

# Ethnic Minorities and Mental Health in Ireland:



## Barriers and Recommendations





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# **Ethnic Minorities and Mental Health in Ireland:**

## **Barriers and Recommendations**

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**‘From my experience, clients come to solve practical issues and everything is in the background. I think it is important to explore [...] the pre-migration situations/stressors and pre-defined/pre-diagnosed illnesses such as depression, schizophrenia that has been diagnosed back at home. You learn about family breakdowns, bereavements, all sort of stuff..’**



**Health inequalities experienced by many ethnic minority communities are directly linked to the structural inequalities in Irish society and to the wider determinants of health. In a health context, it is well documented that there is a strong link between poverty, social exclusion and poor access to public services. Socially excluded communities often experience difficulty accessing information on their rights and entitlements and on available public services. A direct relationship, therefore, has been established between health status and social and economic factors, with differences in health experiences and life expectancy clearly linked to variables such as economic status, ethnicity and gender (Blackburn; 1991).**

Adopting the social determinants of health model, described above, recognises the wide range of economic, social, physical and psychological factors, among others, that impact on individuals' and communities' health. Studies invariably find that there is a very serious causal relationship between poor physical health and social and economic factors. These include accommodation, education and training, employment, childcare, financial security, residency status, racism and discrimination and other asylum/immigration issues, as well as access to and experience of health services. This model recognises that the circumstances within which people live affects their access to health services and their health status.

But what about social inequalities and mental health? The World Health Organisation (WHO) has defined mental health as '*a state of well-being in which the individual realises his or her own abilities, copes with the normal stresses of life, works productively and fruitfully, and makes a contribution to his or her community*'.<sup>1</sup>

Achieving mental well-being is also subject to a wide range of social determinants. In fact, mental health is intimately linked to physical health and there is ample evidence that demonstrates that poor mental health can be a consequence, and also a cause, of socio-economic and health inequalities.<sup>2</sup> Other factors that influence what constitutes mental well-being, include '*cultural beliefs about health and illness, societal values, norms and social influences*'.<sup>3</sup>

- 1 WHO, 2001 p1
- 2 WHO, Social determinants of mental health, 2014
- 3 Margaret M. Barry. "Addressing the Determinants of Positive Mental Health: Concepts, Evidence and Practice". International Journal of Mental Health Promotion Vol. 11 No. 3, August 2009.

As a community based advocacy organisation operating in the area of health, Cairde is committed to the empowerment of ethnic minority communities in order to facilitate their social inclusion and improve their health status. Cairde, therefore, advocates not merely for equitable health service provisions, but also works to address the broader social inequalities that impact on health. In this process, Cairde utilises the social determinants of health model for developing policy and practice. For Cairde, working from this model means employing a holistic understanding of health. In doing so, Cairde works with communities to identify and address factors affecting their health and mental well-being

Cairde has previous experience in analysing the factors that systematically affect ethnic minorities' health. As there was little or no existing data or information on health and ethnic minorities in Ireland, in 2005 Cairde conducted a health needs assessment on people from ethnic minority groups in Dublin North Central, utilising a community development approach. The research found that immigration status, accommodation, racism, discrimination, employment and education impact upon the health of ethnic minorities. Participants of this study also reported how satisfied they were with their health: 38% stated that stress, anxiety and/or depression were the main reasons they were dissatisfied with their overall health. Another project, 'New Communities and Mental Health: A Needs Analysis', conducted in 2008 by Cairde in collaboration with Dublin City University under the Science Shop Framework, also identified some of the barriers that ethnic minority communities experienced with regard to accessing mental health services. These barriers included:

- » Lack of information among ethnic minority communities about mental health services available in Ireland
- » Language and communication barriers
- » Cultural barriers and stigma attached to mental health

The participants also described the components of good mental health as *'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'*.<sup>6</sup> This research provided Cairde with a useful insight into ethnic minorities' experiences and their understanding of mental health. The analysis of the results allowed Cairde to focus its health advocacy and information provision work on the particular needs of the various communities. However, the project's limitations did not allow for a more in depth consultation with the communities regarding recommendations.

4 Sanders, T. and Whyte S. (2006) *Assessing the Health and Related Needs of Minority Ethnic Groups in Dublin's North Inner City*, Cairde.

5 Sanders, T. and Whyte S. (2006) *Assessing the Health and Related Needs of Minority Ethnic Groups in Dublin's North Inner City*,

6 R. Lakeman, A. Matthews, R. Munck, M. Redmond, T. Sanders, J. Walsh (2008) *New Communities and Mental health in Ireland: A Needs Analysis*, Cairde, DCU.



Cairde's on-going work through its health advocacy services has indicated that many issues leading to the exclusion of people living with mental health issues require attention. In late 2013, as a response to the growing number of mental health related issues presented by the users of Cairde's Health Information and Advocacy service, Cairde initiated the 'Be Aware, Be Well: Migrants Mental Health Initiative' which aimed to improve access to mental health services and to engage communities so that health services could reflect their needs. The main purpose of this initiative was to enhance knowledge about the many factors that shape the individual and collective experience of mental well-being or poor mental health among ethnic minority communities living in Ireland. A further aim of the initiative was to establish practices that could be pursued to promote and protect mental health. As Cairde saw the need for a concrete set of recommendations to address issues regarding mental health in ethnic minority communities, a main emphasis of the initiative was to establish a consultation process.

Funded through the National Lottery Fund 2013, Cairde's Be Aware, Be Well: Migrants Mental Health Initiative aimed to further explore the barriers and pathways of access to mental health services among minority ethnic groups by conducting community consultations. It also attempted to address the lack of recommendations as identified in the previous studies. The main objectives of the initiative were:

- » To facilitate the participation of ethnic minority communities in identifying their mental health needs and addressing barriers in accessing mental health services;
- » To build the skills and capacities of ethnic minority community activists in order to engage their own communities to raise awareness of mental health issues;
- » To collectively develop recommendations to address emerging issues;

The project was conducted in the following phases:

1. **A quantitative survey** of clients attending Cairde services was conducted between March 2014 and December 2014. 175 questionnaires were completed. The questionnaire was designed to identify if Cairde's service users or their close families had experienced mental health difficulties: what stressors were affecting them; where and if they sought professional or other help to deal with their issues; and what kind of support Cairde could provide in this area. The results of the questionnaires were utilized to inform the subsequent stages of the consultation process.

- 4 Sanders, T. and Whyte S. (2006) *Assessing the Health and Related Needs of Minority Ethnic Groups in Dublin's North Inner City*, Cairde.
- 5 Sanders, T. and Whyte S. (2006) *Assessing the Health and Related Needs of Minority Ethnic Groups in Dublin's North Inner City*, R. Lakeman, A. Matthews, R. Munck, M. Redmond, T. Sanders, J. Walsh (2008) *New Communities and Mental health in Ireland: A Needs Analysis*, Cairde, DCU.

2. **Consultations** with several ethnic minority communities and with health professionals, working with the ethnic minorities, were conducted in order to explore the use and experience of accessing mental health services, as well as the existing issues and barriers. The overall aim was to collectively develop solutions to address the issues affecting their mental health and establish practices that would enable ethnic minority communities to engage with Irish mental health services where appropriate. The discussions also sought to identify the informal routes that people follow when they do not engage with mainstream services.

These consultations also attempted to determine the information and support that are needed to foster leadership in mental health at the community level and to identify recommendations for change. 25 consultation meetings (16 focus group discussions and 9 interviews) took place between March 2014 and December 2014 involving over 100 participants.

The communities were selected on the basis of ethnicity, religion, gender and language. The following groups participated in the consultations:

- » African (3 focus groups with community members and 1 focus group with Pastors)
- » Chinese (5 interviews with community activists as well as community members)
- » Lithuanian (1 focus group conducted with minority mental health professionals)
- » Muslim (2 focus groups conducted; 1 with men and 1 with women - including both health professionals and community activists)
- » Polish (1 focus group with community activists and 1 focus group with mental health professionals, including psychotherapists and psychologists and 1 interview with a consulate representative)
- » Romanian (1 focus group with mental health professionals and 1 focus group with community members)
- » Roma (1 focus group with men and 1 focus group with women; both groups were of mixed backgrounds and involved both professionals and activists as well as individual community members)
- » Russian speakers (1 focus group of mixed background, involving both professionals and activists)
- » Eastern European (1 focus group of community members of Eastern European background)
- » Irish service providers (1 focus group, 3 interviews - included health service managers, mental health social workers, councillors, General Practitioners, domestic violence and family resource workers)

Different methodologies were applied to collect information from the various communities. Methodologies were chosen by the community activists carrying out the research in order to reflect that which they determined to be the culturally appropriate method for their group.

**3. Capacity Building Training in Mental Health** to ethnic minority community activists. This phase included the delivery of a series of training modules to community activists on mental health. 15 Mental Health Community Liaisons from various communities attended and participated in several capacity building activities that were organised to meet their needs.

A number of sessions were delivered on the topics below:

- » Mental health needs of migrants in Ireland and internationally;
- » Training in research methods;
- » HSE based mental health services. Pathways of access;
- » Counselling in Primary Care;
- » Wellness workshop for community activists; introduction to the services provided by Suicide or Survive and Jigsaw;
- » Working with people with mental health difficulties;

# Barriers to Accessing Mental Health Services



**‘I have a client who was diagnosed [...] with a psychosis. This person didn’t understand what is going on around her, as she didn’t speak English. So it was just situation psychosis. She was scared, there was a great confusion, and it was really a fear.’**



**This section explores the most common barriers that were identified by the participants of the focus groups that took part in this research and by the analysis of the questionnaires completed by our clients.**

The survey conducted among the users of Cairde's Health Information and Advocacy Centre shows that over 50% of the respondents do not seek help in relation to their mental health difficulties. However, if they decide to do so, informal sources of support such as family, friends, religious leaders or community activists are preferred to Irish mainstream services. The findings also show that if ethnic minorities decide to seek professional help, they tend to look for support among professionals from their own ethnic and/or cultural background. The feedback from the focus group discussions also confirms these findings.

But what are the factors that prevent ethnic minorities looking for support beyond their close networks of family and friends and beyond their own ethnic/cultural background? These factors vary as a result of financial and employment related difficulties, integration issues, changes in family structure, isolation and racism, to name a few. Moreover, often migrants come from utterly different health systems and thus have no familiarity with the Irish health care structure.

'I need to explain a lot [...]. They don't know what the difference is between a psychologist, psychotherapist and psychiatrist. Most people don't differentiate them, they need to be explained.'

(Lithuanian Focus Group)

Before moving on to discuss particular barriers to accessing mental health services, it is vital to remember that people come from different backgrounds and with different issues. While some might decide to migrate because of economic reasons and the lack of financial means to survive in their country of origin, others are forced to migrate because of problematic socio-political situations. Very often, the reasons are interlinked and the 'baggage' that ethnic minorities bring with them significantly shapes their experiences in the country of migration, as the quote below demonstrates:

'From my experience, clients come to solve practical issues and everything is in the background. I think it is important to explore [...] the pre-migration situations/stressors and pre-defined/pre-diagnosed illnesses such as depression, schizophrenia that has been diagnosed back at home. You learn about family breakdowns, bereavements, all sort of stuff...'

(Community Health Workers Focus Group)

### DISCRIMINATION AND RACISM

Discrimination and racism, both overt and covert, hold significant implications for the well-being of ethnic minority communities. Individuals participating in the consultation shared their experiences of racism, physical aggression or other forms of offensive behaviours, including bullying in the workplace.

The following are some examples of racism experienced by the participants of the focus groups:

‘It (racism) is such a broad term. There is no way to explain racism if you are not part of that group. You may not see it as racism. Once the person is conscious or has experienced it, they start to look at very little things and sometimes those things multiply based on the person’s experience or fear. For example, when I get on the bus, you will see when the bus fills up you are the last person to get a partner on the bus. It is not racism. It is an unconscious choice that people make when they jump on the bus, but people pick people like them [...] Sometimes I can sit on the bus and everyone has a partner except me. For a person who feels threatened, or [...] they feel a little discriminated that it is a big issue for them’.

(Community Health Workers Focus Group)

The experience of being discriminated or unwelcomed in Ireland was emphasised in the consultations with various groups. In particular, such experiences arise from interaction with neighbours, schools and Garda Síochána.

‘Yeah when you don’t report an incident, when you feel like you are afraid to go to report to the Garda because you think they are not going to do anything about it, of course that is stress, who are you going to depend, if the Gardai is not going to be on the side of the truth, who are you going to depend on then, you know. If you call an ambulance guy and if you are very sick, you don’t want to call an ambulance, you don’t feel like calling ambulance even though you are sick, how stressful could that be...’

(African Community Leaders Focus Group)

‘Another Roma guy was telling me that he was one time asked about why he was begging [...] the Garda took his passport and threw it out to the Liffey [...]. There are a lot of these stories [...]. If you are from unprivileged background like Roma [...] you have really little chances that the Garda will believe you’

(Community Health Workers Focus Group)

For some, dealing with racism constitutes an everyday battle. Experience of racial and ethnic discrimination has been associated with mental health problems such as stress, depression, anxiety, substance abuse and thoughts of suicide.

### STIGMA AND SHAME

Consultation participants emphasise the stigma attached to the concept of mental health. They widely share the opinion that shame together with isolation and exclusion are the most challenging barriers that ethnic minorities face when dealing with mental health issues. Thus the negative stigma attached to mental health impacts directly on migrant ethnic minorities help-seeking behaviour which contributes to further isolation.

‘From the African context [...] mental health as a topic is not spoken about. It does not exist. It is viewed as “mad”. Some people still have the perception in that if you are mad no one wants to associate with you. People don’t want to talk about it. They don’t want anyone from their community to know [...]. Someone from Nigeria doesn’t want another Nigerian person know the situation. It is across the board. It is madness. It is one word’.

(Community Health Workers Focus Group)

‘Romanians associate mental health with madness and losing control of reason, that’s why they are so scared of that’.

(Romanian Health Professionals Focus Group)

The stigma that comes with mental health issues is a significant barrier influencing individual’s willingness to search for support and services. In cultures where this stigma is particularly strong, individuals suffering from mental health difficulties are often considered to be problematic and shameful by their family and society.

### INTEGRATION

Integration is a multidimensional process and it involves numerous changes in people’s lives. The process of integration can range from the acquisition of a new language to adopting specific socio-cultural behaviours. However, integration is not a linear process. Cultural clashes and lifestyle differences appear to be one of the factors fuelling integration difficulties:

‘Russian speaking people with whom I interact are afraid to be assimilated, they are afraid to lose their Russian identity’.

(Russian Speaking Focus Group)

The quote below demonstrates how a lack of integration can impact on health and well-being:

‘I have been living here almost one year. For me the first period was very stressful. I thought I was just sick physically and I really experienced it. After returning to Poland all those symptoms disappeared. Then again, even on the plane landing in Dublin, I already felt those sickness symptoms again’.

(Polish Health Professionals Focus Group)

A lack of culturally specific community spaces was identified by some members of the focus groups as a factor that hinders the integration process. The sudden dislocation from a familiar culture can be detrimental as the following quote testifies:

‘We have been separated from our culture and plunged into this culture that is why the common everyday problems have become bigger here’.

(Russian Speaking Focus Group)

### DOMESTIC VIOLENCE

Domestic violence has been identified as a source of shame and embarrassment among ethnic minorities taking part in this study. It is evident from the analysis of the focus groups that the shame attached to the experience of being abused together with the stigma attached to mental health issues stop women from various ethnic minority backgrounds from seeking help.

‘There is a shame in the ethnic community is the shame that people know your husband doesn’t treat you properly that is a big shame. They like to put upfront that their marriage is perfect (there is no perfect marriage at all). But the point is they don’t want to be put in a shame that my husband is abusing me verbally or physically.’

(Muslim Women Focus Group)

Participants of the focus groups also agree that people facing domestic violence issues are afraid to seek help outside of their own community. They emphasise on many occasions that women do not usually seek help from the Garda and other Irish services due to cultural misunderstanding and language barriers. Moreover, the issue of surveillance from partners in domestic abuse situations was raised. It was emphasised that it is very difficult for women who are in abusive relationships to access any type of resources or services.



It is important to note that apart from the stigma attached to domestic violence, it can also cause or exacerbate mental health issues. Therefore, domestic violence can be both a barrier to seeking support while also a possible determinant.

### CULTURAL, COMMUNICATION AND LANGUAGE BARRIERS

Language skills significantly impact on mental health and general well-being. Language barriers experienced on an everyday basis can cause isolation, limiting the opportunity to interact in the host country. This is predominantly relevant for older generation migrants who often do not speak English and therefore are particularly vulnerable.

‘I have a client who was diagnosed [...] with a psychosis. This person didn’t understand what is going on around her, as she didn’t speak English. So it was just situation psychosis. She was scared, there was a great confusion, and it was really a fear’.

(Polish Health Professionals Focus Group)

‘They often use GP, they are referred sometimes to Irish specialists but they don’t go simply because they don’t know the language. Especially the older Polish would definitely not go to the Irish specialist’.

(Polish Community Activists Focus Group)

‘I had a client a Chinese lady who did not speak English very well. She said she wanted counselling services. She contacted someone on the phone and they said her English was not good: “You need to find some interpreters”. She said my friend can come with me. But they said ‘no’ because your friend is not a professional level. You have to get an interpreter from translating company. That is extra money. But she finally did not come back to me. [...]Communication is something we need to get a solution for’.

(Community Health Workers Focus Group)

Language barriers constitute a very significant factor that severely impact on the accessibility of mental health services. During the consultations, not only did participants discuss language barriers, but service providers also openly discussed how difficult it is for them to provide services while being unable to communicate.

Participants of the focus groups also mentioned that in migrant families where parents have not mastered the language of the country they relocate to, children and adolescents sometimes act as translators on their parents’ behalf.

‘Quite often we have family members translating as well, as it’s really inappropriate, particularly inappropriate when you have children translating for [...] it’s very difficult to conduct consultations, I would be very non-judgemental but the [child] is filtering everything...it just doesn’t go there what’s happening with patient...’.

(General Practitioner, Interview)

The use of children’s language skills therefore poses difficulties and challenges for both parties: migrant families and Irish service providers.

Some informal translation practices, as discussed during focus groups went beyond using family support when on some occasions other staff members in the hospital were asked to interpret during psychiatric examination.

‘[...] psychiatric exam is different to medical exam, it is very language dependent, the quality of communication is directly related to the quality of assessment and treatment, and so on... so it’s very important in that service. [...] but there is somebody on the floor, [...] say, cleaner who might be asked if they speak different language, and they might be asked to interpret. I am not happy with that. You know it’s different if it’s just, you know do you want jam or do you want cheese it’s fine, but when it comes to, you know communication around medical issues...it’s not ok’.

(Social Worker, Interview)

Lack of culturally sensitive and relevant services, bias and communication problems related to language barriers and cultural distinction were highlighted. For instance, downplaying the role of religion and spirituality in the client’s life or failing to take into account the client’s cultural values - these were all classified as clinical-procedural barriers.

‘It can be ethnic sensitivities, so they can, you know - I’m thinking of Roma client - we might have a Roma clients who comes to the hospital and we might have someone Romanian who speaks the language but there is an issue there because of the historical factors, there might be issues around trust that effects the quality of interpreting as well’.

(Social Worker, Interview)

### EMPLOYMENT AND FINANCIAL DIFFICULTIES

Employment related difficulties are identified by participants to significantly affect the mental health of ethnic minorities. Loss of occupational status and underemployment result in frustration, anger and lower self-esteem.

‘We lose our professional identity; people come here with 3rd level qualifications and they start sweeping the streets, [...] people lose their professional qualification automatically, no matter how strong we are. No matter how much we try to convince ourselves that things are well, our self-esteem starts from zero, or it’s even less than zero’.

(Russian Speaking Focus Group)

‘Depression...I could not find a job for a while, I was told that I was overqualified and I did not have relevant Irish experience. Then I got hired and sexually harassed while working. I had a breakdown, but I received support. I’m also in the situation of being less integrated and less paid than my husband, even though my qualifications are higher’.

(Romanian Health Professionals Focus Group)

Employment difficulties and financial insecurity have been associated with the increased prevalence of anxiety

‘My biggest stress is financially as I am single mother of 7 and I am claiming social welfare, so I fear that one day my payment will stop and I have no other source of income’.

(Roma Women Focus Group)

The difficulty of obtaining employment is strongly connected with immigration policies, which are specifically relevant for those migrants who are not originally from the European Union Area. Legal status directly influences one’s ability to find employment. Those ethnic minorities who are denied the right to work are more exposed to exploitative work environments and this greatly impacts on their well-being. Issues related to legal status do not only impact on the possibility of finding employment, but also on the ability to access services in general and health services in particular. Complex immigration policies greatly impact on the lives of minority ethnic communities and their well-being in Ireland.

‘Residency status issues... 8 or 10 years ago... 90% of Chinese people coming over came as students. You are not entitled to apply for citizenship. From student status to change to employment permit is very hard. Only few people can pass the system. Maybe they are here 7 to 8 years ... The recession ... Visa is a big issue. It is hard to renew and people do not want to be undocumented. Some people have become undocumented already. People are really nervous’.

(Community Health Workers Focus Group)

Focus group participants emphasised that meaningful employment contributes to the integration process by decreasing experiences of isolation and by enabling migrants to build social networks outside of their ethnic communities.

### ISOLATION AND LONELINESS

Often, as result of challenges faced while settling in the new country, and in addition to language barriers, participants highlighted that their peers and other community members are exposed to various degrees of isolation. This, along with lack of family or secure social network support, results in the pervading feeling of loneliness.

‘But in Ireland, you are always addressed as where are you from originally? So Ireland does not welcome other people. They blame us for not being able to integrate but also they are not creating the right environment for us to integrate. Lack of integration leads to isolation and what happens in France keeps repeating itself, for example. Sometimes you go to certain areas in Ireland you find yourself feeling you are in a different country’.

(Muslim Men Focus Group)

‘So people are stuck with their own people because you are afraid of being rejected by an Irish person or you are afraid because your neighbour is not happy looking at your children playing outside or they are throwing comments or giving you dirty looks, you know [...] but a lot of people who are, you don’t have anybody to talk to, they are just at home, they drop their kids, they come back, they have no communication with their neighbours. In this country where you are not, you know you just become shut up.’

(African Community Leaders Focus Group)

Whilst integration into Irish society was experienced as difficult, so was building connections with their fellow community members in Ireland. Many participants argued that this is a result of mistrust, confidentiality concerns or a perceived lack of empathy within ethnic communities.

Although some argued that friends, family and religious leaders were the first port of call in seeking support, others felt hesitation when seeking advice or help from these sources due to the fear that their story would be spread around the community. They worried that they might become excluded or a subject of derision.

‘Romanians are very mean, are not united, are isolated. You can’t go to another Romanian to ask for help, you have to stand on your own feet’.

(Romanian Health Professionals Focus Group)

‘In our community, we have close friends but everyone is too busy there is no enough caring for each other. We do not have family support, as a minority we feel vulnerable’.

(Lithuanian Focus Group)

‘[...] because I know a Nigerian lady, she get very, very sick, very sick and she refuse for any Nigerian person to know what has happened to her. She said I don’t want one single Nigerian person to know this, it became like a big secret, this woman had a serious illness. And that broke my heart, like she don’t want one Nigerian person she trusts, [...]’

(African Community Leaders Focus Group)

Many participants noted that issues of loneliness and isolation experienced in Ireland by ethnic minorities would not happen in the country of origin where people are part of an already established social support network.

‘And especially in terms of emigration - being somewhere, where you didn’t have time to build that support network or before and you have a child straight away and they you realise, oh dear I’m alone with the child, mum! Mum can’t take that child or she won’t make it that you can go upstairs and have some sleep’.

(Polish Community Activists Focus Group)

‘Secondly, we need to do everything on our own In Ireland. We cannot get any support from our family, like parents, sisters and brothers’.

(Chinese Community Member, Interview)

As highlighted in the focus groups, many migrants, especially single mothers, face extreme isolation. The loss of support that once was very strong in their home country can contribute to the further development of mental health difficulties.

‘The husband is constantly working and working and working... and after all come on how much time can you spend at home with children. Children mean decibels! Acoustically they can do a lot, especially when you add up...it’s very trivial but if you add up two nights without or with very little sleep through few months...your mental immune system gets weaker and weaker’.

(Polish Community Activists Focus Group)

‘I would also say isolation. Often times you have woman who are foreign to Ireland, does not speak language and is living far from the centre, they would be lonely and wouldn’t obviously have family members here so I think isolation would cause different types of problems and demotivate them to seek help. If she would be in contact with any other women, she might be able to go and seek help’.

(Muslim Women Focus Group)

## GENDER

From the analysis of the focus groups it emerged that while in some families traditional gender roles are challenged, in others they are reinforced. Some of the focus group participants explained that while migration provides a great opportunity to renegotiate traditional gender roles, it also represents a challenge. Changing gender roles seem to be a particularly prevalent issue among men when their role as breadwinners and head of the family transforms and it is a woman who either shares this post or becomes the main provider for the family. Therefore it was identified throughout the consultations that some men were struggling to deal with their changing role in the family structure.

‘Most of the issues we deal with is the change of culture of an African man and a woman who has always been low in his family coming into society and suddenly it becomes 50/50. And even actually, the woman has more rights than the man. It gets the man crazy’.

(African Pastors Focus Group)

All the participants mentioned the lack of affordable and accessible childcare as a major stress factor, emphasising that while this restricts their possibilities for finding employment, it also reinforces traditional gender roles.

‘I feel isolated as I have no social life due to the kids and all the housework because my husband has no role in helping me at all as he comes homes late from work and it’s also in my culture for men to be this way’.

(Roma Women Focus Group)

As explained by one of the women participants in one of the focus groups, childcare constitutes the major obstacle for women not only when they search for employment but also when they require basic support or advice.

The issue of cross-cultural marriages and their influence on mental health has also been discussed. The most commonly highlighted difficulties tend to be linked to communication and lack of understanding, not only linguistic but also on cultural grounds. Such problems were particularly prevalent among Russian speaking, Romanian and Lithuanian communities.

‘The intercultural relationships, for example in mixed families, there are a lot of communication problems and misunderstanding. I consider that miscommunication exist even when people speak the same language but when they come from different culture these problems multiply by 88’.

(Romanian Focus Group)

### ADDICTIONS

Participants revealed that some ethnic minorities turn to substance abuse in order to deal with the barriers and issues mentioned above. Alcohol was identified as the most prevalent addiction among the focus group participants, but this was also culturally specific.

‘Many Lithuanians have a feeling of loneliness as they leave families, hard to adapt. Many are lonely and isolated. It’s hard to interact with Irish, to become their friend. More often we become friends with other foreigners so there’s nobody to talk to when you come here. Also there is a culture shock. Person doesn’t know where to go, what to do. So they drink’.

(Lithuanian Focus Group)

‘From the medical point of view, the biggest problem Russian community deals with is addiction, this concerns people from Baltic countries also and it eventually leads to mental problems. At the surface there is stress and panic but the problem could be so deep that can even cause death’.

(Russian Speaking Focus Group)

Sometimes turning to alcohol or other substances is a last resort when searching for help, when all other possibilities fail.

### HEALTHCARE SYSTEM BUREAUCRACY

Participants from the Irish Service provider focus group in particular highlighted that how and where we deliver mental health services in Ireland is not conducive to easily engaging with the ethnic minorities. They viewed the bureaucracy of the system as a significant barrier to minority communities attending services. This 'bureaucracy' as they called it included the manner in which an individual can be referred into the service, the limited consultation time available to health professionals to build rapport with clients and ultimately decide the most appropriate care for them, the waiting lists to get into a service and the rigidity of appointment schedules.

'[...] so I meet tones of people who, really could do with the support of the mental health services and would be quite happy to but I have to unfortunately say I'm sorry, I'm not allowed work with you, you have to go and get your appointment through a GP, convince a GP to send you to a psychiatrist, convince the psychiatrist that you have a severe enough mental health problem so that eventually in maybe 9 to 12 months' time you will get an appointment where you might then get to see me officially, so I can officially be allowed to work with you. So how can that possibly be a service?'

(Irish Service Providers Focus Group)

The Irish service provider focus group discussed how the various barriers that the health system has constructed often lead many individuals to give up trying and thus resort back to the supports in their community. The services evident atypical approach to supposed early intervention leads individuals to enter the service at crisis point;

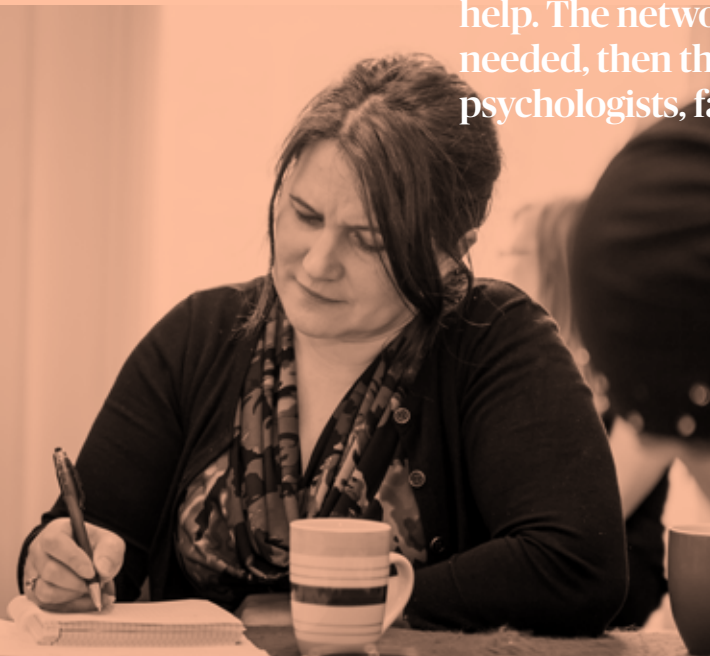
'There would be at least a 12 week minimum waiting list and then can I afford it, where is it located, how can I get there, there's so many barriers that they have to go through that most people are back to depending on their friends and family and sometimes church in relation to supports around it. And particularly if they're in crisis, the fact that they're in crisis and being told that they might have to wait 6, 12 months for this, it's too late for them. With ethnic minority communities we would definitely find that a lot of them would be more inclined to be at crisis point by the time we would get first contact and then'.

(Irish Service Providers Focus Group)





'What is missing is the multi-disciplinary teams, when a person is in crisis. One person, no matter how good is, can't help. The network of specialists is needed, then the person go to a GP, then psychologists, family to family support'.



# Recommendations



**‘Should religious leaders be trained in the area in mental health? The HSE should approach for submission of ethnic minorities on their approach on dealing with this issue as a religious entity. Then we will establish what is missing and needs to be addressed between both sides benefit from each other’s. There has to be training.’**

Participants of the consultation process identified a range of recommendations with respect to the barriers related to accessing mental health services and to the wider determinants of positive mental health. The recommendations stress the need for a multi-sectoral approach to mental health and well-being where actions are undertaken not only at a policy level, or within the health service, but also at a grassroots level, within the communities themselves.

A key component to the change would lie in the collaboration and partnership of health service providers and ethnic minority communities, leading to the development of accessible and culturally competent mental health services. The three key recommendations that emerged from this consultation process can be used as a tool in the development of such an approach.

### **3.1 BUILD ETHNIC MINORITIES' COMMUNITIES CAPACITY TO ADDRESS MENTAL HEALTH NEEDS**

Participants in the consultation process identified culturally specific understandings of the concept of mental health within their various communities as one of the major factors shaping not only the experience of mental health issues but also help-seeking behaviours. Community activists are often mentioned in the consultation process as a port of call for people facing mental health issues. In order to provide better support to community members experiencing mental health difficulties, people who are active in their communities should be offered training and acquire relevant skills and knowledge on the matter. Participants identified the need for a basic training with respect to mental health issues and services. This training would provide them with the ability to identify worrying symptoms, explain which of them require professional intervention and inform them how to make referrals.

#### **Mental Health Awareness**

Awareness raising activities about mental health and well-being should be delivered in a culturally appropriate manner. Information about mental health services for ethnic minorities should be provided in their native language with particular focus on issues related to certain communities. Such information should be made easily accessible through mainstream and migrant channels ranging from TV, leaflets or articles in ethnic media to information booklets.

The lack of information and support available in rural and disadvantaged areas requires more creative solutions regarding information provision. For example, an online information platform where people in need are able to search for relevant activities, workshops and therapies available at a community level as well as provided by mainstream services.

‘We should make leaflets – written information – and place it at the airport, churches, embassy on the notice boards. For the creation of the leaflet, regular migrants should be asked simple questions like “what is depression to you, how do you feel?” to create definitions in their own words’.

(Romanian Health Professionals Focus Group)

‘Because if we look back, the way we have it in our country, we don’t really talk about it, we don’t really know much about it. Maybe now it could be possible, we have that awareness about mental health but before I left home I have not heard about this mental health issue. So there should be an awareness of that, that yes this is, this is it.[...]Yeah something like it, so when you start feeling this way, it’s just to understand that there is something going on, so you need help’.

(African Community Leaders Focus Group)

### **Challenging Mental Health Stigma**

Stigma was raised as an issue universally across different ethnic minority groups involved in the consultation process. In order to challenge negative perceptions linked with the concept of poor mental health, anti-stigma activities should be developed and adequately resourced, targeting specific ethnic minority communities. Campaigns can work to reduce the stigma of mental health issues. Furthermore, targeting these campaigns at specific ethnicities may be crucial to their success. Such initiatives should inform, build acceptance and awareness that mental health is a common issue.

‘There needs to be discussion on the taboo of mental health’.

(Community Health Workers Focus Group)

‘Informative actions in order to sensitize the Romanian community towards mental health issues among migrants; [...] to raise awareness that there are people who are confronted with these problems and to motivate them, to change the people’s mentality about these things’.

(Romanian Focus Group)

### **Mental Health Training**

Mental health training should be developed for ethnic minorities, incorporating topics such as suicide awareness, domestic violence, life coping skills, anger management.

Mental Health First Aid training was also identified as essential. This training provides the skills and the confidence to comfort and support people in crisis until appropriate help is accessed. Community leaders and people active within their communities and interested in mental

health issues, will benefit the most from this type of training since they are often the first point of contact and most trusted among ethnic minorities, providing one-to-one support. These individuals can also further train smaller groups within their communities. The other element of this training could involve information regarding referral procedures and legal matters related to using mental health services in Ireland.

‘Should religious leaders be trained in the area in mental health? The HSE should approach for submission of ethnic minorities on their approach on dealing with this issue as a religious entity. Then we will establish what is missing and needs to be addressed between both sides benefit from each other’s. There has to be training’.

(Muslim Women Focus Group)

‘Now the man died suddenly, a young man. From Africa to go to an Irish white church, they are from different parts of Nigeria, and that has cultural implications of what happens next to their children. Now the pastor hadn’t a clue what he was dealing with. He doesn’t even know what to do. Because the family is not talking and the children are now, if you got the husband’s family that’s bye-bye, they’re never going to see them and if you go to the wife’s family, that’s bye-bye. They’re never going to see them. How do you begin to deal with that? You can’t change their culture. It’s something that needs to be recognized. You can’t adopt them into your culture that would be the wrong point. That’s not going to change. So the best thing to do, you have the pastors they can be intermediate, have the training, be able to navigate between the two and help people live in that balance’

(African Pastors Focus Group)

### Peer Support Groups

Culturally adequate support groups in the language of origin should be organised on mental health issues. Sharing with others who have similar problems or share migration and re-settlement experience is of utmost importance in managing mental health, not only for those immediately affected but also for their families and friends.

There is also a need to look beyond conventional therapies and explore building individual and collective empowerment, mindfulness, stress management, meditation and other relevant coping skills.

‘This was very helpful for me [...]. I was convinced then that this therapy is very helpful for families that go through bereavement; I know that this problem exists and that therapy brings healthy relationships in the family and helps deal with depression and other issues. This group is formed by people from all walks of life; teachers, poets, priests that speak openly about problems that are normally considered taboo’.

(Russian Speaking Focus Group)

### 3.2 IMPROVE ETHNIC MINORITIES' ACCESS TO MENTAL HEALTH SERVICES

It has been emphasised that mainstream services should be more accessible for ethnic minorities. In particular the following aspects of service provision should be considered:

#### Cost of Mental Health Services

Mental health services should be free of charge, especially for people on low income. This is particularly relevant when an individual is referred to a private counsellor who can provide services in their native language. Private mental health practitioners usually involve a significant cost. Accessing a quality mental health service through a GP referral should not be a financial burden for a person experiencing mental health issues.

‘Usually those people visit GP before, as they have problems, are stressed, cannot sleep. They come very often with antidepressants. GP is the main contact. But the more therapeutic service - no, and if so, usually it comes to money, as the Polish services are payable. People who have the Medical Card, they try to use other services as well. Many times, when people call me, the first question they ask is the price. They don't even ask how the therapy will look like or other issues, just how much the session costs and if the Medical Cards are accepted’.

(Polish Health Professionals Focus Group)

#### Quality Interpretation Service

At present, there is a need for qualified accredited interpreters in Ireland. This is particularly evident in the health services. As presented in the previous section of this report, the inability to communicate in the language of the host country was identified as a major barrier to accessing and participating in health service delivery. On many occasions, professionals mentioned how language barriers are often dealt with unprofessionally by using family, friends or unqualified staff members to act as translators.

Appropriate training should be also given to service providers in order to facilitate collaboration with interpreters. This should be delivered as a part of cultural competence training for professionals. Furthermore, information about interpreter services should be communicated to ethnic minority communities.

‘Language is a huge issue. Community members don’t want an interpreter that they know personally. And the interpreter must be trained in medical terms and be able to translate cultural issues’.

(Muslim Women Focus Group)

### **Cultural Mediation Service**

In developing culturally competent services, participants highlighted the need for cultural mediation. It was felt that Irish health professionals need to be more aware and sensitive with respect to the culture and beliefs of different communities. The roles of interpreter and cultural mediator have been defined as distinct functions which should not overlap. Cultural mediators should be employed to build a communication bridge between health care providers and ethnic minority patients, creating greater cultural awareness amongst healthcare professionals

‘This is all about culture. How can we integrate as a special service in Irish services? We can become professional interpreters in a group, because except for the language skills we have experience on how to make contact with a client/patient. To be able to read between lines, not simply to express what the person is saying but what he means by what he is saying. No interpreter will be able to translate this because they will not notice it.’

(Russian Speaking Focus Group)

### **Intercultural Training for Health Service Providers**

The training of healthcare professionals is an important part of cultural competency and it should be provided routinely in order to provide ethical and appropriate standards of care, diagnosis and treatment. Cultural beliefs and practices are used to provide explanations and coping strategies for mental health issues; they also influence how mental health is experienced differently by various cultures. Therefore the role of a particular socio-cultural context must be recognised and professionals must understand how individuals’ backgrounds and culture impact on their health status. The cultural competency training should have a consideration for the following aspects among others:

- » Pre-migration factors
- » Migration experience
- » Settlement and integration process in the new country
- » Trauma
- » Language and communication ability
- » Symptom expressions
- » Changes in gender roles
- » Intergenerational issues
- » Economic distress and employment situation
- » Marginalization
- » Resilience
- » Intersectionality of identities that come into play
- » Racism
- » Support networks

#### **Support for People in Mental Health Crisis**

During consultation it was highlighted that the current system is inadequate in terms of effectively dealing with ethnic minorities in mental health crisis, mainly as a result of lengthy waiting lists. Crisis interventions could be improved through strengthening networks and collaboration between agencies, and through the provision of additional tailored supports.

‘What is missing is the multi-disciplinary teams, when a person is in crisis. One person, no matter how good is, can’t help. The network of specialists is needed, then the person go to a GP, then psychologists, family to family support’.

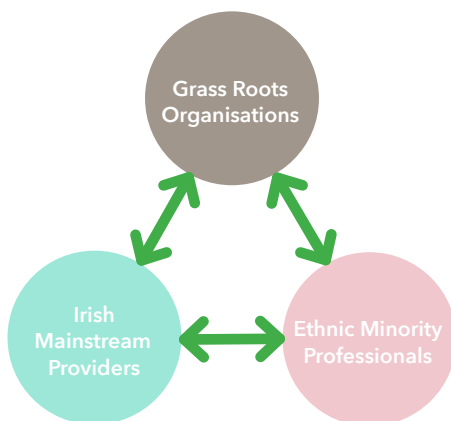
(Lithuanian Focus Group)

Participants also highlighted the importance of health advocacy services or any other support service that has workers who come from different ethnic and cultural backgrounds. In such settings people can receive advice from either their fellow nationals or someone who is fluent in a language that the client speaks. This reduces the potential for barriers and misunderstandings.



### 3.3 A PLATFORM FOR COLLABORATION

The need for equal collaboration was prominent throughout the whole consultation. Improved collaboration between Irish health service providers, grassroots organisations and ethnic minority health professionals was identified as vital.



‘It should not be as a 2 separate services private-ethnic, Irish-public mainstream, they should be connected...They are totally marginalised and nobody cares’.

(Community Health Workers Focus Group)

‘My question is; do we want to create a ghetto of Polish psychologists or do we want to do something what would connect us with Irish organisations? It is a plan to create a service acting together, not only between us, but also with someone else’.

(Polish Health Professionals Focus Group)

Participants suggested a platform or a forum where community members, ethnic minority health professionals and mainstream services providers could share ideas, skills and knowledge. Other key components of the effective partnership that were identified are listed below.

#### Resources to Participate in Mental Health

Ethnic minority led organisations should be adequately resourced to be able to deal with mental health issues as they arise. These resources could be utilised to fund mental health training and other initiatives; to fund peer mental health workers and community liaisons who would work at a community level supporting community members. These

resources should be allocated to grass roots organisations which would identify the specific needs within their own communities.

‘Definitely...support organisations that offer psychological help, either Polish or those who have Polish workers so they can be easily available...it’s difficult to get funding’.

(Polish Community Activists Focus Group)

### **Accreditation for Mental Health Professionals from Other Countries**

Through the consultation it became apparent that there is an urgent need to revise the rules of accreditation for individuals who already have professional qualifications in health related disciplines from their home countries. Current legislation does not allow certain health professionals qualified elsewhere to continue their practice without a long and expensive accreditation process that many cannot afford. As a result, professionals qualified in their country of origin are often unable to resume professional practice in Ireland and, as a result, are often greatly underemployed. They may work in jobs completely unrelated to their education or qualifications. Yet, these professionals could provide invaluable services to their fellow community members should they be employed within Irish healthcare sector.

‘It is also the issue of documents validation, often additional internship (which would be unpaid). So, there is a big time investment. Not everyone can afford it. When it comes to the private practice, when we finish our psychological studies we don’t need any additional requirements to meet. However, the problem starts with the accreditation, validation. If you don’t work for organization belonging to HSE or if you would like to be on the list, then it seems to be quite hermetic.’

(Polish Health Professionals Focus Group)

Employing multicultural and multilingual staff in mainstream services is also beneficial as it contributes to a diverse workplace environment, creating a cultural bridge between ethnic minority service users and Irish service providers.

‘Social workers and psychiatrists, it is crucial for the HSE to employ professionals to serve their own communities’.

(Muslim Men Focus Group)

**Directory of Mental Health Practitioners and Community Based Supports**

A directory of migrant mental health professionals and community based supports should be created and made widely available for mainstream providers in order to improve referrals to mental health professionals with particular language competencies. This will facilitate and improve the delivery of adequate care and after care support.

‘Not only Cairde, but other service providers they should have a list of ethnic mental health professionals who would work with clients if there is nobody in the mainstream services that would provide that particular service. But it should not be as a 2 separate services private-ethnic, Irish-public mainstream, they should be connected’.

(Community Health Workers Focus Group)

# Conclusions



Inequalities in mental health within any community impact society as a whole. Participants of the project, drawing on their own lived experiences, demonstrated the impact of a wide variety of social determinants on the mental health of the communities in which they live. Factors like discrimination and racism, employment, integration, culture and language concretely influence individuals' mental health and inevitably change the policy responses required.

Community participation is integral to the process of addressing the barriers identified. However, there are no formal provisions for community participation in mental health services design and delivery. The capacity to meaningfully engage in the process of identifying and analysing their own needs should be built into ethnic minority communities in order to develop their own mental health agendas and strategies to address social determinants of mental health.

The findings of this consultation also demonstrate that communities experiencing multiple forms of disadvantage and disempowerment need to address mental health stigma from within their own socio-cultural context. This means that existing anti-stigma campaigns and mental health initiatives do not reach minority ethnic communities and that understanding and awareness need to be fostered at a community level. National anti-stigma campaigns and initiatives must also move away from Westernised medical concepts of mental health illness and develop new approaches in order to target minority ethnic groups by placing greater emphasis on positive dialogue with communities, families, spiritual and religious leaders and youth groups. This would require developing new models of engagement to create more effective partnerships with ethnic minority communities regarding mental health.

## ABOUT CAIRDE

Cairde is a non-governmental organisation working to reduce health inequalities among ethnic minorities and is committed to supporting the participation of minority communities in enhancing their health. Cairde works through the rights based approach believing that the absence of equality and respect for human rights is correlated to the existence of health inequalities. Cairde supports new and existing community-based groups in taking an active role in the analysis and redress of the issues effecting them as well as providing individual advocacy and information to ethnic minorities.

Cairde operates two Health Information and Advocacy Centres in Dublin North Central and in Balbriggan, Co. Dublin. The centres provide individual health advocacy and relevant, culturally appropriate health information to ethnic minority individual and groups.

## CAIRDE'S CORE ACTIVITIES

### 1. Individual Advocacy

The Health Information and Advocacy Centre provides frontline support service, guided by the advocacy principles, to individuals from the disadvantaged ethnic minority communities. The range of interventions, depending on the issue presented, can include helping a client to access welfare entitlements or a medical card, support in filling forms or claims, negotiating with the relevant service providers over the phone on client's behalf, support in writing a complaint or accessing medical records.

### 2. Information Provision and Outreach

Cairde provides relevant and culturally appropriate information about rights and entitlements of ethnic minorities to health and other services. Information services can be accessed in one-to-one consultation; through phone/email; or in a group setting on an outreach basis. Outreach is an essential part of Cairde's work. In complex advocacy cases Cairde's Health Advocacy Officers also accompany most vulnerable clients to different locations such as local social welfare office or a hospital.

### **3. Group Support and Development**

Cairde supports and facilitates the Balbriggan Integration Forum. Established in 2012, it is a forum of representatives of local agencies, schools, voluntary groups and individuals working and living in Balbriggan who are also of various cultural and religious backgrounds including Irish, Polish, Nigerian, Congolese and more. BIF membership consists of 31 groups and residents of various nationalities. Cairde Balbriggan Centre is providing space to 16 various community groups with the overall membership of 294 people. In its Balbriggan centre, Cairde facilitates and coordinates Women's support and Development Group, Family Mirror group, English Literacy classes for Roma women and conversational English classes.

### **4. Networking, Policy & Research**

Cairde networks effectively with relevant statutory and non-statutory organizations to highlight ethnic minorities' experiences and outcomes from use of health services at a policy level. Cairde is engaged in building partnerships with health service providers at a local and national level such as hospitals, primary care teams and specialised services on health issues relevant to ethnic minority communities.







*Cairde*

*Challenging ethnic minority health inequalities*

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