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Foreword

The Intercultural Healthcare Pilot Project has been an exciting innovative response to the identification of the need to provide health advocacy for residents living within the five direct provision centres (DPCs) within the South East.

It is a collaborative working model developed by the Health Service Executive (HSE) and the humanitarian non-governmental organisation (NGO) the Integration and Support Unit (ISU) in Waterford. The model is based upon the principles of community development and empowerment and is transferable to other groups and regions.

Working with skilled and competent champions who have experienced the asylum seeking process in Ireland, we sought to enhance their knowledge and understanding of health services within the South East so that they in turn could provide access information and signposting to individuals and families currently seeking asylum and residing in this region.

Although the initial planning and proposal focused on asylum seekers, with the growing Roma population we expanded the pilot to include Roma Health Advocates. This has proved to be extremely successful with two strong Roma health projects now fully operational in both Wexford and Waterford.

The training and health advocacy learning was tailored to meet the emerging needs of DPC residents, which was challenging but also dynamic and effective. An example of which was the training in respect of human trafficking for both staff and services as well as for residents themselves, which led to further identification of needs and the provision of supports and services.

The project would not have got off the starting blocks had it not been for Ms Angela Joy, Senior Community Participation Coordinator, Regional Social Inclusion Team, HSE Community Healthcare Organisation Area 5 and Ms Anne Nolan, Manager, ISU, Waterford. Their insightfulness into the health needs of new communities, their experience in community development, their innovation and their determination have ensured the success of this project from an idea into reality.

It was clear from the start that Social Inclusion would not be able to address health needs outside of the mainstream health services. The participation of Susan Scully, Health Promotion (Chair of the Local Implementation Group (LIG) which oversaw the development of the project); Tara Hunt and Susan Murphy, the Primary Care Leads for the areas where the DPCs are located; Niamh McGrath, Primary Care Social Worker; Claire McNamara, Tulsa; Gerry Devine, Community Mental Health Nurse, Homeless Services; Andy Hargreaves, Substance Misuse Services; and Victoria Kalimo Rosette, Service User Representative was imperative to the success of the pilot project as it ensured that any blocks or gaps to accessing services could be addressed locally.

The external evaluation was conducted by Clonmel Community Resource Centre who were an invaluable asset to the overall pilot project. The evaluation findings show the complexity, achievement and learning from the pilot phase.

The learning from the pilot project has been immense for all involved. Key learnings include: the integration of services; the impact of the provision of targeted responses to vulnerable

groups; the development of stronger connections and improved communication processes between statutory and voluntary services as well as between statutory and non-statutory services; the welcoming of Community Knowledge Workers (CKWs) and Health Advocates to Primary Care Team (PCT) meetings and the acknowledgement of the skills and knowledge that they bring with them to this work; the development of a modularised intercultural awareness and practice training programme for staff and toolkit that will be shared nationally via HSeLanD and the national social inclusion office and the transferability of the model to other groups and regions.

The high standard of work and the importance of the model used have been acknowledged through its successful nomination for initial shortlisting and submission as a finalist in the Health Management Institute of Ireland (HMI) Healthcare Awards 2016.

I am delighted to welcome the 'Intercultural Healthcare Pilot Project Report' and wish the Health Advocate and CKWs well in imbedding this model through the services they continue to provide within the DPCs for asylum seekers and in the new Emergency Reception and Orientation Centre (EROC) for Syrian refugees. The model has been enhanced through the development of this work including within the Roma initiatives in both Waterford and Wexford within CHO Area 5. There is potential for transferability of this model to other CHO areas and within other settings

Kind regards,

Dr Derval Howley
Regional Coordinator for Social Inclusion
HSE, South East
CHO Area 5
August 2016

Executive Summary

This Intercultural Healthcare Pilot Project Report shows the successful working partnership between the Integration and Support Unit (ISU), a humanitarian non-governmental organisation (NGO) and the Health Service Executive (HSE within Community Healthcare Organisation (CHO) Area 5 in the South East of Ireland. This partnership approach resulted in the initiation and development of an intercultural healthcare model through this pilot phase during 2014/15. The pilot project aimed to develop a transferable and sustainable model of intercultural healthcare that can address gaps and barriers preventing equitable health outcomes for vulnerable migrant service users. Initiatives were developed to build on the intercultural skills, knowledge, capacity and experience of both service users and service providers.

This report shows the process outlined in detail through Sections 1 and 2, which relates to the methodology and findings of healthcare gaps for refugees, asylum seekers and vulnerable migrants. This pilot project was focused on asylum seekers living in direct provision centres (DPCs) as they are a unique group with health needs and who may experience health inequalities that are further compounded by their lived experience in DPCs. A key health concern is mental health and wellbeing, which can be linked to a lack of social supports, trauma and persecution experiences, having no control over their lives, not being able to articulate their needs due to language barriers and living in uncertainty. Evidence of how the pilot project developed within the social determinants of health model is shown throughout this report.

> The need for improved communications with asylum seekers and refugees and coordinated action between agencies within and beyond the medical system is widely noted. Improved data to support intersectoral working to address the healthcare needs of asylum seekers and refugees are imperative.[1]

There is limited data on the health status of asylum seekers and refugees in Ireland, with access to health services based mainly on entitlement or ability to pay. Barriers to accessing health services include language difficulties, cultural issues, gender sensitivities, distance from services and a lack of information published in other languages. The direct provision accommodation system and the length of the asylum process can have a negative impact on health outcomes. Impediments to access relate to how health services are delivered and the wider context beyond the medical system, where non-governmental organisation (NGOs) can assist in identifying the hidden needs of vulnerable migrant groups. Access to primary care is promoted by collaboration between multidisciplinary teams and facilitated through outreach supports and advocacy to organise for example hospital appointments and general practitioner (GP) registration.

A training programme was designed and delivered to up-skill peer 'Community Knowledge Workers' (CKWs) who had themselves lived in direct provision or were members of vulnerable minority groups, to assist with the research process. A Local Implementation

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[1] Bradby, H. Humphris, R. Newall D, Phillimore J, *Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region*. Copenhagen: WHO Regional Office for Europe, 2015, 'Health Evidence Network Synthesis Report', p44

Group (LIG) was established and oversaw the project development, including the need for health and wellbeing research.

This research was conducted as a peer health and wellbeing research programme to establish a baseline of the healthcare needs of residents in direct provision, and the analysis of findings is detailed in Section 2 of this report. Findings are evidence-based by a sample selection of case studies across a number of categories, for example, child and family health, impacts of social determinants of health on individuals, and human trafficking.

There is a need to ensure that this work remains focused on ensuring equitable access to health promotion and disease prevention for our target groups. In 2014 Ireland reported that it had 5,853[2] refugees/asylum seekers. This figure is likely to continue to rise to facilitate programme refugees from Syria and Afghanistan. In 2015 Ireland had 1,450 first-time applications for asylum.[3] It is not clear if these figures include undocumented migrants, unaccompanied minors or Roma. In Waterford 10.8 per cent of the total population is registered as non-Irish; this is just one of the counties within the CHO catchment area.

Evidence-based public health measures to mitigate the health implications of migration could save a significant number of lives and reduce suffering and ill health. Insufficient knowledge hinders effective planning and implementation of effective strategies to address migration and health.[4] To address this, HSE Social Inclusion made a successful funding application for the pilot project through the HSE National Social Inclusion Office, which included the requirement for an external evaluation.

Clonmel Community Resource Centre (CCRC) secured this tender following a tendering process. CCRC has been engaged as the external evaluator since the end of 2014. The evaluation report of the pilot project is contained in Section 3. CCRC has all evaluation documentation available.

Section 4 is the concluding section, focusing on overall outcomes of the programme and identifying observations and recommendations for future intercultural healthcare developments in the South East and beyond. The process mapping documented throughout this programme, and copies of methodologies such as the questionnaire, steering committee membership and structured meetings, etc. are included in the Appendices at the end of this report.

This pilot project is underpinned by a number of policies and practices shown throughout the report. These link to the vision of a healthy Ireland, where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone's responsibility.

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[2] UNHCR (The UN Refugee Agency) 2015
[3] 'Healthy Ireland; A Framework for Improved Health and Wellbeing 2013–2015'
[4] Op cit. Health Evidence Network Synthesis Report, p 44

Section 1 Overview

Section 1 provides an overview of the pilot project's context and development.

1.1. Overall Aim of Intercultural Healthcare Pilot Project

To develop a model of intercultural healthcare that will address barriers and gaps preventing equitable access to health services and supports. The project is focused on those who experience cultural disadvantage and those who provide health and social services to them. This pilot phase concentrates on asylum seekers who live in direct provision accommodation centres (DPCs) within the HSE South East region of Ireland (Carlow, Kilkenny, Waterford, Wexford and South Tipperary)

1.2. Rationale

Evidence gathered over a period of time confirms that the health and wellbeing of asylum seekers in DPCs is impacted upon negatively due to their current living conditions over which they have no control.

The following policies and elements further informed the development of the pilot project and therefore the model development: the HSE's 2007-2012 National Intercultural Health Strategy[5], Health Information and Quality Authority's (HIQA) National Safer Better Healthcare Standards[6], and the Healthy Ireland Framework, which envisions a healthy Ireland where everyone can enjoy physical and mental health and wellbeing to their full potential, and where wellbeing is valued and supported at every level of society and is everyone's responsibility.[7]

1.3. Social Determinants of a Health Model

Community-based health models promote the medical and non-medical aspects of health and consider the impacts that our lived environment has on determining our health and wellbeing. Many of the participants in this pilot programme are carrying the physical and mental impacts of their previous environment with them, for example, poor nutrition, poverty, war, trauma, working in dangerous environments or with hazardous materials/by-products (mining, making bricks, silk dying, etc.) often linked with issues of poverty or trafficking, previous ill health, no access to retroviral or other drugs, etc.

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[5] Health Service Executive: National Intercultural Health Strategy 2007–2012 (2008), available at www.hse.ie/eng/services/Publications/Social
[6] HIQA National Standards for Safer Better Healthcare (2012), available at www.hiqa.ie/system/files/Safer-Better-Healthcare-Standards.pdf.
[7] Healthy Ireland; A Framework for Improved Health and Wellbeing 2013–2025, available at www.health.gov.ie/healthy-ireland
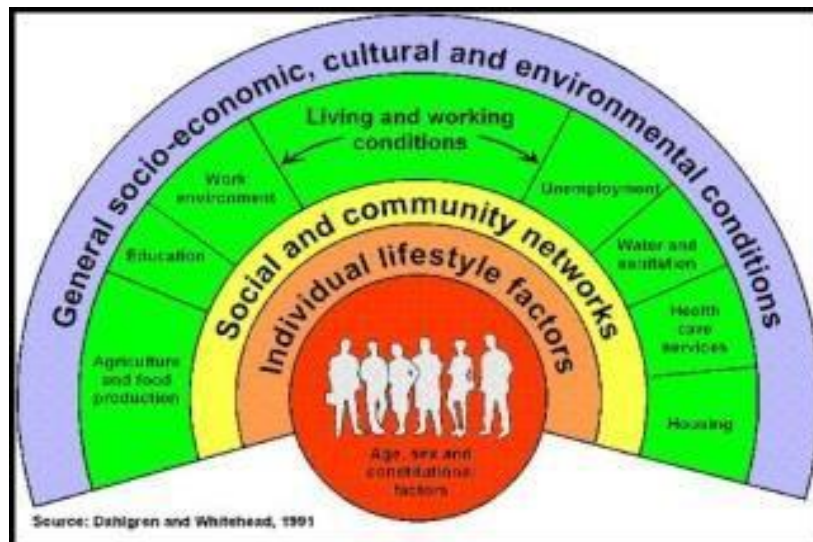
Figure 1

Each of the five social determinant areas (see Figure 1) reflects a number of critical components/key issues that make up the underlying factors in the areas of social health, which include neighbourhood and the built environment; health and healthcare; social and community factors; educational/information; and the current economic status of the environment.[8]

1.4.   Some Intercultural Considerations for Health

Cultural differences and understanding of what are acceptable behaviours in the context of now living in another country should always be considered; it cannot be assumed that refugees, asylum seekers or other migrants are familiar with this country's laws regarding childrearing, age of consent for sexual relations or marriage, and patriarchal or matriarchal dominance, including domestic or sexual violence.

- **Poverty issues** for marginalised and vulnerable groups lead to other concerns, for example, malnutrition, childhood vaccinations, school attendance of their children, and in some cases legal implications, for example, where Roma children may accompany adults for street begging/selling purposes, placing them at risk.

- Links to **human trafficking** where sexual violence is endemic in the trade of victims. Trafficking is not necessarily linked to gender (no one is immune from abduction for trafficking); however, it is generally acknowledged that higher incidences of women and girls are trafficked for sexual services and the porn industry, as opposed to men who are usually trafficked for labour purposes or criminal activity (rent boys are often victims of trafficking for the male sex industry regardless of their own sexual orientation).

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[8] Social Determinants of Health adapted from Dahlgren and Whitehead (1991) and Grant Barton (2006) cited in Healthy Ireland Framework

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- **Unaccompanied minors** who present in Ireland have limited protections in all areas of health and wellbeing once they reach the age of 18 years, despite their increasing levels of vulnerability (many succumb to addiction, self-harm and suicide ideation as a means of dealing with traumatic experiences in their life).

- **Mental health problems** are increasingly identified throughout migrant communities, whose members are reluctant to acknowledge their symptoms due to the cultural stigma and isolation in many cultures that still experience the fear and overbearing influence of witchcraft practices regardless of where they are now located in the world.

Essentially it is important to highlight that we cannot treat health in isolation and need to consider the coordinated interagency supports required by vulnerable migrant groups (regardless of status) to achieve a holistic approach to their immediate and long-term wellbeing.

This pilot project is underpinned by the ISU healthcare programme and the HSE's National Intercultural Health Strategy 2007–2012.[9]

The main issues and recommendations highlighted through the Intercultural Health Strategy are:

1. Access to services
2. Data, information and research
3. Human resources and organisational development

The following subsection sets out the agreed aims, objectives and projected outcomes for the pilot phase of the project as a means of addressing the needs of vulnerable migrants, and developing the model, including its transferability to other groups/areas.

1.5. Aims, Objectives, Expected and Actual Outcomes

<u>Aims</u>

1. To improve the health and wellbeing of marginalised refugees, asylum seekers and other vulnerable migrants, especially those living in the DPCs in the South East.

2. To provide a training course for up to 10 non-Irish nationals in the provision of a peer-led community-based health service as CKWs and Mentors.

3. To identify inequalities that may exist in healthcare provision for those living in DPCs through research and development to enhance outcomes.

4. To act as a support between these health service users and health service providers to provide access to information, medical cards, GP registration and other primary services.

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[9] Health Service Executive: National Intercultural Health Strategy 2007–2012 (2008), available at www.hse.ie/eng/services/Publications/SocialInclusion

5. To monitor, evaluate and develop best practice guidelines for this model to be transferable to other areas and adapted to other groups, for example, LGBTI or Roma.

Objectives and update of actions

1. **Establish an intercultural primary healthcare group of CKWs.**

   A team of four CKWs is now established, along with three ISU staff who provide additional supports toward the provision of equitable health information, access and advocacy. This shows the alignment of the work within the ISU and the commencement of the development of the model.

2. **Develop and deliver training opportunities for the CKWs.**

   Training gaps identified and a comprehensive programme of accredited and non-accredited training elements put in place. A table of completed training is listed in the Appendices.

3. **Engage with HSE Primary Care Teams (PCTs), health promotion, statutory agencies, and community and voluntary agencies to support the process.**

   A Local Implementation Group (LIG) was developed as a management structure for the pilot project with interagency representation. The LIG is one of the structures within the community participation strategy of primary care and has facilitated the process of interagency engagement and referrals now in place.

4. **Host a series of information sessions about the process for potential participant groups.**

   Four information sessions were held to explain the process relating to the participating centres. Other information sessions and meetings were held with stakeholders within the catchment area.

5. **Get CKWs engaged with the clients and identify potential new clients who will benefit from the process.**

   Clients were identified from the current ISU database as well as self-referrals from clients with health needs. This will be an ongoing process due to the transient nature of this client group of service users.

6. **Map out prioritised health areas for discussion and delivery, including information directory and access/referral routes to services.**

   Access to information, medical cards, GP registration and assistance with mental health and sexual health were prioritised by client groups through information sessions. Human trafficking was added at a later date by client request.

7. **Inform GPs of the process to keep them updated about developments and link with other services/information they may have to offer.**

   All relevant PCTs members have been informed through meetings with the project partners about the project facilitated by relevant PCT leads who are members of the LIG. It is envisaged that this will be further enhanced by the sustainable development of the model post-pilot phase. It is envisaged that positive change in organisation structures and operating procedures that incorporate this model will be further developed in all partner organisations.

8. **Provide opportunities for diversity training for frontline service providers.**

   Intercultural training tender process completed; Quality Matters and Nasc provided training to HSE teams, CKWs and other agencies in the community. CKWs and 22 individuals have successfully completed the Train the Trainer course as a follow-up and will provide training in agency/community settings.

   An information session about the asylum seeking process and its impact on asylum seeker health and wellbeing was delivered for health and social care providers. Some of the CKWs shared their personal experience as part of this.

   A human trafficking seminar for service users was held as part of this pilot project. Some members of the LIG attended this seminar.

9. **Conduct research and development where required to enhance the project outcomes.**

   At a very early stage it was evident that research would be required to establish a baseline of the needs of the beneficiaries, which became a much bigger piece of this programme than had been originally anticipated. (See Section 2 for findings.)

10. **Document the model to inform other areas.**

    Model documented as part of the development and completion stages throughout this report. The report and associated appendices, including the mapping process, will help to develop a toolkit for other areas/groups that can benefit from similar interventions and our learning.

11. **Evaluate the model from the commencement of the project to measure health-related outcomes, such as increased health information and engagement.**

    Section 3 of this report focuses on the external evaluation of the process, including the goals already reached and key recommendations.

1.6. Expected and Actual Outcomes

Expected Outcomes	Actual Outcomes
Clients are better informed about the health services on offer, which will lead to increased access and participation in a coordinated way.	More clients are now in possession of medical cards and accessing health in a more appropriate way. There is a decrease in the use of A&E as an initial course of accessing health. The CKWs have the knowledge and skills to discuss and refer service users, especially within culturally sensitive areas such as mental and sexual health.
Training programmes delivered to community leaders (CKWs and ISU staff) who provide peer supports and information within their respective and wider communities in line with best practice models, for example, mentoring.	Training delivered, leading to a QQI Special Purpose Award in community-based healthcare. Increased dissemination of information, advocacy and mentoring through outreach services. Further links into the community now in place.
Linked to issues of access: communities enabled to facilitate, identify and make decisions around their health needs.	Communities better informed and requesting specific supports, some delivered on-site in DPCs, for example, health information sessions, Health Outreach Workers in place, advocacy supports, etc.
Longstanding health and quality of life issues dissipated with increased engagement and knowledge acquisition.	Additional supports and successes with sourcing required services. Mental health information pack developed and delivered to each DPC with follow-up from CKWs. Evidence from CKWs of appropriate sexual health referrals made to the Sexually Transmitted Infections clinic in University Hospital Waterford (UHW). Still some gains required, especially in the areas of accommodation and resettlement for beneficiaries during transition periods.
Migrant communities will themselves benefit from increased engagement and leadership from peer models from within the community.	Increased interest in education and language programmes (109 now attending ISU for English language classes each week). Improved language enables participants to become community leaders, some representing their community on local development structures, for example, PPN (Public Participation Networks).
An integrated approach developed by the health service providers for conducting health needs assessment that includes equality and diversity – with a strong community participation element.	Some signs of improvement but stakeholder buy-in still required for continued benefits, for example, agency providers in areas such as optical and dental health services would benefit from additional information and opportunity to participate in intercultural training.

1.7.   Structures/Partnerships

The **Integration and Support Unit (ISU)** and the **HSE Social Inclusion Team in CHO Area 5** (South East) have been working in partnership since 2013 to initiate and develop an Intercultural Healthcare Programme through a pilot phase in 2014/15.

The ISU is a humanitarian NGO based in Waterford City, meeting the needs of refugees, asylum seekers and other vulnerable migrant groups. Since 2006 the ISU has served in the region of 4,000 clients within the South East region. The ISU work with other NGOs, agencies, academics, researchers and the private sector to provide a variety of supports to clients, including but not limited to: intercultural healthcare and family support programmes, advocacy, integration, professional service referrals, English language classes, outreach services (particular attention is paid to those living in DPCs), coordinated supports for victims of human trafficking, policy development, education, training and employment programmes, minority youth protections and initiatives and assisting frontline providers with important resources and information when communicating and serving vulnerable client groups.

The ISU has an integrated approach to services provision, linking language and training with employment needs and community needs through local peer advocates. Services are provided in a holistic approach, which takes into account cultural needs and more. This work is based on core principles of promoting basic human rights, respect to all, social inclusion and integration. The main service users are asylum seekers, refugees and the Roma communities who present in person through the drop-in service or who may be referred through other sources/agencies.

The HSE Social Inclusion Team in the South East (now CHO Area 5) covers five counties: Carlow, Kilkenny, South Tipperary Waterford and Wexford. Its overarching aim is to improve health outcomes in the South East for minority and vulnerable communities. The significant role of poverty in all its formats in influencing the health status of socially excluded service users requires a socio-determinant approach. As noted in the National Intercultural Health Strategy (NIHS), 'socio-economic factors exert a powerful influence on health status. Poverty is a particularly significant factor leading to health inequality and subsequent poor health outcomes'. Furthermore, 'the links between poverty, ethnicity and health status are well established, while the broad range and nature of social determinants that have an impact on health is widely accepted'.[10]

In 2013, the HSE Social Inclusion staff worked with the ISU to deliver on a range of health actions in accordance with the ISU Intercultural Healthcare Programme, which was initially developed in 2009, and the HSE's National Intercultural Health Strategy 2007–2012.[11] This collaborative approach has initiated the further development of the project and ensured greater engagement of other HSE services, for example, primary care leadership and services in South Tipperary and Waterford and health promotion and substance misuse services in Waterford.

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[10] Health Service Executive: National Intercultural Health Strategy 2007–2012 (2008), available at www.hse.ie/eng/services/Publications/SocialInclusion
[11] Ibid

The ISU, through regular consultations with clients living in DPCs, identified that concerns of health and wellbeing were increasing. In 2009/10 the ISU developed a comprehensive healthcare plan to address those concerns but did not have the financial or staff capacity to deliver on all of the actions. The health and wellbeing initiatives initiated by the ISU can now be seen as the pre-development stage of this pilot project.

1.8.   Client Group/Service Users

At the initial stages of developing this model a decision was taken to focus on the people living in the five DPCs in the South East. The focus on the health implications for asylum seekers living in DPC accommodation requires an understanding of what their health needs are, as well as the poor life experiences that are underlying factors of their current health status. We cannot focus on the physical aspects of health alone but should consider the other factors that require the understanding and supports of health service providers. Asylum seekers living in DPCs:

- Can have little information or knowledge of how to access the appropriate healthcare services to fully meet their needs

- May require specialist assistance to overcome issues of language, literacy and basic health knowledge

- Need access to medical cards for basic services,

- Require recognition of gender and cultural difference

- Have little understanding of Western childhood diseases and the value of immunisations

- May be survivors of torture and trauma or human trafficking

- Have experienced traumatic journeys coming to Ireland.

The DPC system was established to provide the basic needs of asylum seekers while their application for refugee status is being assessed. Their placement in DPCs is outside of their control: with limited choice on where they want to live, which foods to eat or the type of accommodation available to them; children share rooms with parents and reside with other adults in communal living. The high numbers of residents in communal living could potentially impact on the persons overall health and wellbeing. Understanding the relationship between how such population groups experience their place in the community and the impact of 'place' on health is fundamental to the social determinants of health, including both social and physical determinants.[12]

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[12] 'Disparities in Health Care: Methods for Studying the Effects of Race, Ethnicity, and SES on Access, Use, and Quality of Health Care', The Institute of Medicine, 2002

1.9. Developing a Project Model

The development of this model required that there was agreed understanding of purpose, common to all stakeholders, leading to clarity of aims, objectives and outcomes.

In order to identify and address any barriers to equitable health information and access, the developing model is underpinned by the two key principles of knowledge transfer and competency development; these have been developed through the increased realisation of the need for raised awareness and greater understanding, together with enhanced capability to address them for all stakeholders. While some of this relates to the training and information sessions delivered, it also relates to the process of developing a LIG, which has enabled developments beyond individuals within organisations and structures, understood as 'alignment'.

Alignment is important in developing this model as a means coordination of activities of different people from different organisations aligned around this common work. For transferability and sustainability, alignment within organisational structures and procedures is needed. Some of this is developing and is evident in the ISU as health outcomes have become a clear focus of its work, and the HSE Social Inclusion Team has developed intercultural health and Roma health as CHO strategic developments linked to national health strategies and structures.

The involvement and participation of communities and individuals in the design and implementation of this pilot project and its initiatives to tackle social exclusion and poverty in the context of preventative, primary and community-based healthcare and other local services have been supported and actively encouraged. This is another example of aligning the activities of community, voluntary, NGO, statutory and regulatory organisations to achieve a common purpose. At the commencement of this project the decision to focus the pilot phase of the intercultural health project on people living in the five DPCs within the South East region was made because at the time these were deemed to be the most vulnerable of minority groups.

1.10. Planning for Project Start

Following communication from the HSE Regional Social Inclusion Office to the Reception and Integration Agency (RIA), a meeting between the RIA and HSE Social Inclusion in the South East was held to discuss the project. Other initial information steps taken included the HSE Social Inclusion staff visiting each DPC to meet centre managers in person, and the ISU (as the project office) sending information letters to each DPC manager. The HSE held a national consultation process in Dublin, the outcome from which was also fed into the report, and the chairperson of the pilot project Local Implementation Group (LIG) and ISU manager attended to represent the South East.

A regional information session on the asylum seeker process and the impact on their health was provided for health and social care staff. The HSE Social Inclusion context, the asylum process and ISU Centre information were presented at the session. A number of the CKWs were supported by the project to share their personal experiences of living in a DPC and the impact on their health and wellbeing. Approximately 20 staff from health services and supports attended and feedback was very positive; the CKWs' sharing of their personal

experiences was the most commented on. This feedback in turn had a very positive impact on the CKWs during the reflective learning following this event.

The ISU Outreach Worker position covering the five DPCs became vacant during the pilot project and a volunteer worker from the ISU was successful in obtaining the part-time post. She participated in all the training within this project. The post was funded until November 2015 by the Edmund Rice International Centre but is now funded by HSE Social Inclusion with an enhanced health focus to the position. The need for a male Outreach Worker became evident during this project because of personal safety, cultural and gender based issues. This need is currently being addressed.

The racist attacks on Roma families in Waterford during this time resulted in some families being displaced, leaving the Roma community presenting as significantly vulnerable. Supporting initiatives that were developed through the life of this pilot project became central within HSE Social Inclusion, in partnership with the ISU and the newly established Waterford Roma Interagency Group (WRIG). Roma health services and supports were also later developed in Wexford. The Roma Health Advocate employed by the ISU and funded by HSE Social Inclusion was included in all the health advocacy training provided within the healthcare pilot project.

1.11. Development Process

As outlined the ISU and HSE Social Inclusion staff worked in partnership to initiate and develop the intercultural healthcare project; this is a key component of the process. At the initial stages of development both agencies met with the HSE Primary Care Lead for Waterford to discuss the pilot project and plan the next steps forward. It was agreed at this stage to develop a LIG as the management structure similar to the practice within the community participation strategy of primary care HSE. The LIG was established with agreed terms of reference developed in October 2014 and revised in June 2015. (See Appendix 1.)

The ISU discussed the pilot project with some clients and other stakeholders, for example, tutors, trainers and other groups and agencies. Through this and the ISU's direct work with clients they identified and recruited potential participants.

The HSE's Regional Community Participation Coordinator (RCPC) met with potential LIG members to discuss the project and the development/membership of the LIG structure. These meetings were held with representatives from Waterford Tusla and Waterford HSE Health Promotion, the Community Mental Health Nurse, the Homeless Services Team in Waterford City and County, Primary Care Social Worker in Carrick-on-Suir, Co Tipperary and discussed with the Transformation Development Officer managing PCTs in South Tipperary. A link was also established with Waterford Women's Centre and the Local Area Network on Violence Against Women, gaining their support of the project. This in turn raised awareness among the Local Area Network (LAN) membership, including the family resource centres and Waterford Area Partnership who were also informed through a meeting at the very early stages of the project. The ISU had been a central part of the development of Waterford Integration Strategy 2012–2016.

Information and access is a two-way process; there was a need therefore to meet with the health service providers to inform them about the project. Facilitated by the primary care

lead for Waterford and the Transformation Development Officer (TDO) for South Tipperary, the ISU Manager and HSE Social Inclusion RCPC met with the relevant Primary Care Teams (PCTS) in each geographical area that has a DPC to inform the team members about the pilot project, and to highlight the DPC residents as clients, raising awareness of their living conditions/circumstances and the ISU as a network resource.

As a starting point there needed to be an understanding of health and what it is like to be well; what health services and supports are available and how to access these; and an understanding of what influences health and wellbeing (this can be linked to the social determinates of health). Addressing health inequalities requires actions within all the factors that influence health; this in essence suggests that health services and support cannot be addressed in isolation, which is in line with the principles and practices underpinning community development.

Healthy Ireland 2013 presents a framework where principles and proposed actions are well aligned with the work of social inclusion around supporting people from marginalised groups to access care, reducing health inequalities and developing cross-sectoral, coordinated solutions to health-related issues.[13]

In its Intercultural Strategy the HSE has expressed its commitment to working with NGOs like the ISU in the design and delivery of appropriate health and support services for ethnic minority communities. The ISU's experience of working with the target communities had raised a number of concerns in relation to health issues, which focused mainly around information and access to mental and sexual health supports. These then became the initial training/information sessions we had hoped to deliver to the CKWs. However, through meetings and planning sessions with both CKWs as participants and potential trainers it became apparent that these topics and our response had layers of emerging areas that needed to be explored and planned further. At this time it also emerged that substance misuse was presenting as a problem within centres for residents and this was one of the initial training sessions provided.

The role of the Community Knowledge Workers

This pilot project aimed to provide the best possible service through developing CKWs to become peer leaders in their respective geographical, cultural, religious and ethnic communities. For the purposes of this report the term 'Community Knowledge Workers (CKWs)' includes all seven outreach workers (including the Refugee Resettlement Worker, ISU Outreach Worker and the Roma Health Advocate). The definition of CKW was agreed as it recognised community leaders. The CKWs come to the project with a wealth of knowledge and qualifications, including QQI certification, as well as primary degrees and master's degrees in the community development, health or social care sectors. A decision was taken through the project phase that a programme of standard training opportunities would be offered to this CKW team.

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[13] Healthy Ireland; A Framework for Improved Health and Wellbeing 2013–2025, available at www.health.gov.ie/healthy-ireland

Core areas of CKW work

Mental health

As a pre-development support the project provided 455 mental health information packs for every room/family unit living in direct provision accommodation to coincide with Mental Health Week in 2014 to raise awareness of the local services on offer and how to access those services in a coordinated way through GP referral. Feedback from the CKWs highlighted that cultural understanding and indeed acceptance of mental health is a barrier to participation and understanding. Some discussion and case management with the Community Mental Health Nurse as a member of the LIG and subsequent meetings between HSE Social Inclusion and the mental health services highlighted the particular needs of this social inclusion client group.

A Vision for Change; Report of the Expert Group on Mental Health Strategy, referenced in the HSE Intercultural Strategy 2007–2012, in section 2.2.10 highlights that Specific issues that have an impact on the mental health of members of this cohort, resulting from the implementation / lack of implementation of various policies, will be explored with other sectors, in an effort to ameliorate these effects. The HSE is committed to using all available resources to advocate and highlight the detrimental effects to health of such policies. Discussions with structures in the Department of Justice, Equality & Law Reform around the effects of the direct provision system [14]

HSE recommendations state that 'mental health services should be provided in a culturally sensitive manner. Training should be made available for mental health professionals in this regard and mental health services should be resourced to provide services to other ethnic groups, including provision to interpreters.'[15] Specific issues that have an impact on the mental health of members of this cohort, resulting from implementation/lack of implementation of various policies, will be explored with other sectors, in efforts to ameliorate these effects.[16]

The length of stay in DPC's impacted negatively on mental health and was highlighted in the national review and this project has some anecdotal evidence of this. The pilot project management team agreed to work with Mental Health Ireland to develop and deliver a number of training sessions adapted for the CKWs to enhance their awareness and skills as peer workers. HSE Social Inclusion met with the Counselling in Primary Care (CIPC) Coordinator regarding the support/peer mentoring for CKWs. A support mechanism was established between ISU debriefing and a referral to HSE Social Inclusion and a potential link for further support services if and when necessary.

Community participation in health is acknowledged as a key component of improving healthcare information, and access to groups that would not culturally recognise issues of mental health due to the stigma attached and cultural associations with voodoo practices.

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[14] HSE National Intercultural Health Strategy 2007–2012 (2008), p18
[15] HSE Intercultural Health Strategy, p87
[16] Ibid p88

Sexual health

Collective experience suggests that sexual health promotion is better received when delivered by a member of the ethnic community who is very aware of cultural, social, ethnic and religious considerations. Likewise, aspects of sexual health delivery for service users from minority ethnic groups will be addressed within the context of the development and implementation of an anticipated forthcoming National Sexual Health Strategy.[17]

Discussions and planning meetings were held with the HSE Health Promotion Department in relation to adapting their Sexual Health Foundations Training and/or developing a pre-development phase that was culturally sensitive to the client group. Health promotion staff worked with the CKWs and developed a training programme for them. Through this pilot project a link is now established from the ISU directly to:

- The HSE Sexual Assault Treatment Unit (SATU) for the region, based in University Hospital Waterford (UHW). This service has 21 translators as part of its service and supports, and is directly linked to the rape crisis centres (RCC) within the region

- The STI Clinic, also based in UHW. One of the practice nurses has attended all information sessions and greater linkages have been established

- LGBTI Service providers such as; Belong2 and Transgender Equality Network (TENI) delivered LGBTI awareness sessions, as an increase in self-harm related to sexual identity was being identified especially among young people

- The foundation training programme in Sexual Health Promotion Training

It is hoped that there is now greater awareness and confidence among the CKWs to openly discuss sexual development and health, and of the appropriate referral pathway.

Rape and sexual assault are well documented as weapons of war. People living in DPCs are seeking asylum/safety from mainly war-torn countries. When relationships of trust and understanding were established with the CKWs, some of these traumatic experiences were shared. Two of the CKWs attended specific training in the Dublin Rape Crisis Centre to assist them and were supported through the project in this area of work.

While human trafficking has mainly been associated with the sex industry it is not always the case. There have been a number of victims for various reasons placed in or discovered in the DPCs in the South East and the ISU has provided support and services both before and during the pilot project. A second human trafficking seminar for services users was delivered as part of the project: 45 people attended and 3 self-referrals were made from this seminar. A separate report on this seminar is available. Guest speakers included representatives from the HSE Anti-Human-Trafficking Unit, Ruhama and the International Organisation for Migration (IOM). The seminar was facilitated by the HSE Regional Coordinator for Social Inclusion.

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[17] Department of Health National Sexual Health Strategy 2015–2020, available on www.hse.ie/publications

Health service information and access

Since the GP is the first point of access to health services, there is a need for a medical card unless you have the financial means to pay for health services. A medical card is the primary means of access to all health services and is the initial door opener; this has become very apparent during this pilot project.

There is a lack of information, understanding, language, awareness and skill/ability to complete the application forms. While the Reception and Integration Agency's (RIAs) position is that all DPC residents are entitled to apply for medical cards, it became clear through the project's engagement with residents that many of residents still do not have them. This is particularly so if the resident is new to the area or if English is not their first language. Even when the DPC managers provide information there is also the assumption that all residents are literate; our experience is that this is not always the case.

The application process for a medical card appeared to be one of the main blocks to access health services. Training/information to the CKWs was provided by the HSE Lead for Primary Care in Carlow/Kilkenny and South Tipperary. HSE Primary Care Reimbursement Scheme staff were contacted and made aware of the increasing numbers of potential applications and the concerns. An application was made to enable the ISU to have access to the system for their client group; this was unsuccessful to date. It became obvious through the project engagement with DPC residents that the number of those who had or did not have a medical card was unclear. This became one of the lead questions in the questionnaire.

The HSE Primary Care Lead for Waterford provided a health information and access session to the CKWs. The PCT is the central point for service delivery and actively engages with communities to address the medical and social care needs of the population in conjunction with a wider range of health and social care network (HSCN) services. HSE Social Inclusion is situated within the Primary Care Directive and plays a key role in supporting the most marginalised service users to access services on an equal basis with any other service user. Its key role is one of facilitating access of the marginalised service users to health services at a local level, as well as from primary care to services in more specialised settings. While facilitating improved access to services is a key objective of social inclusion, it is also accepted that equality of access does not always equate to equality of participation. Measures continue to be developed to ensure that vulnerable service users are assisted to use and receive healthcare at all levels. Supporting vulnerable service users to access care appropriately at a primary level is conducive to improved outcomes for the person, as well as being more cost effective for the health system in avoiding unnecessary or inappropriate use of accident and emergency departments or other acute services.

The HSE Primary Care Division is committed to promoting a 'quality and safety' culture by ensuring effective governance, clear accountability and robust leadership. Quality and patient safety is the responsibility of all staff, from frontline to senior management. This pilot project is committed to supporting the implementation of the HIQA National Standards for Safer Better Healthcare. These standards include person-centred care and support which requires that:

- The planning, design and delivery of services are informed by service users' identified needs and preferences

- Service users have equitable access to healthcare services based on their assessed needs

- Service users experience healthcare which respects their diversity and protects their rights

- Service users are enabled to participate in making informed decisions about their care

- Service users' informed consent to care and treatment is obtained in accordance with legislation and best available evidence

- Service users' dignity, privacy and autonomy are respected and promoted

- Service providers promote a culture of kindness, consideration and respect, and

- Service user's complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process[18]

It was agreed to develop the Community Participation in Primary Care model further, enhanced through the development of the CKWs' model for health information and support delivery. Therefore, this pilot project design was to build the capacity of individuals who *had* lived in the direct provision system and were now resident in the community to enable them to bring the information and supports to the residents.

Progress to date (CKWs)

Seven (7) completed the training listed above as a core part of this pilot project as follows:

- Four (4) CKWs were involved as volunteers; there has been some change due to CKW personal circumstances.

- Three (3) ISU staff members:

    - DPC Outreach Worker

    - Roma Advocate

    - Refugee Resettlement Worker

A lot of planning meetings were held and this is ongoing in terms of direction, partnership working and engagement with health service providers. The recruitment and subsequent commitment of the CKW throughout this pilot project have been the cornerstones of the developments to date. Through the developing stages of this pilot project and the engagement of HSE Social Inclusion staff with the Waterford Roma Interagency Group, the

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[18] HIQA National Standards for Safer Better Healthcare (2012*)*, available at
www.hiqua.ie/system/files/Safer-Better-Healthcare-Standards

needs of the Roma community in Waterford became evident. A Roma Health Advocate had been employed on a part-time basis funded by HSE Social Inclusion and employed by the ISU.

A programme refugee family was placed in Waterford during 2014 and a Refugee Resettlement Worker was engaged by the ISU to provide supports to this critical needs family. Both the Roma Health Advocate and the Refugee Resettlement Worker participated fully in the training and development provided to the CKWs, as they are facing the same challenging issues with their respective client groups.

The establishment and implementation of a schedule of the diverse range of skills and competences required for CKWs with suggested avenues for delivery and unique accreditation elements is a key element of the pilot project, which is developing dynamically as the project progresses. As the project has developed, the support, supervision, debriefing and management of this core group of both volunteers and staff have increased significantly, and the increased demands on the ISU managers' time and resources is hard to capture in real terms.

The CKWs and other outreach workers have traversed through a comprehensive training package that will culminate in a QQI Special Purpose Award on successful completion of the final module. Training topics have included information on the medical card application process; sexual health promotion; addiction and substance misuse services; working sensitively and effectively with refugees and asylum seekers who have experienced sexual violence and other trauma; mental health; self-harm awareness training: Primary Care Teams' understanding, information and access; restorative practice; leadership, information advice and advocacy; and Intercultural Awareness and Practice in Health and Social Care.

Many are now skilled in areas that enable them to deliver training and information sessions to others in the community. A full list of this training is available in Appendix 2.

For the sustainable and transferable development of this model and for the pilot project to act as a support between health service users and providers it became apparent that there was a need to:

- Increase awareness and understanding about the intercultural health and social care needs and service delivery. This led to the design and delivery of the service providers training course 'Intercultural Awareness and Practice in Health and Social Care'. It is envisaged that this model of training might be sustainable and developed further within other services.

- Establish baseline information regarding the health and wellbeing of asylum seekers. This led to the development of the health and wellbeing questionnaire, which is covered in Section 2 of this report.

1.12. Training for Service Providers – Intercultural Awareness and Practice in Health and Social Care – CHO Area 5

Through the engagement and ongoing work of the Intercultural Healthcare (ICH) Pilot Project it became evident that there was a need for staff as service providers to be upskilled in the area of intercultural health. HSE Social Inclusion Unit South East CHO Area 5 successfully sourced funding from the HSE National Social Inclusion Office to develop a training model in Intercultural Awareness and Practice in Health and Social Care. Following a tendering process HSE Social Inclusion Unit South East CHO Area 5 contracted Nasc (the Irish Immigrant Support Centre) and Quality Matters (not-for-profit consultants) to deliver the training.

The Intercultural Awareness and Practice in Health and Social Care Training and the Train the Trainer programme are aligned with access to services, human resources and organisational development. In line with recommendations contained in the National Intercultural Health Strategy, the aims of these programmes are to:

- Enhance existing knowledge, skills and resources to enable staff to respond effectively and appropriately to the health needs of a multicultural, multi-ethnic society

- Enhance the provision of culturally competent health services that are respectful of, and responsive to, the cultural and ethnic diversity of service users so as to enhance quality, effective service delivery

- Develop a sustainable model of delivering intercultural health training

As part of its programme for enhancing inclusion within the health services in South East CHO Area 5, the pilot project team has worked in partnership with Quality Matters and Nasc to develop the Intercultural Awareness and Practice in Health and Social Care training and toolkit for the delivery of a Train the Trainer course.

Intercultural Awareness Training Programme details

A one-day training programme on Intercultural Awareness and Practice in Health and Social Care was delivered in each of the five counties in the South East during 2015. The programme was designed for all health service providers, including community support services.

The overall purpose of the training was to:

- Enhance existing knowledge, skills and resources to enable staff to respond effectively and appropriately to the health needs of a multicultural, multi-ethnic society

- Enhance the provision of culturally competent health services

A total of 129 people participated in the one-day awareness training within the South East CHO Area 5.

All participants were surveyed prior to the training to identify training needs and to ensure the programme addressed these.

Accreditation
This training was accredited with continuing professional development (CPD) points available for:
- General practitioners (GPs)
- Social workers
- Nurses and midwives
- Counsellors and psychotherapists
- Chartered physiotherapists
- Speech and language therapists

Rationale and policy context
The provision of intercultural training is contained in recommendations in the National Intercultural Health Strategy (2007–2012), which guides the work of the Social Inclusion Unit in the South East CHO Area 5.

Evaluation of the training
A total of 98 per cent of people who attended the one-day training course said that they would recommend it to a colleague. (A separate evaluation piece is available.)

Train the Trainer
The training was designed on a train-the-trainer basis and so a two-day Train the Trainers (T4T) module was held on September 29th and 30th 2015 for participants who had completed the one-day training course. The aim of the T4T is to equip trainers with the tools, ideas, support and strategy for delivering Intercultural Awareness and Practice in Health and Social Care training, with a view to ensuring the sustainability of intercultural health information and knowledge in the region.

Outcome and link to CKW
In total twenty-two (22) people were trained as trainers for the delivery of this Intercultural Awareness and Practice in Health and Social Care course. Five (5) of the CKWs were trained as trainers and will be delivering this training in partnership with other trainers in a supportive and capacity building framework with a long-term view for the CKWs to become the deliverers to health and support services. (The model developed from this training is written up and available.)

Training pre- and post-survey
Analysis suggests that Intercultural Awareness and Practice in Health and Social Care training had a positive effect on the attitudes and behaviours of training participants. Since attending the training, there were statistically significant improvements in motivation to improve intercultural working, personal reflection on intercultural issues, knowledge gathering on intercultural issues, communication about intercultural issues and active efforts to improve intercultural practice.

The thematic analysis suggests that participants are more open to minority groups, that they are making changes to their work environment to improve the service experience for

minorities and that they are sharing the information they received at training with their work colleagues.

<u>External landscape</u>

It should be noted in this report that there have been a number of external influences during the pilot project including:

- Dissent nationally in DPCs, including two in the South East, which led to public protests and a lockdown of services within the affected centres

- The increase in emerging numbers of human trafficking victims who required coordinated supports within the South East

- The emergence of healthcare issues for Roma communities placed additional immediate demands on services

- The anti-Roma sentiment in Waterford, which led to a full-scale racist social media campaign forcibly displacing Roma families from their accommodation

All of these changes have an impact on the ability to work in an integrated interagency manner with all stakeholders during a time of transition.

<u>Emerging issues</u>

Emerging issues that needed a response from the project were:

- Cases of human trafficking

- Allegations of substance misuse within the DPCs

- Undocumented migrants requiring supports for regularisation and employment

- The lack of medical cards for some residents

- Complex medical cases, not all in DPCs but post-asylum, presenting with complex vulnerabilities

- The presenting of young vulnerable migrants and their specific healthcare needs

- Sexual health concerns

- Mental health presentations/concerns

1.13. Summary of Section 1

- The overall aim of the project is to develop a model of intercultural healthcare that will address barriers and gaps preventing equitable access to health service and supports. Evidence of a developing model is shown throughout this report. This is in line with the National Intercultural Health Strategy which is 'aimed at reducing the social exclusion experienced by many in this cohort (minority ethnic service users), enhancing their access to health services and, in the longer term, promoting positive health outcomes and social gain'[19]

- There is a core group of CKWs who are better informed about health services and how to access same

- Health service providers are aware of the pilot project and the developing model

- The process of establishing links that will benefit both clients and health service providers is developed and ongoing

- Overall the development of this pilot project has raised awareness of the health-related concerns for the people who are living in DPCs in the South East CHO Area 5

- The developmental process highlighted the need to work with all stakeholders and to understand health within the social determinates model while taking into account the cultural understandings and experiences of these client groups

- The health concerns highlighted are complex and encompass a learning process for all involved

- The development of a LIG that is linked to primary care has proved invaluable in terms of the engagement of health services providers

- ISU staff have now been invited to participate at primary care case management meetings when appropriate by HSE Personnel

Key pieces of work include the information session on the asylum process and the impacts of this and life on the health of the asylum seekers, and the second human trafficking seminar for service users/clients. The connection to and support of the development of the Roma initiatives, both in Waterford and Wexford, were all within the timeframe and have a link to this Intercultural Health Pilot Project. The design and delivery of the Intercultural Awareness and Practice in Health and Social Care training as a support and upskilling opportunity for service providers is key in terms of sustainability and, particularly, capacity building of the CKWs as trainers in this area in the long term.

Through this pilot project the extreme vulnerability of clients who have transitioned from the asylum process has become evident. All are vulnerable to homelessness, are de-skilled and institutionalised, often with complex medical and social health-related needs.

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[19] HSE National Intercultural Health Strategy 2007–2012 (2008)

Another area the project has highlighted is the victims of trafficking who are placed in DPCs; the complexity of these cases and demands on relevant health-related supports and services are apparent. All the learning will influence the next steps for development when the pilot phase and evaluation is completed.

The Intercultural Healthcare Pilot Project delivered in 2015 aims to build a sustainable capacity within services. The concerns highlighted for this client group need to be addressed at interagency level in order to develop holistic integrated plans for this client group. The National Intercultural Health Strategy states that:

> The anticipated benefits to service users and service providers of implementing this strategy are wide ranging, encompassing improved health and wellbeing, increased social capital and enhanced integration on the part of service users, and increased cultural competence, pride, confidence and satisfaction of service providers as they strive to deliver an effective, equal, non-discriminatory service [20]

The training capacity building of the CKWs has been paramount to the project in line with all health, community development and ISU policies and procedures. These CKWs are now in a position to utilise new-found skills to encourage engagement of migrant communities to access all of the health services required through the provision of information, advocacy supports and training opportunities to deliver culturally sensitive health support services in the community. This is in line with sections 2.2.11[21], 2.2.17[22] and 2.3.6[23] and includes intercultural/diversity training for frontline staff where required, as per 2.6.3[24] of the Intercultural Strategy.

The development of the health-based questionnaire as a necessary piece of peer research and which has provided an analysis of health and wellbeing of the participants living in the five DPCs in the region will be addressed in Section 2 and will influence post-pilot development in the area of intercultural health within the South East CHO Area 5 region.

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[20] HSE Intercultural Health Strategy 2007–2012 (2008 HSE)
[21] Community initiatives aimed at providing care and support around the mental health needs of people from diverse backgrounds will be supported and promoted within the context of the model of community mental health endorsed in 'A Vision for Change' (HSE Strategy, p18)
[22] Aspects of sexual health delivery for service users from minority ethnic groups will be addressed within the context of the development and implementation of an anticipated forthcoming National Sexual Health Strategy (HSE Strategy, p19)
[23] Cultural mediation has a role in promoting interculturalism in the health service. Pending evaluation of existing projects in this area, consideration should be given to ways of optimally using Cultural Mediators at community level (HSE Strategy, p20)
[24] Current initiatives aimed at the capacity building of staff to plan and deliver appropriate, responsive, culturally competent services to service users from a range of cultural and ethnic backgrounds should be expanded and implemented on a phased basis (HSE Strategy, p22)

Section 2 Research

This section focuses on the responses from research questionnaires and storytelling through the case studies as examples of the complexities of the work. As a pre-development action the ISU delivered a mental health awareness information pack (445 packs) to each person resident in a DPC in 2013/2014 (to coincide with National Mental Health Awareness Day). Many of these packs were not responded to for a variety of reasons, which will be discussed in Section 2.4 Findings.

2.1. The Research

An intercultural healthcare questionnaire was designed by the ISU, and HSE Health Promotion 'to specifically identify the health needs of families and individuals living in the direct provision system and the needs of the wider migrant communities'. The five DPCs in this research are located in the following areas: Waterford City (2), Tramore, Co Waterford (2), and Carrick-on-Suir, Co Tipperary (1).

Location	Location	Residents	Numbers
Waterford City	Waterford City	Family units including children, single residents (mixed gender)	65
Waterford City	Waterford City	Single males only	87
Waterford County	Waterford County	Family units including children, single residents (mixed gender)	90
Waterford County	Waterford County	Family units including children, single residents (mixed gender)	59
South Tipperary	South Tipperary	Family units including children, single residents (mixed gender)	81
		Total	**382**

Fourteen (14) questionnaires were completed from Centre 1, nineteen (19) from Centre 2, eleven (11) from Centre 3, twelve (12) from Centre 4, and thirteen (13) from Centre 5, giving a total of sixty-nine (69) responses.

The ISU Outreach Worker and four CKWs visited these DPCs in the South East region and recorded information through an interview process supported by completed questionnaires. Over a period of five months, from mid February to mid July 2015, these workers regularly visited the DPCs.

The questions were designed primarily to ascertain the health needs of the residents and collate information regarding their physical health/mental health, and the services they access. The research was targeted at adults (over 18 years). The rationale is premised on the health issues identified by the residents on an ongoing basis and, in particular, aspects

of their mental health such as depression, lack of motivation, despair, stress and suicide ideation. There were 14 questions in all and these are outlined in Appendix 3.

2.2. Aims and Objectives of the Research

The five (5) DPCs in the South East region have a total capacity for 528 residents comprised of single adults, family units and separated children over the age of 18 years.

The ISU identified concerns surrounding the health and wellbeing of residents in these centres and developed a comprehensive healthcare plan to address these issues in 2009/2010. At that time the ISU did not present their model to the HSE or other agency as it was not yet fully developed. This was during a time of embargo on recruitment within the health services; without staff capacity and financial resources it was not possible for the ISU solely to deliver on the actions identified. In 2013 a collaborative partnership was formed between the HSE and the Social Inclusion service (HSE–SI) and the ISU to look at the earlier plan and deliver on the main concerns highlighted in that strategy, in line with the national HSE Intercultural Healthcare Strategy ensuring:

- Access to a medical card
- Access to health services
- Information on health services available
- Research and human resources (to document gaps)
- Organisational development (building CKWs' capacity for delivery)

This pilot programme was to highlight the challenges experienced by residents of DPCs with a particular focus on physical and mental healthcare provision, acknowledging the social determinants of health, as well as building the capacity for a number of CKWs acting as peer Health Advocates.

2.3. Limitations of the Pilot Project Research

The main limitations when dealing with these culturally sensitive subjects lay in the fact that there was always a concern that participants could become upset during the process, or at a later stage. There was a reticence displayed by many of the DPC residents to participate in the research. The major factors contributing to this lack of engagement were given as:

- Inability to answer questions due to not being in a good place mentally

- Other commitments, such as children to attend to

- Lack of trust issues

The research team also encountered difficulties during the process such as:

- A lack of privacy in order to conduct interviews discreetly

- Language and literacy barriers

- Trust issues (particularly gender and culture based)

- The continuous forms and questionnaires that the residents are asked to complete is challenging for them

- Recording medical cards and access to general social services while in the direct provision (DP) system

The ISU research team comprised five members, three women and two men, all of whom are of African origin. Four of the team had resided in the DP system themselves and therefore had first-hand knowledge of the difficulties encountered by those still living there. Choosing this team was central to the methodology.

Their expertise and their personal experiences of life in DPCs enabled them to approach the interviews in an empathetic and understanding way, thus putting them potentially in a better position to elicit more information than people who had not experienced this way of life. Trust was a concern and although the team encountered some trust issues, their prospect of success was vastly enhanced by their own personal experiences. Getting clear answers to the questions presented some difficulties with language and comprehension issues. Members of the ISU team assisted each willing participant to fully understand the questions and record their personal answers, in order to avoid any misunderstandings. In this way the possibility of misrepresentation was avoided in so far as possible.

Observation was central to the research. The team were aware that there were issues with some of the residents that had not yet been spoken about. Through careful observation some serious challenges were identified by the team as outlined in the case studies documented further on in this report.

Ethical considerations were always at the forefront and each respondent signed the questionnaire displaying their willingness to be part of the process. Participants were free to refuse to answer any question that they misunderstood or were uncomfortable with, and had the option to terminate the session at any time, as is their prerogative under our research code of ethics.

Counterfactual analysis as a methodology focused on what had not been documented or said ('reading between the lines') but may have impacted on the client or the desired outcomes. In terms of evaluating the information received from the team, it is important to emphasise that there were a number of DPC residents who were unable or refused to participate in the process at that particular time. Their inability/refusal and their reasons for same are documented as part of this analysis. Furthermore, in this research counterfactual analysis identified some potentially serious health implications that could have escalated had this research not taken place and intervention and support provided. CKW intervention meant that problems were identified and dealt with in an expedient manner.

2.4. Findings

- The questionnaire comprised 14 questions (see sample questionnaire in Appendix 3)

- Time period of this research: February–July 2015

- Total number of adults (over 18 years of age) residing in the programme DPCs at this time was two hundred and sixty (260)

- A total of one hundred and twenty-one (121) residents were approached to participate in the research

- Sixty-nine (69) questionnaires were completed and returned for analysis

- This number represents fifty-seven per cent (57%) of those who were asked to engage

The questions centred on the physical and mental wellbeing of the residents in the five DPCs under enquiry. Resonating from the residents was a feeling of:

- Hopelessness

- Depression

- Boredom

- Poverty

- A lack of freedom

A short section on mental health issues was included, as a large number of answers emanating from the questionnaires dealt with psychological challenges felt by the residents. The majority of residents in this research have spent a number of years in these centres.[25] This pilot programme specifically examines the effects on residents in the five centres in the South East, which (to our knowledge) have not been examined before in relation to health-based outcomes.

Gender sensitive issues were taken into consideration, for example, male interviewers spoke to male residents and female interviewers spoke to female residents. As previously highlighted cultural concerns were sensitively dealt with as the interviewers had experience of life in direct provision. Others who had difficulty or refused to be interviewed and complete forms voiced their reticence to do so which appeared to emanate from:

- Apathy

- Frustration

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[25] The direct provision system was introduced in 1999 and became operational in April 2000 as an emergency measure where asylum seekers would spend a short time (six months being the estimated period), would receive full medical cards and education for their children while their applications for refugee status were being processed. The scale of the asylum crisis escalated within a short period of time and DPCs were no longer fit for prolonged purpose.

- Lack of trust

Some were unwilling to discuss the situation with the ISU team and in a few cases became aggressive toward the CKWs when they were approached. This anger that resonated from a number of the residents is visible both in their responses and in their general attitude toward the living conditions within the DPCs, a fact that has been observed over time by the interview team. A large majority of the residents in the five centres have been there in excess of five years. We do not have exact figures on the percentage of these, due to movement between centres making accurate tracking more difficult.

2.5. Responses to the Questionnaire/Interview

Q1. What keeps you/your family well?
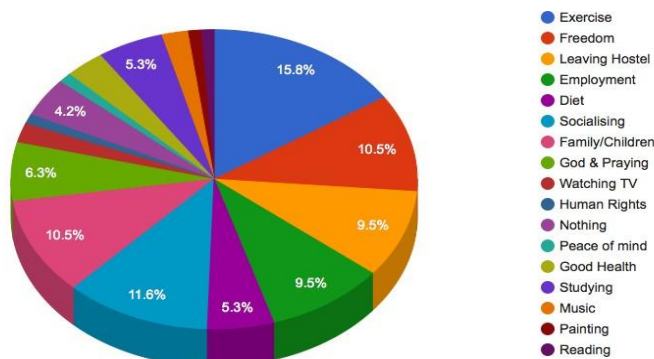

Figure 2

Responses in Figure 2 highlight the importance of keeping active, having freedom to choose about their future, and that family and children are prioritised. Access to education and employment has a bearing on wellbeing and many focus on the day when they can leave direct provision. Socialising with others that share a similar cultural background is also highlighted.

Q2. What stops you from being well?

When asked 'What stops you from being well?' the responses were as follows:

What stops you from being well?

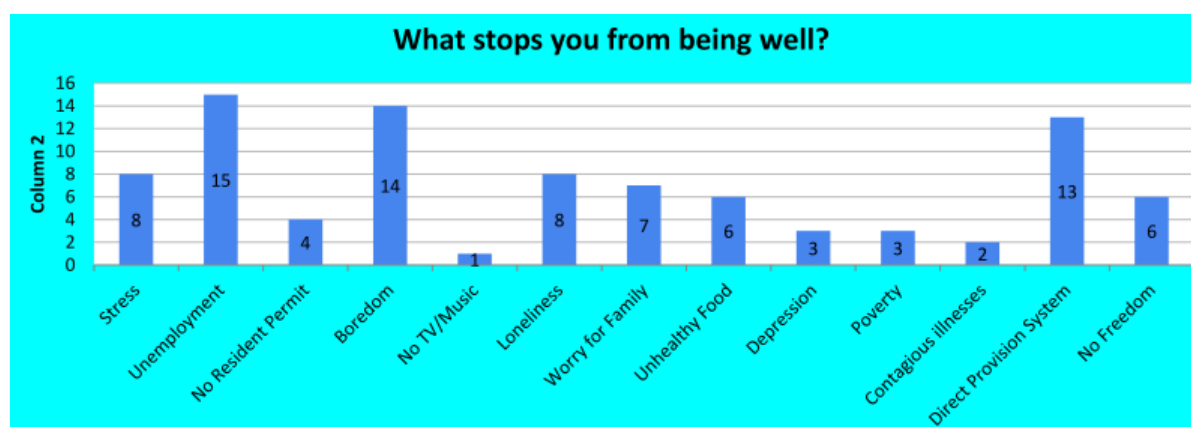| Factor	Value
Stress	8
Unemployment	15
No Resident Permit	4
Boredom	14
No TV/Music	1
Loneliness	8
Worry for Family	7
Unhealthy Food	6
Depression	3
Poverty	3
Contagious illnesses	2
Direct Provision System	13
No Freedom	6

Figure 3

As can be seen from Figure 3, the three most common factors within the social determinants of health that impact on wellbeing are; unemployment, boredom and living in direct provision. Lack of freedom, feelings of stress, worry and loneliness are also major factors reported by respondents as denying them feelings of security and health. A feeling of hopelessness is a common thread reported throughout the five DPCs as evidenced on the vast majority of the questionnaires. Every respondent expressed unhappiness and concern for their own wellbeing and that of their children.

The majority of the interviewees in this research have been allocated medical cards and have registered with a GP in the area. The GP is the main health professional the residents voice their concerns to and, although they express feelings of depression and mental health issues, they are reluctant to talk to a psychologist or counsellor. Mental health is stigmatised in most of their communities and therefore the residents are unwilling to expand on their feelings or seek professional advice from a mental health specialist. There is a genuine fear expressed by the respondents that sharing their vulnerabilities or concerns may negatively impact on their application process for refugee status. This goes some way to explain their reluctance to engage.

It should be noted that this research was focused on how asylum seekers viewed their health, their understanding of health and other services available to them and noting the way in which they accessed required services. Their responses were more focused on the social determinants of health and how day-to-day living impacted on their general health and wellbeing. Thus, although it may seemthat the research is based on the direct provision system; this is not the case. Instead we are documenting what affects the health of our most vulnerable in society in the way they themselves see and understand it.

Initially this project was designed to provide basic services to access health and to build capacity within ethnic cultures to serve their own communities through information and advocacy supports. The missing link was the need to establish a baseline of levels of understanding to access health-based entitlements and barriers faced. We did this through participatory primary research, the outcome being to develop a model of practice that would be transferable to other geographical areas and to other vulnerable ethnic groups, for example, the Roma community.

<u>Q3. In what way does it [living in direct provision, as identified by respondents] stop you from being well?</u>
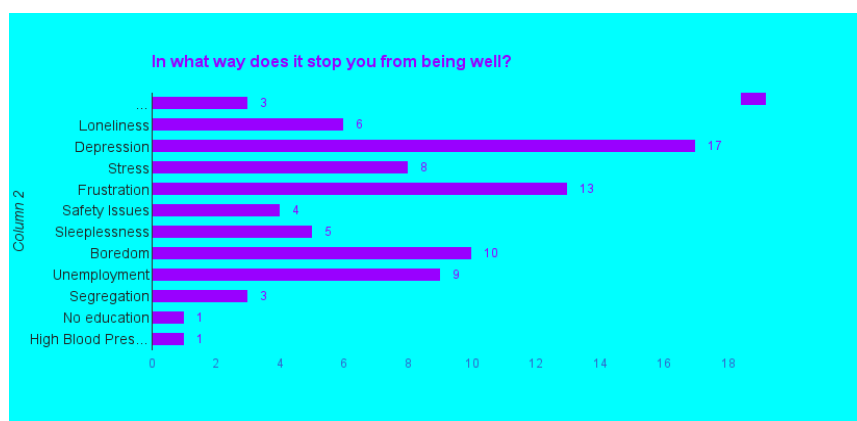

In what way does it stop you from being well?

Category	Value
...	3
Loneliness	6
Depression	17
Stress	8
Frustration	13
Safety Issues	4
Sleeplessness	5
Boredom	10
Unemployment	9
Segregation	3
No education	1
High Blood Pres...	1

Figure 4

The majority of the respondents (17 in total) replied 'depression', 'frustration', 'boredom', 'unemployment' and 'loneliness', followed by 'stress' and 'anger' which were also prevalent responses.

While respondents were male and female it was noted during the early stages of the research that male residents responded better to male interviewers, thus indicating the importance of gender sensitivities when communicating with multiple ethnicities (some cultures do not encourage dialogue between the sexes, thereby creating barriers of participation in collating information/opinion).

Communicating, socialising and understanding are necessary for good mental health and the lack of these basic necessities was recorded in the questionnaires.

Q4. How does it [DP living] affect your health in general?
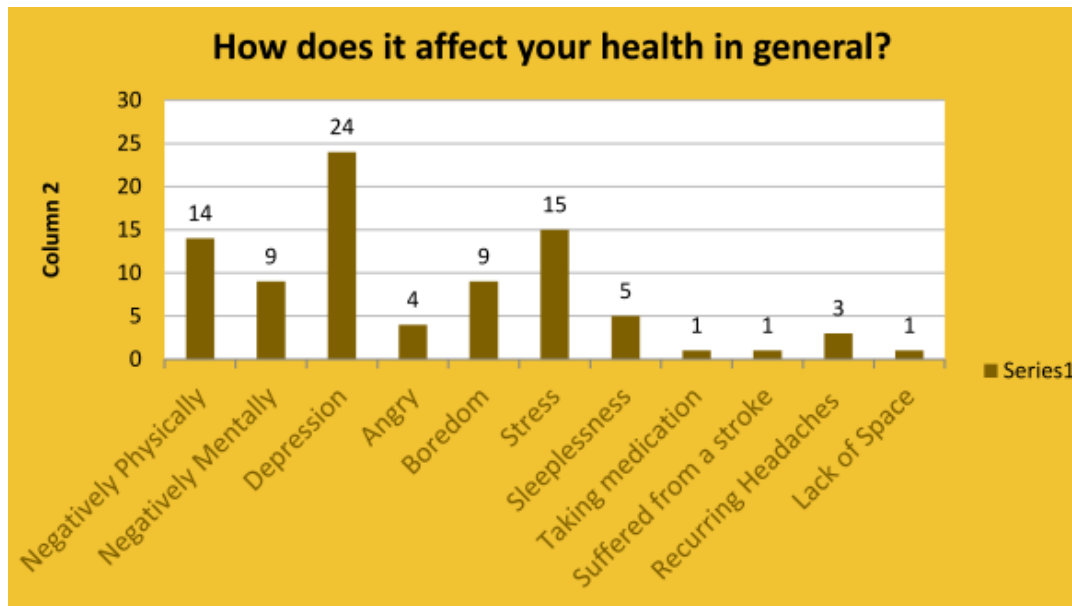
Figure 5

From the graph in Figure 5 it can be seen that 'depression' ranks as the most prevalent health problem. 'Anger', 'boredom' and 'stress' are mentioned as major contributors to ill health.

Some of the residents gave multiple answers which points to the fact that there are a number of issues affecting their general health. 'Boredom', 'stress' and 'anxiety' are emotions that are evident throughout the responses and these feelings lead to physical expressions of frustration.

This in turn makes an already difficult set of living conditions fraught with an underlying feeling of uncertainty and fear. As the graph in Figure 5 shows, respondents are suffering both physically and psychologically. This is a recurring theme throughout the research.

Q5. What do you think you can do to support your health?

What do you think you can do to support your health?

Category	Value
Education	20
Councelling	3
Exercise	31
Privacy	1
Leaving Hostel	3
Healthy Food	7
Religion	2
Freedom	6
Employment	6
Volunteering	1
Positive Attitude	1
Music	1
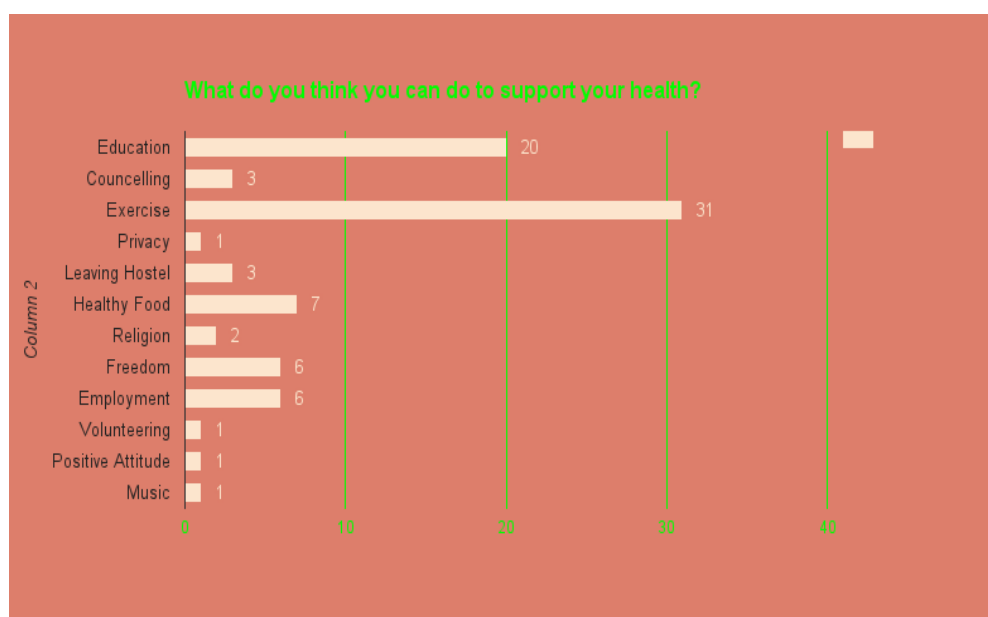
Figure 6

When asked what they believed they could do to support their own health the majority of residents believed 'exercise' was most important, while 'education' was also recorded as a primary source of health support, followed by 'freedom' and 'employment', which are ranked as positive supports also.

It is clear that a multi-agency response is required to improve the health-based outcomes of this vulnerable group through the provision of education, training and employment programmes, as well as resettlement supports to make the transition into the wider community successful.

Q6. What can others do to support your health?
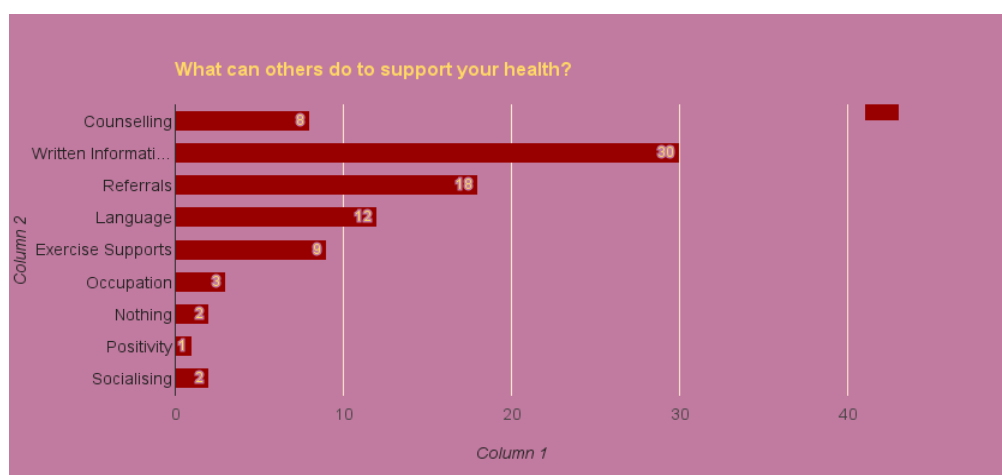
Figure 7

The large majority felt 'written information' was very important, and 'referrals', 'language supports', 'exercise' and 'counselling' were also very important aids which could be delivered by others. The majority of respondents currently access GP services.

Q7. What health services do you currently access?

Figure 8

Eleven (11) of the participants in this research did not access any health services at all. This situation obviously negatively affects their overall health, both physical and mental. We need to understand and establish what the underlying factors are that makes them reluctant to access healthcare supports.

Q8. What specific health needs do you have difficulty talking about?

Specific needs you have difficulty talking about
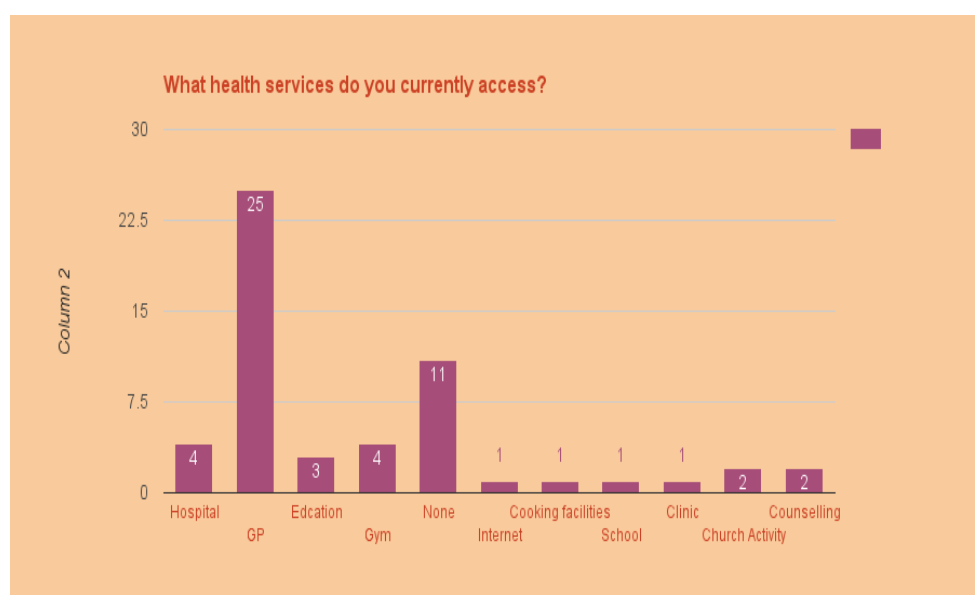
- None
- Yes
- Dental and other medical issues

30 · 22 · 1 · 4 · 1 · 3 · 1 · 1

Figure 9

Twenty-two (22) reported that they had specific health needs that they found difficult to talk openly about, including past experiences of torture and trauma linked with their persecution in their native countries.

Many require specialist counselling but the main organisation providing such supports (Spirasi) is based in Dublin. The ISU provide supports to locally based clients of Spirasi between their Dublin based appointments. The ISU's experience is that some clients have been victims of organ harvesting. Poverty is the main reason for families selling body parts to the highest bidder and others unfortunately have had teeth and organs removed against their will. Women and children have been used as weapons of war, as either child soldiers or providers of sexual services to roaming militia groups.[26]

Q9. Would you like to arrange a more private chat?

Would you like to arrange private chat?

- Not Now
- Yes
- No

5% · 49% · 46%
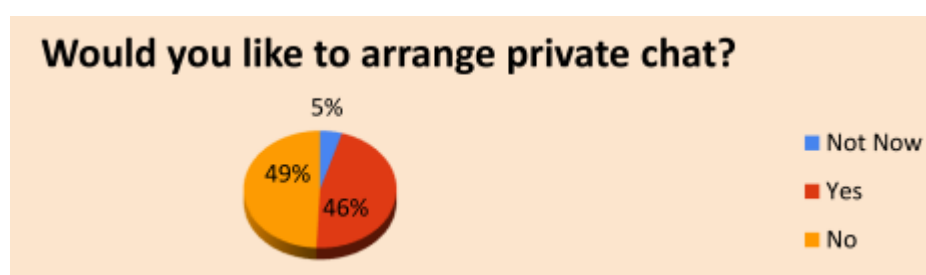
Figure 10

As can be seen from Figure 10, although a large number of residents would be willing to engage in a private chat, the majority were not ready at this point, and a small number are uncertain (some of this is linked to not yet having the time to build up a relationship,

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[26] See additional reference to these issues in the ISU trafficking reports: Migration, Movement and Trafficking and Trafficking Issues for Service Users

particularly with newcomers). When asked were there any specific areas they had difficulty talking about there was a visible reluctance to comment. The responses, as outlined in Figure 10, point toward apathy and a feeling of hopelessness. Those who replied indicating that they had particular difficulties were unwilling to specify or explain what these difficulties were while in their current circumstances, for fear of jeopardising their asylum application.

Q10. Is there any area of health/wellbeing you need support with/access to?

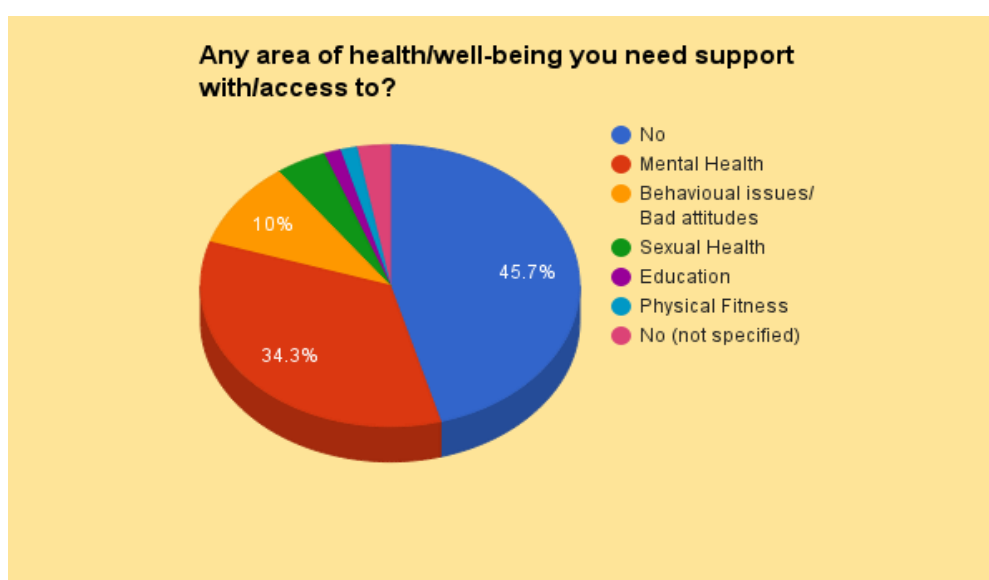
Figure 11

The majority responded negatively to needing support of any kind. The largest number who felt they need support indicated that the support they required was in the area of 'mental health'. 'Behavioural issues and bad attitudes' (possibly linked to mental health) were mentioned as a concern and 'sexual health' was also expressed as an issue for some (male and female respondents).

Q11. Do you have any particular concerns regarding the health/wellbeing of your family members?
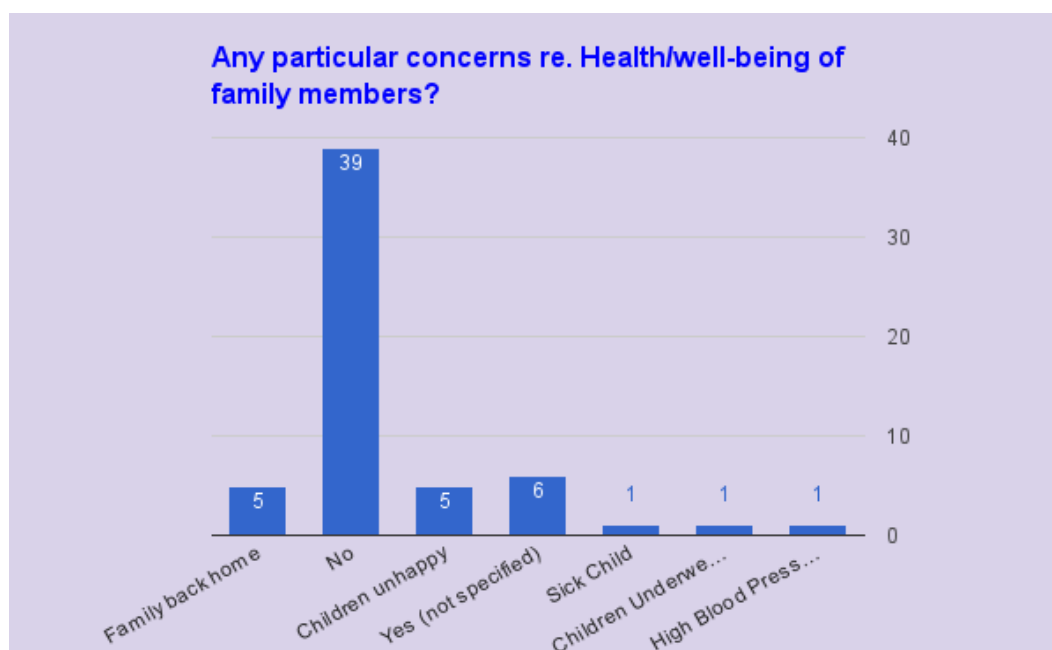
Figure 12

The main concerns are linked to worry about family members back home and the health and happiness of their children who were born into or who are growing up in a lifestyle that damages their outlook on life and keeps them from living a carefree childhood in line with other children living in the State.

Q12. Do you have a current medical card?   Q13. Are you registered with a GP?
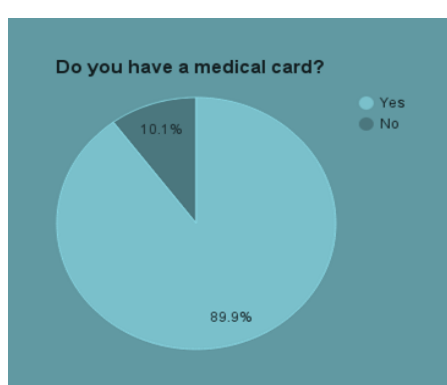
Figure 13

Figure 14

Sixty-two (62) of those interviewed had a medical card and sixty-five (65) are registered with a GP. This is a very high percentage of those interviewed, but it must be stressed that it is only indicative of those residents who were interviewed at this specific time. The transient nature of residents in DPCs poses a real risk to their health and is discussed further in Section 4 Recommendations.

Surprisingly, three (3) respondents stated that they had never visited their GP. We should note that two of these were newly arrived. Twenty-six (26) had not visited a GP in the last three months, five (5) could not put a date on it but recalled that it was a long time ago, possibly more than six months. The introduction of costs per item in prescription charges were prohibitive and affected ability to pay, meaning that some would put their recovery on hold until they could afford prescriptions. During this pilot project since June 2015 asylum seekers are now exempt from prescription charges.

2.6.   CKW Focus Group Report on the Research Process

When all the questionnaires had been returned a focus group meeting was convened between the ISU Research and Development Analyst and the CKWs who had carried out the research in the DPCs. A number of questions were put to the group regarding the procedure of information gathering in the DPCs and their role in the process. Their personal reflections on the information gathering and their reflections as a team are recorded here.

Their comments and reflections highlight the challenges inherent in the DP system. Their experiences dealing with the various situations encountered highlighted a complex level of difficulties for residents. For each of the interviewers it was a new learning experience. The research project and their reflections were pertinent to the findings since, as already stated, four of them had lived in DPCs. The team would have benefitted from more training in conducting participatory research methods. Overall, this was a valuable learning experience for the interview team as recorded in their reflections:

- They felt a strong connection with the residents

- They experienced some personal challenges during the process, as memories of their own experiences while living in DPCs were very much in their consciousness

- They believed that through their example they could give hope to those still residing in DPCs, proving that there is a possibility for them and their families to move on, receive an education or work opportunities and to improve every aspect of their physical and mental health in the long term

In general the CKWs found the managers of the centres cooperative and willing to provide a space to carry out their task, but some difficulties of access were encountered in the early days. There were mixed responses when asked how they worked as a team. The CKWs expressed some frustrations, which they saw as part of the learning process, for example:

- They felt that sometimes there was little team coordination

- It was important that the managers of the centres knew the CKWs and their role in this pilot process

- Permissions were sought from the appropriate bodies, i.e. Reception and Integration Agency (RIA), and participating centre managers

- The transient nature of the residents between centres made it difficult to keep track of developments

- It was often the case that they were not known by the residents

- They, in turn, had not seen some of the newer residents on previous visits. This presented a problem regarding the acquisition of medical cards and other important information that new residents had no knowledge of. These residents were assisted to make full applications immediately

- Time schedules allocated for filling out the questionnaires were much underestimated, as there were a number of issues that the residents wanted to discuss in the course of the sessions and which required attention from the interviewers

- They all expressed their inability to disregard the concerns voiced by the residents, and getting them to answer the questions without going into detail about their personal problems was a challenging learning curve

- Privacy was a problem all the interviewers expressed concerns about, as often there were no facilities available to conduct interviews quietly, discreetly and without interruption (interviews were conducted in DPCs to facilitate participation)

- Respondents were concerned about other residents eavesdropping on their conversations

- Topics, such as mental health, were emotive issues that required a safe and secure environment to articulate

- This lack of privacy was also a concern for the research team and from their comments it would appear that there were no available alternative spaces within the DPCs where the required level of confidentiality could be provided. Participants were offered the opportunity to conduct the interviews off-site, for example, in the ISU, which was taken up by some

2.7. Comments on Findings

- Day-to-day facilities in the DPCs are very limited, as they were designed to cater for people in the short term. Families living in this environment are severely restricted in terms of privacy for adults and children. This results potentially in children being exposed to age-inappropriate behaviours, such as sexually explicit behaviour, anti-social incidents and even domestic violence

- The GP is the only professional they voice their concerns to and, although they express feelings of depression and mental health issues, they are reluctant to talk to a psychologist or counsellor (mainly linked to a cultural lack of understanding). Mental health is stigmatised as in most societies and therefore respondents are unwilling to expand on their feelings or seek professional advice or specialist services

- While some of the female respondents expressed willingness to have a private discussion 'chat' with a counsellor, the men were far less willing to engage in this process. This would also suggest a certain 'macho' element or fear of disempowerment, which appears to be evident in the all-male facilities. Aggression and tensions, because residents are no longer in control of their own destinies or those of their families, provoke negative responses that can be felt from the interviews and the responses to the questions. This lack of control also potentially leads to addictive behaviours and mental health issues. Residents believe that all these concerns will be resolved when they leave direct provision and are free to pursue their own lives in their own way. These elements can lead to a somewhat negative perception of all 'foreigners' within the wider community and provoke racism and further marginalisation for those who have spent long periods of time in DPCs

- It should also be noted that along with external racism and discrimination there is a certain amount of internal racism evident within the DPCs among the residents themselves. This phenomenon must be taken into account, as it too can cause tension and lead to challenging behaviour and fear

- The fact that nothing changes in the system is a common theme. Moving residents from one DPC to another is a contributory factor to depression and mental health issues. The whole issue of uncertainty, filling out forms for a process that changes regularly as forms are re-written, and the dearth of basic safe and secure facilities, space and privacy are all described in the questionnaires as directly contributing negatively to the physical and mental health of residents who feel trapped in the DP system. There are a number of issues that negatively affect the lives of these DPC residents and there are many recommendations being examined by the Government at present

- Reflections from the CKWs highlight many issues they identified concerning mental health challenges. Many residents were willing to fill in the questionnaires but there were a large number who were unable to engage for the reason given that other people had come to them offering hope but they had never seen these people again. They became disenchanted and depressed and felt they were being used. They were unwilling to go through the process again as it was, in their eyes, pointless and potentially destructive

- According to one CKW, helping newcomers to complete the questionnaire enabled her to identify gaps/lapses in services in relation to people who are admitted by the RIA, as newcomers do not get their refugee/asylum cards straight away. Because of this, residents who are dispersed to their DPC cannot apply for their PPS number, medical card or even get the standard payment (€19.10) for the first 4–6 weeks after their arrival in Ireland. This information was relayed to the RIA who identified that demands on the system were unavoidable due to sheer numbers but they are addressing the issues on a daily basis

- Another of the CKWs described an incident where she came across a woman who was six months pregnant. She had no medical card and had not been seen by any doctor. Supports were immediately put in place while her application for a medical card was being processed

- All CKWs reported the stigma attached to mental health issues. Their perception is that mental health refers to people who are crazy or deranged. People in DPCs are more susceptible to depression and lack of focus due to the circumstances they are living in, with hopelessness being a prevalent feature in residents' responses and reflections to the interviewers

- Of the sixty-nine (69) people who participated in this project the majority, sixty-two (62) in total, had medical cards and a total of sixty-five (65) were registered with a GP. This number reflects those who engaged in this pilot project but in recent follow-up visits to DPCs the CKWs have met with a number of newly transferred residents who have no medical cards and are not yet registered. The problem of transience presents many challenges for the CKWs and compiling real numbers of people with medical cards, access to essential services, etc. is made extremely difficult in this environment. This is one of the issues that iterate the necessity for a longitudinal study, as this research already clearly demonstrates the changing nature of life in direct provision

- The health needs of residents of DPCs under review are not being fully addressed as the system is not fully equipped to deal with the problems that arise on a daily basis. In many of the centres people have to share rooms with strangers; the population is transitory and this creates problems for people, such as privacy, distrust, trepidation and misunderstanding. People from different countries and religious and cultural backgrounds may be required to share a room with others who have been on opposite sides of conflict in their native countries. It has been indicated to the ISU that communication and understanding is more difficult in these situations

- There are no open cooking facilities in these centres, which challenges the traditional roles of women as primary caregivers. Children pose particular concerns in relation to the provision of nutritional food for better health outcomes. Women reported being unable to provide adequately for their families and this causes stress and worry

- Children are exposed to situations that are inappropriate, such as sexual contact between parents and other adults, arguments and physical and mental violence, all of which can have the potential for long-term repercussions

- Education is another area that is regularly mentioned in the questionnaires. Children and adults need access to English language classes to participate in schooling and to carry out basic everyday needs, i.e. shopping, GP visits, requesting information and general everyday tasks. Form filling presents huge problems as the forms are often technical in nature and require more than a basic knowledge of the English language to complete properly. The CKWs visit DPCs regularly to assist in form filling and recruit the aid of a translator when necessary

- Communicating, socialising and mutual understanding are necessary for good mental health and the lack of these basic necessities is recorded in the questionnaires. Inability to feel part of the community and the feeling of there being no end to living in DP have taken their toll on all the residents who took part in this pilot project

- Fear is an emotion that is displayed. Many of the residents complain that there are incidents of anti-social behaviour and periodically there are incidents of violence and

addictive behaviours. Fighting among the residents, particularly in the male centres, has been identified as a problem. Boredom, stress and anxiety are emotions evident throughout the responses and these feelings lead to physical expressions of frustration. This in turn makes an already difficult set of living conditions fraught with an underlying feeling of uncertainty and fear

- Direct provision, in its present incarnation, does not offer much hope, safety, comfort or opportunities for residents to fully integrate into their new community in a fair, safe and equitable way. The responses from the residents researched clearly display this situation and their mental and physical health is impacted as a result of their circumstances. Further reaching consequences need to be studied over a period of time. Numbers in direct provision vary from time to time and this can create difficulties for support workers and residents alike. Gaining access to medical cards, registration with GPs and other essential services is difficult and time consuming and creates even further frustration for newer residents and those who are endeavouring to assist them

Health starts at home and in our communities but it is very much determined by access to social and economic opportunities. The conditions in which we live (our environments) help to explain how and why some members of our community are not as healthy as they could be. The National Intercultural Health Strategy (NIHS) Ireland and other models, such as the Canadian Healthy People 2020 Strategy, highlight the importance of addressing the social determinants of health by creating social and physical environments that promote good health for all.[27]

The South East Primary Care Teams play a pivotal role in protecting the health and safety of the communities they serve, and they network with other services in the community to provide a comprehensive quality service to promote the health and wellbeing of the client groups. This approach is also shared by the World Health Organisation, whose Commission on Social Determinants of Health in 2008 published the report *Closing the gap in a generation: Health equity through action on the social determinants of health*.[28]

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[27] Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020. Healthy People 2020: An Opportunity to Address the Social Determinants of Health in the US (2010) http://www.healthypeople.gov/2010/advisory/SocietalDeterminantsHealth.htm
[28] World Health Organisation, Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health equity through action on the social determinants of health* (2008). http://www.who.int/social_determinants/en

<u>So why is access to health services so important for this client group?</u>

It is important in the achievement of health equity and for improving quality of life issues for the most marginalised and those furthest removed from accessing services. Access requires a number of stages, including:

- Gaining information and entry into the healthcare system

- Accessing a healthcare location where the needed services are provided

- Finding a healthcare provider with whom the patient can communicate and trust[29]

- Having access to healthcare resources

- Achieving overall physical, social and mental health improvement

- Promoting the prevention of disease and disability

- Detecting and treatment of health conditions

- Promoting a better quality of life

- Preventable death

- Life expectancy[30]

Disparities in access to health services affect migrant individuals and their communities, thereby impacting on their ability to reach their full potential. Barriers of access, language, information, knowledge and culture as outlined in this report lead to:

- Unmet health needs

- Delays in receiving appropriate care

- Inability to get preventative services

- Hospitalisations that may have been prevented.[31]

Improving healthcare services for asylum seekers and other migrants includes increasing access to and use of evidence-based services to prevent potential physical and mental illness by detecting early warning signs or symptoms before they fully develop, or to identify them at an early, more treatable, stage. In this pilot programme in the South East to address the health situation for our client groups, we prioritised a range of actions to promote a better quality of life, such as:

- Increasing access to information, health and primary care services

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[29] Bierman A., Magari E.S., Jette, A.M., et.al, 'Assessing access as a first step toward improving the quality of life of care for very old adults', J Ambul Care Manager, 1998 Jul; 121(3):17–26 quoted in Healthy People 2020
[30] Healthy People 2020, accessed December 2015
[31] Ibid

- Providing language and literacy programmes

- Providing education, training and employment opportunities

- Sourcing appropriate housing and improved socio-economic conditions

- Challenging social norms and attitudes (racism, discrimination, ghettoisation, etc.)

- Coordinating community-based resources, such as peer advocacy (CKW outreach work) to overcome barriers of knowledge and access

- Instilling a greater understanding of culture by service providers through intercultural training

- Showcasing improved access to recreational/sporting facilities through exercise programmes based in the DPCs or engaging with mainstream corporate providers

- Promoting and enabling increased participation and representation on local community structures through training, mentoring and additional supports

All aspects of the social determinants of the health model outlined in Section 1 need to be addressed in relation to the specific client groups' understanding of health and wellbeing across the five areas, thereby identifying gaps in services in each category.

A number of strategies are required to address these social determinants of health for migrant communities, such as:

- Use of health impact assessments to review needed, proposed and existing social policies for the likely impact on health

- Application of a 'health in all policies' strategy, which introduces improved health for all and the closing of health gaps as goals to be shared across all areas of Government. [32]

> By working to establish policies that positively influence social and economic conditions and those that support changes in individual behaviour, we can improve health for large numbers of people in ways that can be sustained over time. Improving the conditions in which we live, learn, work, and play and the quality of our relationships will create a healthier population, society and workforce.[33]

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[32] European Observatory on Health Systems and Policies, 'Health in All Policies: Prospects and potentials', 2006. Accessed December 29, 2015
http://www.euro.who.int/_data/assets/pdf_file/0003/109146/E89260.pdf [PDF-1.23MB]

[33] Healthy People 2020

Medical card issues

Our initial concerns focused on the assumption that all clients have access to a medical card. The reality is that the evidence in this Section 2 showed that while many did have medical cards, others were not yet organised to apply for or transfer medical card details from previous address. This may be due to:

- The transient nature of the clients

- A lack of information and knowledge about how to access a medical card or medical services

- Barriers of language, literacy and cultural understanding

Our aim is to provide a more equitable system of accessing healthcare through ensuring that all residents have access to a medical card and services as required. Therefore, through counterfactuals we measure outcomes for those who do not have the same access opportunities, i.e. those who receive health treatment and those who go without. A number of these documented in the case studies section for example;

- No PPS numbers (thereby restricting opportunity for medical card application)

- No medical card (due to transience, no English, no cultural understanding, no information on how to access and no PPS number to establish eligibility)

- No access to maternity health (due to no medical card, cultural understanding, information on access through free maternity health regardless of medical card status)

- No aftercare health services for many residents in direct provision (see Case Study #2 and Case Study #3 in case studies section)

The assumption that all residents have access to medical and health services was a constant among some health service providers and statutory agencies charged with providing services for these marginalised people. This research and report showed a willingness for engagement and change through professional participation in intercultural awareness training.

A human-rights-based approach to the work

All the work of the project healthcare practitioners is linked to human-rights-based approaches that have the potential to empower the recipients, ensure accountability and improve their protection[34] while resident in the DPC system. We documented and compared the added value of human-rights-based approaches with the risks and challenges that may arise from it.

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[34] Benelli, Prisca, 2015, ATHA, 'Advanced Training Programme on Humanitarian Action; Human Rights in Humanitarian Action and Development Cooperation and the Implications of Rights Based Approaches in the Field', p1

Many of the case studies documented in this report are complex cases and warrant a multi-agency response. *It is to be noted that in some rare exceptions beneficiaries opt to refuse personalised supports despite the genuine interest in improving their situation because they are distracted with immigration, family or health-based issues.* In such cases we continue to provide supports from a distance and assure the beneficiary that the assistance will remain on offer should they change their mind and fully engage in the future. This enables service providers to adopt the aspect of rights-based approaches that are the most beneficial in specific contexts (person-centred) and for specific purposes. For example, the needs of a person who has been trafficked will be different from an individual who has been tortured. They may share a common background, country of origin, culture and sense of place but their needs will be quite different and their ability or willingness to engage may also differ. Therefore we need to be sensitive to the context in which we are working as human rights health practitioners. Our view is that human-rights-based approaches entail the coordinated practices of policies and processes of development in conjunction with a system of rights and corresponding obligations.

The health needs of DPC residents define the nature of the programme. All involved share a responsibility to ensure that we utilise a human-rights-based framework along with a process of implementation and appropriate service delivery that ensures accountability and respect for human dignity with desired outcomes.[35] The pilot project recognises this human-rights-based approach as an effective lever for social change in meeting the most pressing healthcare needs of DPC residents and other vulnerable migrants.

The process is not about providing a different service for other health service user but rather to consider how we might together deliver a better universal service through the mainstreaming of:

- Human-rights understanding

- Cultural sensitivity

- Empathy

- Intercultural awareness training for service providers and stakeholder agencies where required

What is different in this context is that we cannot focus on health alone but also on the protective duties that we must apply through advocacy actions to increase better health outcomes, particularly for those who have been trafficked, survivors of torture and trauma, or those who are still experiencing persecution for their religious, tribal or cultural beliefs.

Evidence gained through this project is no guarantee that the work will automatically bring improved outcomes but will bring informed choices regarding access to services and supports. Other internal or external factors can prohibit this. For example, in one case the project invested more than 200 hours of advocacy supports for a client with complex health

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[35] Julia Häusermann, 'Implementing a Human Rights Approach to Development: An Opportunity and Challenge for the UN', presentation at 59th Annual General Meeting of Ipswich and District United Nations Association, Ipswich, 29th April, 2005 IS/Dev/Publ.51/2004

and social care needs. After a number of weeks, the client decided to opt out of interventions stating that he was happy as he was.

The research

The aim of this pilot programme was to examine the health (physical and psychological) concerns of asylum seekers living in the five DPCs, in the South East of the country. The lack of research in the area of health in these centres and this study clearly outlines ongoing challenges that have not been previously examined in this context. This section of the report outlined the methodologies employed to explain findings from the interviews carried out, observations and counterfactual analysis, as well as providing case studies.

Interviews were conducted by trained CKWs from the ISU who have come from the direct provision system themselves, thus giving them a unique perspective on life in the centres. Sixty-nine questionnaires were completed with the assistance of the interviewers in order to ensure the interviewees fully understood what they were being asked. Their responses shed light on their concerns regarding difficulties they regularly confront in the area of health and access to services.

The number and composition of residents in each of the centres are outlined in this section. Many of the residents have lived in DP for an extended period of time and this has contributed to a range of health concerns, which are highlighted in their responses. Conditions are, as the evidence proves, conducive to the exploitation of vulnerable, marginalised residents in search of safety from, in most cases, the dangerous and untenable regimes that forced them to leave their own homes in search of refuge. The responses from the residents in the five centres researched clearly display various concerns regarding their long-term mental and physical health.

The findings, at the time of this research, show that the vast majority of those willing to take part in the interview process, as outlined, had already received a medical card, and just over 90 per cent were registered with a GP. However, due to the transient nature of residents in the centres it can be seen that this situation can change on a weekly basis. The regular movement of DP residents from one location to another presents difficulties as identification papers, health records are often delayed or lost in transition, and it takes time to build up new relationships of trust between the newcomers and the CKWs in their area. Gaining access to medical cards, registration with GPs and other essential services can be difficult and time consuming and creates even further frustration for the new residents and those who are endeavouring to assist them.

Storytelling' to support the evidence

Case Studies (The use of an asterisk denotes that no real names were used, so as to protect the identity of the client.)

Case Study #1: Kaya*

Kaya is an African lady who is in the asylum seeking system and living in DPC accommodation. In 2014 Kaya had a stroke and was hospitalised. Following recovery she

was returned to the DPC where she felt she had no one to support her or tend to her growing needs (her stroke left her with some speech deficits, as well as mobility issues). Due to her illness and limited mobility Kaya became sedentary, isolated and rarely left the DPC.

The ISU Outreach Worker met her while on a weekly visit to the centre. Kaya agreed to participate in the healthcare questionnaire process and identified that although she required rehabilitative care following her stroke, her understanding was that she had been denied this on the grounds that she lived in a DPC. The ISU agreed to refer Kaya to the PCT in her area to try to access the supports she required.

In the interim she was registered for English language classes three days per week, which would help address her isolation issues. Because her mobility was limited and it would take her longer to reach the ISU, we arranged for her to take a packed lunch to class as she would miss her midday meal (which is fixed in the centre). After a few short weeks of walking to the ISU for class, Kaya has lost a considerable amount of weight and is much happier to be out meeting people each day. Her English has only improved slightly; however, her health and wellbeing outcomes are greatly improved.

Kaya has since successfully received refugee status and has now been provided with all the additional healthcare she requires for now. We have recently secured accommodation for her close to our offices where she will be safe and monitored. We hope that we can engage some Home Help services for her in the near future and ensure that she maintains her health goals for life. Without the interventions of the Intercultural Healthcare Programme Kaya is adamant that her health needs would not have been met, as she did not have the language or courage to articulate her needs. Her feeling was that if she spoke about her health needs it would negatively impact on her application for refugee status.

Case Study #2: Abel*

Abel is an elderly African gentleman who was referred to the ISU by the National Council for the Blind of Ireland (NCBI) due to his sight deficits and his reluctance to engage with health services due to language and cultural barriers and his distrust of the health system/workers. He does not speak English despite being in Ireland for more than 10 years. His sight difficulties have made him very vulnerable in the community (he has been burgled and pick-pocketed) and he is somewhat reclusive and lives in fear.

His accommodation is dark, cramped and totally unsuitable for his needs. He does not cook or provide hot meals for himself, and the pile of boxes placed on his cooker provides evidence of this. The ISU agreed to support Abel but was severely hindered by a 'translating friend' who spoke on his behalf and blocked access to services.

Despite many efforts to contact Abel, both by phone and in person at his accommodation, all attempts were futile. Due to rising concerns that Abel had not been seen for a number of weeks, we called in An Garda Síochána who attempted to contact our client to no avail. Following several other attempts at contact over a number of weeks we eventually contacted the recently formed Vulnerable Persons Unit of An Garda Síochána who agreed to make contact on our behalf. They too encountered the 'friend' and were concerned about his

connection to our client and the level of dependency he had created for Abel over time and his alienation of Abel from his friends and his Church.

Following successful contact, members of An Garda Síochána insisted on speaking to Abel without his 'friend' and established that Abel was very dependent on his 'friend', based on his mistrust of everyone else however unfounded. Abel agreed to attend English language classes and where appropriate magnifying supports would be put in place for him.

The ISU assisted him to source more suitable accommodation for his needs. Additional services through the Public Health Nurse (PHN) for his area were identified and his situation was discussed at the PCT meeting for his GP/area. Substantial coordinated supports have been possible through referrals to PHN and PCT services. His accommodation needs are supported by his GP and the ISU has agreed to coordinate additional social supports through weekly visits from our Health Outreach Workers. Abel's Church pastor will also call to alleviate his isolation. Home Help services three days a week have been agreed and will be implemented once he has relocated to ensure that his immediate health, physical and social needs are met. We are working with the PCT, PHN and Respond to secure accommodation in a new development that will see increased services added in the future, which will enhance his quality of life.

NCBI, though based in Cork, will provide supports in Waterford for Abel through their Outreach Worker, who will assess all his growing needs in terms of orientation around any new accommodation he might be offered. They will provide training on how to use a white stick or walking aid and will provide for all his requirements to enable him to participate in mainstream language provision in the ISU.

This has been a very successful example of how coordinated efforts and supports result in specific needs being met in a compassionate and culturally sensitive way that preserves the dignity of the client. However, Abel has recently begun to withdraw from services and appears overwhelmed by the level of medical and social supports all taking place at one time. He has been supported through his decision to withdraw as is his right as a competent adult; all supports will be resumed should his circumstances change or should he change his mind in the future.

Case Study #3: Self-harming

Jacob* is a young male from Afghanistan who witnessed many atrocities under the Bin Laden regime. His past traumatic experiences and the fact that he had no family members in this country made him very isolated.

As a vulnerable young person Jacob struggled within the system and began to self-harm by slashing his limbs with a razor blade. The ISU engaged with him on a regular basis and enrolled him for English language supports and QQI programmes, which were being delivered in Mount Sion.

He had no real sense of time or routine, had a history of disturbed sleep and was not eating well. He was sharing a room with three other asylum seekers who were a lot older than he was and from opposing sides of the war in Afghanistan. He frequently felt under threat and

overwhelmed by his circumstances, compounded by the enormous amount of paper work required for his asylum application.

Jacob's limited English and his fragile mental state meant he was not yet in a place where he was ready to submit work for accreditation; however, his need for participation in some regular occupation was recognised. With continued social interaction and engagement, he became more confident and began to reveal aspects of his traumatic past. Counselling supports were organised and Jacob was introduced to other health-based services.

Over time Jacob has gained confidence, is now working part-time and is willing to share his experience with other young people who can learn from his situation and example. Jacob along with some student colleagues addressed a public group in the local library to mark World Refugee Day; it was great to see him so engaged and animated when telling his story. When we congratulated him after his input he proudly exposed his arms, which no longer had scars. When asked how he managed to curtail his self-harming he stated 'simply coming here [to ISU], establishing a routine and some goals for my life'. He is now better placed to continue to study on a part-time basis; his English is now competent enough to submit his work for accreditation.

Case Study #4: Victims of human trafficking, male and female

Pawel*

Pawel is a young man from Eastern Europe who was trafficked into Ireland in 2013 under the pretext of paid employment. Pawel saw this as an opportunity to earn some money to provide a roof over his head. He had been placed in an orphanage as a young baby and was institutionalised by an extremely harsh regime well documented by Western media in the 1990s, where children were malnourished, lived in poor, overcrowded conditions and spent long hours confined to cots or rooms without toys. His experience was a life without love or nurturing. On leaving the orphanage he was totally illiterate; his social skills were very poor, and he showed signs of learning difficulties and naivety in terms of trust and exploitation. Income poverty is endemic in his extended family and indeed community. When his elderly 'uncle' was approached with the offer of an employment opportunity abroad he agreed that Pawel would travel once a contract price had been paid to him for his nephew.

On arrival in Ireland Pawel was placed in a rural setting and put to work in a carwash facility, where he quickly realised that the promised income and standard of living were fictional. If he complained he was beaten and forced to sleep on the floor of a small residential premises with eight other men. There were no facilities in the accommodation and food was non-existent. He and his fellow victims of trafficking for labour exploitation were paid just €4 per 14-hour day, from which they had to provide all their sustenance for the day.

Pawel challenged his traffickers for the monies promised for his labour but was met with indifference or further beatings. It was obvious that this gang of traffickers were persistent offenders using forced labour as a means of accumulating vast fortunes, which were shored up by alleged crime, racketeering, drug trafficking and prostitution. Pawel escaped to a Garda station after he was threatened with a gun. He was referred to the HSE Anti-Trafficking Unit (ATU) for supports. He was relocated for his personal safety and linked into

services with the ISU who work in partnership with the HSE, ATU and other national and international agencies tackling the issue of trafficking and repatriation.

Pawel was placed in a DPC. He felt he was treated as an outsider as he was not an asylum seeker. His poor upbringing meant that he had many underlying health issues, including severe dental problems. A range of interventions were put in place to assist Pawel access a medical card and to then organise access to general and ancillary health services, including getting glasses. He was registered for English language classes and a translator was on hand to help him understand and traverse a complex healthcare system. Advocacy services were available to him and arrangements were made to access counselling from primary care services.

Although Pawel was progressing well, following an incident that occurred in his DPC he no longer felt safe and was re-located. He is still residing in Ireland and keeps in touch. Without these coordinated interventions Pawel would remain at risk and his health needs would not have been met.

Merita*

Merita is a young female who was trafficked from her native Eastern European home more than four years ago. Her removal was quite harrowing, necessitating her separation from her small baby under force. Her mother was paid a fee by the traffickers who raped Merita and transported her across Europe for the purposes of prostitution. She has spent some time in Italy and Spain as well as Ireland. In each of these countries she was put to work suffering indignity, regular assaults and rape by both clients and her traffickers.

After building up the confidence of her traffickers over her four years in captivity she was permitted to go to the local shop to make emergency purchases. She took the opportunity on one of these trips to flee her attackers. She was lucky to be stopped and questioned by An Garda Síochána who asked for her identification papers. When she could not produce these she was taken into custody. Once her story became known she too was referred to the HSE Anti-Trafficking Unit under the agreement that she would provide a full statement to An Garda Síochána once settled in a place of safety.

Merita was referred to the ISU as it has the translation and advocacy services appropriate for her. A range of health supports has also been provided, including full sexual health screening and appropriate information on sexual health promotion. Basic services such as dental and GP access are also in place. She had been placed in direct provision as a place of safety and to exercise her right to 60 days reflective time to consider wheather to apply for refugee status or she wished to return to her country of origin. Specialist counselling supports are in place, as are English language classes and other social supports.

Her time in DPC has not been an easy one, as her vulnerabilities mean that much of her behaviours are over-sexualised and inappropriate, which attracts negative attention in the centre.

ISU has been working with the relevant embassy and other authorities from her home country to locate her child and establish some initial form of contact. Merita has decided to return home in the hopes of being reunited with her child. The ISU continue to work with her HSE Case Worker and with the International Organisation for Migration (IOM) who has

agreed to repatriate her with added supports of safe accommodation and education to enable her to secure legitimate employment so she can support herself and perhaps her child in the years to come. Authorities in Ireland remain in contact with the regulatory childcare authorities in Merita's home country to monitor the progress of her child and to consider options for family reunification on her return. Without coordinated interagency intercultural health interventions Merita would be at the risk of being re-trafficked or at best be back in prostitution and homeless.

2.8. Summary of Section 2

<u>Key points</u>

- Following this pilot programme there is a requirement for continued services to support health access routes for residents who do not yet have the capacity to do it for themselves. This can be achieved through a range of outreach services and evidence-based programmes, for example, providing outdoor and craft-based activities for children, youth and families in direct provision to aid integration and improve health and wellbeing outcomes

- The CKWs involved in this pilot programme have the opportunity to build on their capacity to deliver peer supports in a professional way in accordance with best practice, ethics and governance principles

- The pilot project highlighted the need for more information and training opportunities to be made available to health service providers so they are better informed when it comes to treating health service users from a multiplicity of ethnic cultures. This should include information and supports around translation requirements and culturally sensitive, gender sensitive or religiously sensitive knowledge that may affect treatment pathways

- There is a requirement for the design, development and support of a suite of fully resourced resettlement programmes to aid better socially determined health-based outcomes for refugees, asylum seekers and other vulnerable migrants during transition periods of their lives

- There is a requirement that the health of children and unaccompanied minors/vulnerable young adults living in DPCs or alone in the wider community be factored into future research developments

- It is strongly recommended that a longitudinal study be carried out using quantitative research methodology that will measure the progress of the residents of the DPCs over a period of time. The issues that have been addressed in the qualitative research will be followed up and changes in conditions with regard to mental health, physical health and attitudes of the residents will be recorded. It is essential that this follow-up study be carried out for the benefit of people living in these centres. Furthermore, with changing legislation in relation to DPCs, it will be necessary to chart the developments that will ensue in light of these changes, which are welcomed and highly necessary

- The recent HIQA report (June 2015) points toward the need for a multi-agency approach to deal with recurring issues in DPCs, which is an ethos strongly supported by the HSE/ISU partnership. Sharing information from practice, expertise and interagency partnership will create a diverse and effective service to meet the complexities of health issues for ethnically centred children and families

- Long-term, culturally appropriate Family Support Framework strategies must be supported by Government and all agencies for better outcomes, particularly in view of the imminent arrival of new immigrants, followed by best practice approaches for people in direct provision

Section 3 Evaluation

Section 3 contains the report for the external Evaluation Team. Following a tender process Clonmel Community Resource Centre (CCRC) was awarded the evaluation contract and has been working on this programme since the end of 2014.

3.1.   Evaluation Process

The purpose of the evaluation is to assist the Intercultural Healthcare Pilot Project to establish the evaluation process for the project. This will include developing a model, and measuring any increase in awareness, access, information and uptake of health services and supports. This work is to be carried out in conjunction with the Primary Care Teams in each of the areas where there is a DPC. In short, measuring if the pilot project did do what is said it would do.

3.2.   Evaluation Questions

The overall aim of the Intercultural Healthcare Pilot Project is to deliver an Intercultural Healthcare Pilot Project in the South East with a particular focus on those living in DPCs, and through this to eliminate/reduce barriers to enable equitable access to appropriate health services and supports.

Arising from this, the main evaluation questions are:

- What did the Intercultural Healthcare Pilot Project set out to achieve?
- What has it achieved so far?
- How do we know this has been achieved? i.e.

    - What evidence is there?
    - How sustainable is it?
    - How transferrable is the model?

3.3.   Pilot Project Background

The background to the project is documented in Section 1 of this report and includes the following:

- Pilot project aims
- The objectives for the project
- Expected outcomes

3.4. Evaluation Methods and Limitations

<u>Evaluation methods</u>

There are significant sensitivities and cultural/linguistic difficulties involved in interviewing service users in DPCs, particularly in relation to their personal healthcare and their experience of interacting with the healthcare systems. These are documented at length in Section 1 in relation to the CKWs and their role.

Given the CKWs' personal experience of living in DPCs and their present role, it is reasonable for the Evaluation Team to accept that the information gathered in its interviews with the CKWs is a reliable indication of change/progress in the service users' experience of the healthcare systems and processes.

The methodology used by the team to carry out the evaluation was to engage extensively with the CKWs and members of the LIG; participate in training events; and meet with service users and providers to identify and clarify, as necessary, progress against the aims, objectives and outcomes of the pilot project.

The research by the Evaluation Team included but was not limited to:

- Attendance at LIG meetings as appropriate

- Meetings with LIG chair, HSE Social Inclusion Regional Representative and ISU manager

- Individual interviews with LIG members

- Individual interviews with CKWs

- Meeting with CKWs collectively

- Inviting CKWs to document individually, the main/most important areas in which they believe progress/change has taken place over the past year

- Issuing questionnaires to all LIG members, seeking their views on main/most important areas in which they believe progress/change has taken place over the past year and why

- Participation in a human trafficking seminar, including gathering and analysing the attendance, evaluation and feedback sheets

- Participation in a Intercultural Healthcare Training workshop

- Participation in an information session on the asylum seeker process

The methodology also involved carrying out on-site due diligence checks to verify where possible the documented evidence /sources supporting the achievement of aims, objectives and outcomes. For example, in relation to the ISU this included the CKWs' questionnaires, focus group notes, ISU policy documents file, case studies files (soft and hard copies), etc.

<u>Limitations</u>

Lack of opportunity to engage with DPC residents/services users directly is limiting. However, as indicated above the Evaluation Team is confident that the optimum outcome was achieved in the circumstances.

In addition, the complexity of the personal profiles and relationships of the CKWs as; former DPC residents, current healthcare services users and services providers to clients in DPCs as CKW in their engagement with healthcare services has emerged as a significant benefit.

In light of these limitations there are different types and levels of presenting evidence ranging from documented changes to systems changes. These changes were verified by senior HSE manager, ISU manager, LIG member and the CKWs.

<u>Findings</u>

The 'pre-development' work of the ISU with the target groups has been key to the development of the pilot project and the realisation of its aims.

The creation of the LIG and the commitment and collaboration of its members, individually and collectively, have been crucial to the viable implementation and operation of the pilot project, bringing a more inclusive multidisciplinary approach to managing these cohorts' health concerns.

The health and wellbeing of refugees, asylum seekers and other vulnerable migrants, especially those living in DPCs in the South East, are being positively impacted by increased awareness, improved access to services, more streamlined access to medical cards, training, upskilling and the intervention of the CKWs.

The beginning of a small but profound shift in the culture of the service providers through awareness, training, LIG involvement, and managers of service providers acknowledging the need for change is apparent.

The training and upskilling of the seven CKWs has been key in effecting change through trust and confidence building, especially with DPC communities and PCTs.

As a result of the CKWs, the ISU and the service providers working together, barriers that exist in healthcare provision for those living in DPCs have been identified clearly as contributing to unequal access, as evidenced by service providers.

The pilot project has facilitated the development of mutual support and collaboration between health service users and health service providers to enable access to information, medical cards, GP registration and other primary care services.

Recognising that this large and complex area requires knowledge and expertise, collaboration between primary care and social inclusion in the management of many crisis situations over the period of the pilot project, is testament to the strong working relationship.

The HSE Social Inclusion's capability and capacity to influence strategically at national levels, while enabling the implementation and resourcing at local and community levels have

contributed significantly to the awareness of the necessity for change at systems and policy and procedures level going forward.

Finally, the model for enabling the transferability of the achievements of the pilot project to other areas and the adaptability to other groups, such as LGBTI or Roma, has been documented and the pilot project has begun to address this transferability.

Clonmel Community Resource Centre has an evaluation chart detailing evidence of their due diligence underpinning these findings.

3.5. Sources/Evidence

How can we know all of this? Where is the evidence? Much of it is self-evident, such as training courses, research, and the existence of CKWs, etc. In addition, we include below some examples of supporting actions/evidence that may not be as obvious:

- Advocacy that has taken place for the waiving of prescription charges, which has contributed to a wavier being achieved at national level

- Provision of training for CKWs in the broad range of relevant areas outlined in Section 1 has created a greater support through knowledge, understanding and expertise of how to help the service users identify their needs in relation to how the healthcare system works

- Provision of outreach support by the ISU in the DPCs and expansion and securing of two years' funding for three part-time posts (including one Roma)

- Provision of knowledge through the hosting of seminars on human trafficking for those living in DPCs and of the asylum process for service providers

- Provision of Train the Trainer and frontline training in Intercultural Awareness and Practice in Health and Social Care, raising awareness and improving competency

- As a result of the provision of hands-on support in relation to medical card applications, financial barriers to accessing medical support have been reduced

The following are some examples, experienced by clients, of barriers to information or access to healthcare services being tackled and resolved on the front line.

- A woman in a DPC was not getting any antenatal care and was unaware of how to access it until CKWs intervened. Following intervention through this pilot project's work this woman was made aware of services and supports and these were put in place for her

- The complex health needs of a young male victim of human trafficking were addressed through CKW intervention (the outcomes are detailed in Case Study #4 within Section 2 of this report)

- The Primary Care Leads on the LIG addressed the medical card issues locally, on a case-by-case basis, and also raised the issue nationally requesting that a specific system be put in place to address this barrier. This was linked to the national development of asylum seekers being exempt from paying prescription charges

- Support services for a very vulnerable DPC resident, who was a victim of human trafficking (complex case involving ISU and the HSE Anti-Human-Trafficking Unit), were coordinated by ISU/staff and volunteers through dissemination of information to all heads of departments across primary care services. All staff are now more aware of these issues and this information has cascaded down to the frontline offices and staff. (The outcomes are detailed in the Case Study subsection in Section 2 of this report)

- Across a huge and complex area requiring diverse knowledge and expertise, the levels of collaboration between primary care and social inclusion in managing so many crisis situations in the last 12 months is testament to strong working relationships

- Of the 69 people living in DPCs who took part in the CKW questionnaire, 62 had medical cards and 65 were registered with a GP

- Health status questionnaires conducted by CKWs with those living in DPCs provided information at a number of levels, systemic and cultural

- The types and numbers of referrals from and through CKWs

3.6. Responses Evaluation Questionnaires

The evaluation questions were sent to members of the LIG, Regional/CHO HSE Social Inclusion Manager and training providers to the CKW. This questionnaire was sent to 14 key stakeholders:

- Two did not feel qualified to complete the questionnaire

- Two did not respond

- Ten completed it (Figure 15 shows the responses)

A copy of detailed responses is available from Clonmel Community Resource Centre.
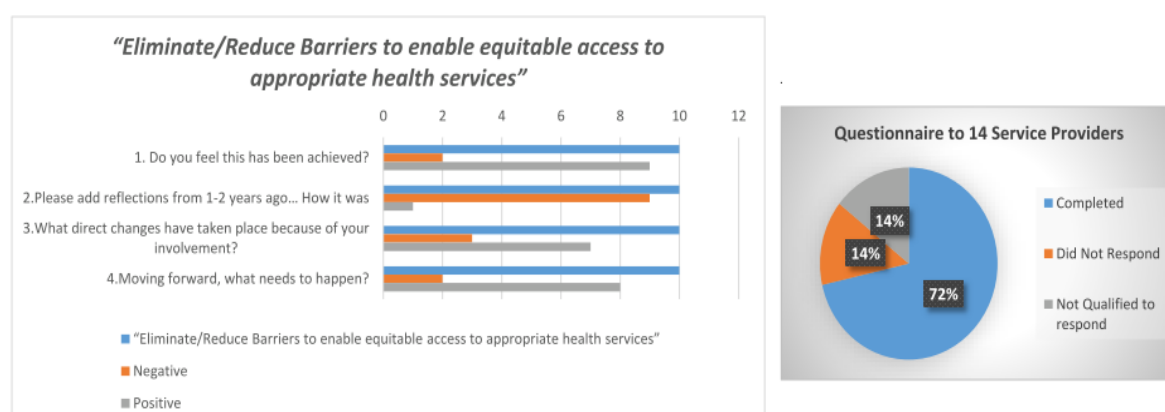
Figure 15

Some responses received included the following:

- This pilot project has raised awareness, particularly within the HSE, of the ISU as a support and information service provider for vulnerable migrants

- That the use of a primary care structure such as a LIG has enabled the multidisciplinary approach to this client group and has raised awareness of the vulnerable migrant client group within the CHO area

- The client-centred partnership approach, especially between the HSE and the ISU, has developed

- The project has addressed two key component of the barriers namely:

  1. Building the capacity of the service users through the ISU outreach work through the CKWs
  2. Building the capacity of the service providers through the formation of the LIG, specific cases being addressed through this structure and the provision of training for service providers

- The project has clearly named the barriers and stated what needs to take place for real work to begin on addressing them

- It was highlighted that barriers are being reduced through an increasing awareness among services within the HSE of the need for equitable access

Some of the examples of reduction/elimination of barriers provided:

- Supports around how to access and fast track medical cards have been put into place. There is evidence of medical card issues being worked through and a system is now in place to fast track applications where necessary

- ISU clients have been able to access primary care services with the help of primary care staff who are members of this project's LIG

- HSE staff are now more aware of asylum seekers living in DPCs in the CHO area and their needs regarding health information and access to the Irish health system. This information has cascaded down to the frontline offices and staff

- More referrals have come to the PCT from ISU

- The provision of training for the CKWs, which has created a greater support through knowledge and understanding of how the healthcare system works. Training has included the following areas: mental health awareness, awareness and prevention in substance misuse, sexual health, Intercultural Awareness and Practice in Health and Social Care, knowledge and understanding of primary care services, and the medical card application process

- The CKWs participated in a workshop/training in mental health awareness, which provided knowledge regarding self-care and personal responsibility. Information provided regarding services available within their community and nationally, and how to access them, breaking down cultural stigma and taboo around mental health

- The provision of knowledge through the hosting of seminars on trafficking for those living in DP and of the asylum process for the service provider

- The development and provision of Train the Trainer and frontline training in Intercultural Awareness and Practice in Health and Social Care

- The health status questionnaire conducted by the CKWs with those living in DPCs provided information at a number of levels (systemic, cultural) on the barriers experienced by service users. Once we have specific evidence of the need, a response can be planned and resources sought to meet this need

- It was said that 'CKWs have been put in place to help disseminate accurate information on services and health-related issues (the importance of this cannot be overstated)'

Where some respondents answered no or partly yes, this indicated that this is only the beginning of the process, highlighting the following reasons for not giving a 100 per cent positive response:

- Asylum seekers living in the DPC are a transient community

- Equitable access to appropriate health services is enormously influenced by factors beyond the scope of this project, i.e. the person's economic and social potential in the society in which the services are provided. 'So long as the service users live in direct provision where they experience poverty and social exclusion, no opportunities to participate equally, have no decision-making opportunities, and are not allowed to work, etc. equitable access is not possible'

- It is not that it has not happened but that there is an enormous distance to travel before we have eliminated barriers to enable equitable access to appropriate health services. However, barriers continue to be reduced

- More information has to go out to the agencies in relation to the importance of keeping files live until all the appropriate information/files have been securely forwarded on to new address/new services provider/GP services, etc.

- Widespread ingrained apathy and prejudice (often unconscious but not always) toward people from different cultures exists in healthcare settings at all levels. This is being addressed on some level by the training that is provided for health and community workers

- It is difficult and time consuming to work with people who speak a different language. This could lead to agencies and workers consciously or subconsciously not making access any easier for non-English speaking clients, i.e. if access is made easier, the perception can be that the job becomes harder, the workload (organising interpreters, paying for them, training staff) increases, more and more non-English speaking clients will access services which will add to all the above 'problems'

- A cultural shift in healthcare services needs to take place in order 'to enable equitable access to appropriate health services'. Funding and training needs to be made available across the board, not just in what are perceived to be the most likely services that will be accessed

Subsequently, a further questionnaire was sent to four services users and providers (three were completed and returned). These were sent to ascertain their understanding of Primary Care Teams, access routes and to identify any changes linked to the pilot project. Below is a synopsis of the answers:

- There has been an increase in knowledge in the five areas where there are DPCs. The ISU and HSE Social Inclusion meeting with the PCT where there are DPCs was the initial step in awareness

- However, following the Intercultural Healthcare (ICH) Awareness Training, the asylum seekers information session and the human trafficking events, there has been an increase in awareness of people living in DPCs, of the ISU and its services and supports and of the HSE Social Inclusion. We would suggest, but have no evidence, that the awareness and upskilling have impacted on all Primary Care Team's in CHO Area 5

- In Carrick-on-Suir, the PCT Social Worker is a member of the LIG and so there is greater engagement awareness and networking. There are no Primary Care Social Workers in Waterford or Tramore

Identified changes in the primary care areas as a result of this increase in knowledge were expressed as:

Carrick-on-Suir, South Tipperary PCT with a DPC

- Linkages with the ISU Outreach Workers/CKW in supporting families living in the DPC and improved interagency working, mainly through the Primary Care Social Worker

- HSE Social Inclusion has a bookable room in the PCT, which has led to increased awareness and visibility of the residents and their health needs. An example is the provision of space for a Roma meeting between ISU staff and HSE Social Inclusion staff

- More engagement, as a lot of South Tipperary PCT staff attended all events that this pilot project arranged. This pilot project was discussed with all PCT staff and GPs

Waterford City 2 DPCs and Tramore, Co Waterford 2 DPCs

- In Tramore the GPs are now asking for assistance from the CKW/ISU Outreach Worker through the PCT Lead. This is as a response to the change in one of the centres being designated a male-only centre, resulting in increased demands on the PCT and GP practices, especially in relation to language, medical cards and understanding the health system and how it works

- One GP practice/PCT in Waterford has a very positive working relationship with ISU and the PCT Lead, and in relation to Roma and victims of trafficking has been very engaged with the ISU

- The linkages are now clearly between the ISU and the PCT Lead in relation to specific cases, mainly complex cases that ISU staff are including in the case reviews/analysis

- The direct link between the ISU and the DPC managers. This relationship has improved in that the ISU has been asked for assistance and support more directly (as is our understanding)

Knowledge and process changes were identified as:

- Through the pilot project there is a direct link between ISU and health service providers on the ground, including a developing link to the hospitals and GP practices

- The ISU has a more defined health-outcomes focus as a result of the pilot project. Health service providers are more aware of and utilising the services and supports within the ISU for the relevant client group

3.7. Evaluation Conclusion

From all the available evidence it has considered the Evaluation Team believe that the pilot project aims, objectives and outcomes have been met. This takes into account the fact that there are some elements that have been put in place and are ongoing but whose completion are not within the scope or duration of the pilot project.

Given the complexity of the brief and the challenge of the pilot project as designed, this is a considerable achievement.

Sustainability in the longer term could be a significant challenge to its success once the pilot project is completed, given the importance of individuals and groups such as the CKWs and the LIG.

The development of the model has been a major step in the identification of the key measures necessary to mitigate this challenge and also to enable the transferability of the work and achievements of the pilot project. In this regard, the clarification of the 'purpose' of the pilot project as: 'To deliver an Intercultural Healthcare Pilot Project in the South East with a particular focus on those living in DPCs and through this to eliminate/reduce barriers to enable equitable access to appropriate health services' has facilitated a clearer understanding/definition of the emerging model underpinning the pilot project's success, and how it enables both sustainability and transferability, as follows:

- A key aspect has been the improved awareness of how the aims, objectives and outcomes define/influence the work to be done, or the activities in which people are engaged, to fulfil this purpose

- Since people and/or organisations that provide services may be approaching their 'activities', i.e. the work they do, from the premise that many if not all of the barriers do not exist, they do not feel a necessity to take any action in this regard

- In a similar vein, people who need services may not know that many of the services are available or how to access them, consequently they do not know what actions or activities are appropriate

- Therefore, work needs to be done to illustrate the barriers to equitable access that exist and that knowledge then needs to be transferred to those who use or provide the services, to enable them to overcome the barriers

- The knowledge transfer may result in the need for increased competencies in either or both service users and providers

- Since all of this may effectively change some of the activities required of the people involved and consequently the work that they do, it may result in the need for change in organisational structures and/or the operating procedures to ensure that it will continue to be done, i.e. that it is not reliant on particular individuals

- This ensures the alignment of the activities of all those involved from the diverse organisations around the new common purpose and the related aims, objectives and outcomes of the pilot project, regardless of their role, organisation, or agency

- This alignment is the foundation stone for ongoing sustainability and consistency of outcomes across the diverse organisations and the success of the model

- It is critical that this is understood and recognised by users of the model

A strategy that addresses the transition from the pilot project phase to the 'normalising' of the above changes as part of the ongoing systems, processes/behaviours of all participating organisations/agencies is obviously key to full implementation of the model and overcoming the challenges of sustainability and transferability.

3.8. Evaluation Recommendations

- As demonstrated in the model, dependence on individuals and/or groups needs to be replaced by changes where possible/appropriate in formal systems, policies and procedures and Service Level Agreements. The systems need to function regardless of the incumbent of the role/position

- Similarly, culture changes made during the pilot project in or across organisations need to be developed and embedded, or institutionalised in the organisations or agencies

- Where necessary, appropriate structures need to be put in place also, to ensure the longer-term sustainability of the changes to operating systems resulting from the pilot project

- Comprehensive documentation of all the changes to the operating systems, policies and procedures needs to be developed, agreed and shared by all involved

- A transition strategy as indicated above needs to be developed and implemented

- Ongoing data gathering and analysis, both qualitative and quantitative as appropriate, is needed to highlight the changes/benefits and provide the evidential basis for further investment

- The current model needs to be agreed and formally documented not only in relation to sustainability and transferability but also as a reference or base point to allow for continuous improvement, learning and sharing as the model itself is further developed, going forward

- The findings would indicate the need for a more in-depth health research piece for this cohort of vulnerable migrants. Precedence for this exists in the All Ireland Traveller Health Study 2010, which clearly indicates the health needs of the Traveller population in Ireland. This in turn would enable evidence-based planning for an equitable health service

3.9. Summary of Section 3

This has been a challenging project, with extraordinary levels of complexity, whose findings and outcomes have the potential to influence future policy in this area.

The introduction and growth of the CKW's role has resulted in very positive outcomes for both the pilot project and CKWs. It has facilitated the highlighting of issues to professionals, and community and frontline workers, and the bringing to light of inadequacies and inequalities by the pilot project.

The commitment and the collaborative approach between HSE Social Inclusion, the ISU and the LIG are very impressive and crucial to the success of the pilot project. It also enabled the organic growth of the project, i.e. expanding and influencing areas that may not have been anticipated.

The development of the model ensures that the outcomes of the pilot project can be sustained and replicated given its implementation and resourcing.

For the Evaluation Team it has been challenging, inspiring and a significant learning experience.

Finally, on behalf of Clonmel Community Resource Centre, we would like to thank most sincerely the members of the Intercultural Healthcare Pilot Project team; HSE Regional Social Inclusion CHO Area 5, the Integration Support Unit, the LIG and members of all the related subgroups for the pleasure of working with them and being part of this hugely significant project, and for their unbounded cooperation, openness, patience and support in our role as evaluators.

Section 4 Conclusions and Recommendations

Through this Intercultural Healthcare Pilot Project, the partnership working to achieve equitable health outcomes for vulnerable migrant community members has been effective and empowering. The importance of working within the social determinates of health framework has been clearly shown. Without the key partnerships' interdisciplinary and interagency supports the pilot project would not have succeeded to this stage. All involved were enabled to act as advocates for this client group living within the CHO area.

The World Health Organisation (WHO) defines health as not just the absence of sickness and disease; it is a positive concept that emphasises social and personal resources, as well as physical capabilities. It involves the capacity of individuals, and their perceptions of their ability, to function and cope within the many settings and environments people live out their lives. The pilot project has shown the capabilities and resourcefulness of the CKWs as volunteer participants who were central to the development to date.

The health inequalities experienced by those living in DPCs within the South East have been highlighted and addressed where possible. The willingness of health service providers to participate in information seminars and intercultural awareness and practice training has further enhanced this pilot phase. The cooperation of the DPC managers and the Reception and Integration Agency regarding access to the centres to meet residents has enabled this development.

A model of intercultural healthcare has been developed that can address the barriers and gaps preventing equitable access to health services and support. The model is transferable and can be made sustainable. The model development was made possible by the engagement of members of the LIG acting as a management structure, the CKW and all who engaged in the process.

- The model focuses on the following main areas: clarity of aims, objectives and outcomes

- It is underpinned by: knowledge transfer and competency development (capacity building)

- It enables a positive change through the two key elements of: organisation structures and operating procedures

A major challenge for its future development and sustainability is the positive change in organisational structures and operating procedures. There is some evidence of this currently. Key elements of the HSE's Intercultural Health Strategy underpinning this pilot project were health information and access. This model shows how these can be addressed.

The pilot project is also underpinned by many policies, including community development.

> A developmental activity comprised of both task and a process. The task is social change to achieve equality, social justice and human rights, and the process is the application of the principles of

participation, empowerment and collective decision making in a structured and coordinated way.[36]

The participation of the team of seven participants as CKW's within all aspects of the pilot project has been invaluable and a key element of the project. Some of the CKW's have gone on to further education and others to health related employment opportunities.

The transferability of the pilot project model is evident as it is developed in Emergency Reception and Orientation Centre (EROC) for programme refugees within CHO Area 5.

The model of training developed for service providers in 'Intercultural Awareness and Practice in Health and Social Care' has been approved by the HSE's Intercultural Health Governance Group for national delivery.

Targeted approaches to achieve full equality for all service users in accessing and using health services and supports as stated in the HSE's Intercultural Health Strategy was central to the pilot project.

This pilot project was one of six national finalists in the Health Management Institute of Ireland Leaders Awards in June 2016.

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[36] 'All Ireland Endorsement Body for Community Work Education & Training (AIEB): All Ireland Standards for Community Work', Community Work Ireland on behalf of AIEB, 2015

The recommendations below are indicated under each section of this report for clarity and ease of reading.

4.1.   Section 1 (Overview) Recommendations

- Disseminate the report to all stakeholders as an information sharing and learning opportunity

- Ensure that all stakeholder engagement remains central to transferability of the Intercultural Healthcare Model

- The need to develop supports to both service providers and service users in order to promote equitable health outcomes is paramount

- An interagency partnership structure with service user representation is crucial to the success of this project. The provision of additional support could be necessary to ensure equal participation of all members

- Maintain openness to awareness of the complexities of vulnerable migrant clients and the appropriate responses required

4.2.   Section 2 (Research) Recommendations

- That the length of stay in DPCs be reduced and the process standardised. Recognising that the length of stay in the DPC can have an impact on the health of asylum seekers as noted in the Working Group Report to Government 2015[37]

- Continue to support vulnerable minority groups to better understand and engage with professional health service providers by establishing trust through CKWs peer advocacy work

- Develop and utilise culturally appropriate care and case management systems for vulnerable migrants service users

- Allocate appropriate time and resources, taking cognisance of language, gender, cultural and religious barriers that require time, sensitivity and respect

- Clients who have experienced persecution, violence, discrimination and human trafficking require specific attention as they are not coming from the same starting point as indigenous populations. Emphasise the need to cause no further harm through inappropriate or insensitive treatment

- Maintain an informed Social Determinates of Health Model in all service provision and support for the vulnerable migrants

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[37] 'The Working Group Report to Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers (Final Report)', June 2015, Executive Summary point 37, p18

- Additional research is required for vulnerable young adults in direct provision as they have no family support systems in place to mind their health, particularly mental health, sexual health and the management of transition periods in their lives

- A training programme needs to be developed to support transition periods for vulnerable migrants, for example, transitioning from DPCs to the wider community, transitioning between DPCs and traversing milestones in their lives, such as leaving school, entering motherhood and progression from illness to wellness

- Create a greater awareness about accessing health services and supports as a human right and not a hindrance or drain on resources. Ensuring that people can have equal outcomes can necessitate putting different levels of support in place

4.3.   Section 3 (Evaluation) Recommendations

- As demonstrated in the model, dependence on individuals and/or groups needs to be replaced by changes where possible/appropriate in formal systems, policies and procedures and Service Level Agreements. The systems need to function regardless of the incumbent of the role/position

- Similarly, culture changes made during the pilot project in or across organisations need to be developed and embedded or institutionalised in the organisations or agencies

- Where necessary, appropriate structures need to be put in place also to ensure the longer-term sustainability of the changes to operating systems resulting from the pilot project

- Comprehensive documentation of all the changes to the operating systems, policies and procedures needs to be developed, agreed and shared by all involved

- A transition strategy needs to be developed and implemented

- Ongoing data gathering and analysis, both qualitative and quantitative as appropriate, are needed to highlight the changes/benefits and provide the evidential basis for further investment

- The current model needs to be agreed and formally documented, not only in relation to sustainability and transferability but also as a reference or base point to allow for continuous improvement, learning and sharing as the model itself is further developed, going forward

- The findings would indicate the need for a more in-depth health research piece for this cohort of vulnerable migrants. Precedence for this exists in the All Ireland Traveller Health Study 2010, which clearly indicates the health

needs of the Traveller population in Ireland. This in turn would enable the evidence-based planning for equitable health service access and outcomes

This pilot project has been a challenging and rewarding project that started as a simple project responding to identified health needs. As the project developed and responded to emerging needs it became complex and complicated in nature.

During 2016 this project work and model have received recognition through the Health Services Excellence Awards and was nominated as one of the six finalists at the national Health Management Institute Leaders Awards.

Some identified challenges for future sustainability are:

- The development of a health outcomes measuring tool that captures qualitative and quantitative outcomes

- To conduct research regarding the health and wellbeing of the vulnerable migrant community

- The further roll-out of the Intercultural Awareness and Practice in Healthcare Training for staff model now documented for dissemination

- Funding for post-pilot developments

Appendix 1 Terms of Reference for the CHO Area 5 Intercultural Healthcare Pilot Project's Local Implementation Group (LIG)

<u>Purpose of LIG</u>

The LIG will oversee the Intercultural Health Pilot Project. This pilot project is influenced by issues and recommendations highlighted through the Intercultural Health Strategy. These are:

- Access to services

- Data, information and research

- Human resources and organisational development

This pilot project will focus on the first two recommendations with a particular emphasis on those in DPCs in the South East.

There are five centres: two (2) in Waterford City, two (2) in Tramore, Co Waterford and one (1) in Carrick-on-Suir, Co Tipperary.

The project is a joint initiative between the HSE and the Integration and Support Unit (ISU) of the Edmund Rice International Heritage Centre. The HSE plays a key role in supporting the most marginalised service users to access services on an equal basis to any other service user.

The ISU is a non-governmental organisation (NGO) providing humanitarian supports and information to refugees, asylum seekers and other vulnerable migrants in Waterford City and environs since 2006. They provide outreach and other supports to five DPCs.

<u>Objectives</u>

- To increase awareness, information and knowledge about healthcare services and supports that are available and how to access these within the target community, especially those in DPCs

- To promote this project and the healthcare needs of the target community within HSE primary care services

- To establish an intercultural primary healthcare group of facilitators and to develop and deliver training opportunities for these facilitators, thus enabling them to be the community link around health services and supports

- To promote the delivery of healthcare services and supports to this project target group

- To work in partnership with all key stakeholders in realising these objectives.

The ultimate aim is to provide seamless and integrated services involving GPs, HSE staff and the community/voluntary sector.

Terms of reference

- To oversee and guide the development of the Intercultural Health Project

- To provide leadership, direction and support to the Intercultural Health Project with particular support to the Integration and Support Unit as the NGO leading this project

- To develop, agree and drive the project action plan, within specific timeframes, that delivers on the targets set out

- To identify the critical processes necessary for delivering and implementing the project and maintain a record of all issues and actions

- To monitor, evaluate and review progress on implementing the targets set out in the project

- To identify key learning from the project and ensure the documentation of these

Membership of the Intercultural Health Project LIG

Name	Role/organisation
Susan Murphy	HSE Primary Care Lead Waterford
Tara Hunt	HSE Transformation Development Officer South Tipperary, Carlow and Kilkenny
Angela Joy	HSE Regional Social Inclusion Office, HSE CHO Area 5 South East
Anne Nolan	Manager – Integration and Support Unit
Susan Scully	HSE Senior Health Promotion Officer Waterford
Niamh McGrath	HSE Social Worker – Carrick-on-Suir Primary Care Team (PCT)
Claire McNamara	Tusla Waterford
Victoria Kalimo Rosette	Community Representative and ISU Outreach Worker
Andy Hargreaves	HSE Substance Misuse Team Waterford (Education Officer)
Gerri Devine	Community Mental Health Nurse, HSE Homeless Services Waterford

Frequency of meetings

Meetings will be held on a monthly basis initially and then quarterly.

Programme of work

Based on the initial proposal and to be further determined by the LIG based on reports and plans developed by the ISU and the HSE Social Inclusion Office.

Agreed roles

Reviewed and agreed in June 2015.
Chair: Susan Scully
Meeting notes: Angela Joy

Reporting structure

- Organisations internal reporting structures

- Progress and final report to HSE Social Inclusion Office (funding received)

Terms of reference agreed at meeting on October 8th 2014 and amended on June 10th 2015.

Appendix 2 Intercultural Healthcare Training Delivered to Community Knowledge Workers as Part of the Pilot Project

	Training	Dates started and completed	Facilitators
1	ISU Induction		ISU Manager
2	Addiction studies	22nd July–18th August 2014	HSE Substance Misuse Team Waterford (Andy Hargreaves)
3	Sexual health promotion workshops links with STI Clinic and SATU service in UHW	10th October–21st November 2014	HSE Health Promotion (Susan Scully and Moira Germaine)
4	Human Trafficking Seminar #2 (for service users)	12th November 2014	ISU, HSE Social Inclusion, Ruhama, HSE Anti-Trafficking Unit, IOM, et.al
5	Working sensitively and effectively with refugees and asylum seekers who have experienced sexual violence and other trauma	3rd and 4th December 2014	Dublin Rape Crisis Centre
6	Self-Harm Awareness Training	18th February 2015	HSE Regional Suicide Resource Office
7	Facilitation Training	4th and 5th March 2015	HSE Health Promotion
8	Certificate in Restorative Practice	10th–13th March 2015 22nd–24th April 2015	Waterford Restorative Practice Network
9	Mental Health Training	1st–29th May 2015	Mental Health Ireland (Linda Thorpe)
10	Intercultural Awareness Training and Train the Trainers	27th May 2015 T4T September 29th and 30th 2015	Nasc and Quality Matters and HSE Social Inclusion staff
11	Information, Advice and Advocacy QQI Level 6	14th May–24th July 2015	ISU professional tutor panel
12	Leadership Training QQI Level 6	October–December 2015	New Links Training
13	Medical cards information, application process etc.	14th July 2015	Transformation development officer (TDO), Carlow/ Kilkenny and South Tipperary
14	Primary Care Teams understanding, information and access	23rd July 2015	Primary Care Team (PCT) Lead Waterford

	Training	Dates started and completed	Facilitators
15	LGBT Information Session	May 2015	Belong 2 Staff
16	Care and Case Management	February 2016 and ongoing	Annie Tudor HSE CHO 5 Social Inclusion
17	Work Practice in Community Health QQI Level 6	February–May 2016	ISU tutor panel
18	Working with Groups QQI Level 5	6-day training programme	ISU completed
19	Homelessness & Information pathway	Once-off with ongoing linkages	Information link and meeting (Gerri Devine and team Waterford-based services)
20	Transgender Information and Awareness	31st May 2016	Transgender Equality Network Ireland (TENI) (Vanessa Lacey) and HSE Social Inclusion
21	Hand Hygiene	June 2016	HSE Social Inclusion nursing staff

Appendix 3 Peer-Led Research Questionnaire

ISU Intercultural Healthcare questionnaire 2015

To identify the health needs of individuals and families living within the direct provision system and wider migrant communities in the South East.

	Question	Your response	Response for your spouse/family/children
1	What keeps you well or what's good in your life?		
2	What stops you from being well?	If the answer here is nothing, then go to Q 5	
3	In what way does it stop you from being well?		
4	How does it affect your wellbeing or health in general?		
5	What do you think you can do to support your own health?		
6a	What can others do to support your health and wellbeing? For example, • Information • Leaflets • Referrals • Language • Other		
6b	What types of health or other services do you currently access?		
7	Are there any specific needs you might have but find it difficult to speak about?		

8	Would you like to arrange a private chat to discuss this?		
9	Is there any area of heath or wellbeing that you would like more support with or access to? For example, • Sexual health • Mental health • Behaviours		
10	Have you any particular concerns about the health and wellbeing of a child or other family members?	If so, do you want to explain or arrange a chat?	
11	Do you have a current medical card?		
12	Are you registered with a local GP?		
13	When did you last visit your GP? What might stop you from visiting your doctor? When and why would you visit a doctor/GP?		

Mental Health Awareness

The ISU delivered a series of mental health and wellbeing information packs in each direct provision centre in 2013/14 for distribution by your centre manager. These packs included specific information aimed at individuals, family units with no children, family units with children, unaccompanied minors, single men under 35 years and over 35 years, and single women under 35 years and over 35 years of age. The aim of these information packs was to assist residents in direct provision to have awareness about any worries they might have regarding their own mental wellness or that of a friend or family member; to have access to supports and services by phone, online or face-to-face with a familiar person, GP or other professional. The ISU are working closely with the HSE through our **Intercultural Healthcare Strategy** to ensure that your needs are heard and documented so that we can put appropriate support systems in place for you. Our staff who are taking your details have come through the asylum system process themselves so are very aware of the difficulties you have been facing and are there to help you. We would be grateful if you would assist in this process so that we can improve access routes to the correct services for YOU and others in the future. Information will be treated with the strictest confidentiality.

	Question	Response
1	Did you receive a mental health information pack?	YES ☐ NO ☐
2a	If you did, what was in your pack?	
2b	If you didn't, would you like to receive a pack now?	
3	Did you read any of the information?	
4a	Did you understand it?	
4b	Would you like the opportunity for someone to go through the pack with you?	
5a	Was the pack useful to you?	
5b	Did you discuss the contents of the pack with anyone else?	
6	What would help you to identify any concerns you may have about your own mental wellbeing or the wellbeing of a family member or friend?	Where would you go/whom would you talk to if you were concerned about your mental health?
7	How does your current mental wellbeing state affect your daily life or that of your children/family members?	

8	Can we assist you with this process?	
9	Is there any other assistance we can offer you? For example, • Counselling • Referral to professional services	
10	What is your overall understanding or attitude to mental health and wellbeing?	

The ISU would like to take this opportunity to thank you for your participation in this consultation process. We will continue to provide outreach supports and coordinate any health or other supports or services that you may require.

Your interviewer will provide you with information on how you can access our regular services.

Can you please sign the following to state that this interview took place; your name will not be identified in any discussions/reports, etc.

Respondent: _____

Interviewer: _____

Date: _____

Appendix 4 External Evaluation Questionnaires and Clarification Process

Community at work !

CLONMEL
COMMUNITY
RESOURCE CENTRE

Intercultural Healthcare Pilot Project Evaluation Team questionnaire

If the overall aim of the Intercultural Healthcare Pilot Project is to:

'Eliminate/Reduce Barriers to enable equitable access to appropriate health services'

1. Do you feel this has been achieved? YES ☐ NO ☐

If Yes, how do you feel the project has helped you/people get the health services they need?

A.
B.
C.

If No, tell us if you think this has not happened, how and why? Please give up to 3 examples.

A.
B.
C.

2. Please add your thoughts from 1–2 years ago: how was it for you then?

A.

B.

C.

3. What changes have taken place because of your involvement? Please give up to 3 examples.

A.

B.

C.

4. What needs to happen, now? Please give up to 3 examples.

A.

B.

C.

Please add any further comments.

Thank you for taking the time to complete this questionnaire. Please return to
admin@clonmelcrc.ie by

Evaluation clarification process

Having worked through all the responses to the questionnaire, the training statements and emails and materials received since our last meeting we have listed some statements relating to commonly occurring themes. Please let us have as much specific information as possible in response to the related list of seven questions below.

Aim

To eliminate/reduce barriers to enable equitable access to appropriate health services.

In order to progress the evaluation report, there are some areas in which clarification is needed:

Some example statements

- 'Centre managers and other agencies have been able to refer clients to ISU for supports'

- 'Due to the instigation of the LIG which was aligned with primary care it allowed us to identify issues that would not normally come through, and because it did structures had to be put in place including emergency medical cards'

- 'From my experience of running 13 Primary Care Teams there is an increased knowledge of the ISU and its functions'

- 'A lot of work is undertaken to ensure that all asylum seekers have a medical card once in the country'

- 'Service delivery has changed'

Common themes

Common themes also running through the data are transience, keeping of files, language, mental health, substance misuse, and sexual health.

How much progress/change/directive has happened in these areas?

Clarification questions (please where possible attach directive, process, procedure of the before and after)

- In how many areas of primary care has the increase in knowledge occurred?

- What has changed in these primary care areas as a result of this increase in knowledge, for example, has the process changed and if so how?

- What was the process before?

- What is the process now?

- What per cent is the difference in requests for health supports from ISU, before and now?

- What changes have been made as a result?

- What new practices are currently in place?

- What processes are happening today that were not there before?

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