Is money available?** If money is available then it should be pointed out to the group that The Science Shop can not be used to undercut University research services.

8. **What support can be provided?** Will there be a direct contact person for the staff member or student who gets involved and what other inputs can the group make? For example accommodation, travel and provision of office space.

### Point Out To Groups

1. The Science Shop is an intermediary – we do not answer research questions ourselves except in the most straightforward of cases. We do not ‘represent’ students or staff.
2. If undergraduates carry out the research the output can have variable standards and there are limitations to what individual students can achieve.
3. There will always be delays before the next action.
4. If any of the groups’ circumstances change then The Science Shop needs to be kept informed.

Document all of the above information as soon as possible after the initial meeting. Open a new file for the request and store information as per the information systems set up.

## University Staff

### Initial Meetings – Find Out

1. **What deadlines the students work to?** When do they finally decide on a project? When will work begin, when can fieldwork take place and when might the final project be delivered?
2. **Any minimum course requirements.** For example, some students need a psychological input into a study, some must use scales in a questionnaire or some may be expected to be placed in the organisation for a period of time.
3. **Extra information requirements** – sometimes academics/students will require extra information in order to answer the question.

### Point Out

1. What the question is, what the time constraints are, who wants to know etc – all the information derived from the initial meeting with the community group representative.
2. There may be some scope for adapting the questions; breaking it up if it is too complicated, adding parts in if it is too simple. This is important as students may get bogged down and feel if they cannot answer the exact question then there is no point in doing the project – this is not the case.
3. The role of The Science Shop is to ensure the smooth running of the project and acting as a reference point to both the community group and the student/academic if there are any difficulties.

## Students

### Initial Meetings – Point Out

1. There is support available from The Science Shop and the community or voluntary group to help the student while they are carrying out the project.
2. There are special circumstances and considerations for working with community and voluntary groups and on a real request. The question can change and develop. The need to develop good working relationships might also be referred to and remember, personalities will vary from request to request.
3. The advantages of working directly with a community group on a project
  - Helping the community
  - Answering a real question
  - Having the support of The Science Shop and the group

- Seeing the results of their labour put to use
- Unlocking data.

## Developing The Request

### Important things to remember

1. Write everything down – there are too many requests to keep details in your head. Record who rang whom, what they said, what information they said they would forward etc. Send written confirmation of any agreements made over the phone.
2. Most things can be renegotiated – if an aspect of a request presents problems (timing, location, size etc) explore other possibilities.
3. People will not always return your phone calls – call again after a few days, be persistent.
4. Do not put all your eggs in one basket – although a good initial contact may have been made it is good practice to make other contacts.
5. Emphasise the name The Science Shop – representatives of community groups may sometimes think of you as an academic and the academics may see you as part of a research centre.

## Upon Completion

1. Keep evidence of what was produced. A copy of the completed project is to be passed on to the commissioning group and a copy kept in The Science Shop archives.
2. Notify interested parties of completion.
3. Let the students and academics know what the information was used for.
4. Arrange publicity if desired.



