Report from the

NATIONAL CONFERENCE
HSE West

ADDRESSING THE MENTAL HEALTH NEEDS
OF
MINORITY ETHNIC GROUPS
AND
ASYLUM SEEKERS IN IRELAND

Radisson Hotel,
Sligo.

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There is an old Irish saying:

“Faoi scáth a chéile a mharainn na daoine”

which translates as:

“We are all responsible for each other”.

The specific mental health needs of asylum seekers, refugees, Travellers and members of other minority ethnic groups have not, until recently, been recognised as a health issue that needs targeted integrated interventions. In organising the National Conference on Addressing the Mental Health Needs of Minority Ethnic Groups and Asylum Seekers in Ireland, the Conference Committee hoped to provide a forum in which concerned stakeholders could share ideas and propose recommendations for further action.

The Committee would like to thank all those who helped in bringing this Conference to fruition. Special thanks go to John Hayes, Donegal Local Health Manager and Kieran Doherty, Donegal General Manager, HSE West, who have been supportive of the idea of this Conference for the past three years. Thanks also to members of the Steering Group who provided useful and thoughtful inputs to the planning process. Our special thanks and gratitude go to all the Speakers who provided the kernel of the Conference with their invaluable inputs. The delegates, too, by their input and recommendations, have given us much to think about.

Thanks go to Fiona Campbell, Conference Co-ordinator, Report Co-Author and Report Editor. Thanks also to Blaithin McKieran, Emer Mullan, Rhonda Russell (Support Team) and the Radisson Hotel staff. Special thanks go to: Patrick Hussein, Haran Roshi and Afia Ahsan, three asylum seekers, who gave of their time to help on the day. Thanks to Narine Stepanyan, a refugee, whose Presentation Plates’ design is incorporated in the Conference Report cover. Thanks also to those who provided technical support and to those who provided displays and stands in the foyer.

It is hoped that this Report will provide inspiration and act as a further step in pushing forward efforts to address the mental health needs of asylum seekers, refugees, Travellers and members of other minority ethnic groups.

“Tosach an maith leath na cuid oibre”. In other words: “A good start is half the work”.

On behalf of the Conference Committee
Dr Fiona M Hardy, Regional Services Co-ordinator for Refugees and Asylum Seekers, HSE West
Addressing the mental health needs of minority ethnic groups is a key challenge and an opportunity for health service professionals in the ever demographically changing Irish context. The changes in our ethnic profile in the last ten years now brings us to a place that requires immediate and concerted action in order to effectively and meaningfully meet the needs of all our citizens.

The Conference proceedings captured in this Report clearly highlight key issues that must be faced and robustly addressed in the coming months and years. Papers presented at the Conference highlighted how issues of discrimination, racism and stigma can undermine the mental health of minority ethnic groups including asylum seekers, migrant workers and Travellers. Additionally language barriers, differences in cultural practices and beliefs twinned with little or no exposure of the indigenous population to cultural difference can serve to exacerbate mental distress.

The Conference sought to highlight the human story of “Minority Ethnic Groups”. It provided a space for the distress and heartbreak experienced as a result of war and displacement; the impact from loss of identity; the impact from inability to work and the risks associated with poverty and homelessness, to be heard. It also allowed for invaluable discussion and sharing of ways forward.

We heard of the gaps in knowledge and experience of cultural differences within the health services in Ireland and the developments that are beginning to address these issues. The Conference explored positive and proactive measures to be taken in order to bridge the gap and to create the climate for dialogue across cultures. The Conference also stressed the need to ensure that opportunities are developed for voices from all perspectives to be heard, leadership and commitment to be provided, support, training and resources to be in place so that our health services can deliver responsive and quality health care to all.
PRESENTATIONS

Key Determinants of Mental Health Policy, Legislation and Mental Health Services
day 7

Setting the National Context
day 10

Cultural Concepts of Health and Illness
day 12

Meeting the Mental Health Needs of Refugees and Asylum Seekers including Victims of Torture
day 14

The Mental Health of the Traveller Community in Donegal:
The Scope of the Problem; The Possibilities for Change
day 16

Working to Reduce Health Inequalities Amongst Ethnic Minorities
day 18

Migrant Workers and Mental Health
day 20

Stress Management and Relaxation for Men
day 22

Interventions with Young Asylum Seekers
day 23

Drama in Action – All Different, All Equal
day 25
**Key determinants of mental health policy and services in Ireland:**

The following documents are key determinants of mental health policy and services in Ireland:

2. The United Nations Principles for the Protection of Persons with a Mental Illness
3. Mental Health: New Understanding, New Hope

These principles and standards of care form the statutory provisions in our own mental health legislation, namely The Mental Health Act 2001.

**The Mental Health Act 2001:**

The Mental Health Act 2001 introduces new and long overdue procedures to protect the rights of people admitted involuntarily to psychiatric hospitals and units.

In 2004, there were 2,467 involuntary admissions to psychiatric units representing a rate of 81.4 per 100,000 population. The 2001 Act places an obligation on the Mental Health Commission to prepare rules of treatment in relation to the use of electro-convulsive therapy (ECT), bodily restraint and seclusion. Work is progressing to enable these provisions of the Mental Health Act 2001 to be commenced as soon as possible.

**The Mental Health Commission:**

The Mental Health Commission, an independent statutory body, established in April 2002, has 13 members representing key groups within mental health including two service users. The Commission has two overarching statutory functions:

- To promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services
- To protect the rights of those involuntarily detained under this Act.

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1. Adopted by the United Nations in 1991; the 2003 Act specifically addresses the rights of people availing of mental health services.
2. World Health Organisation; 2001. This Report has increased knowledge and awareness of mental health, the real burden of mental disorders and the costs in human, social and economic terms and advocates specific areas of action.
5. This document sets out a policy framework for our mental health services over the next seven to ten years.
7. The Mental Health Act 2001, s.33(1).
The themes identified in Quality in Mental Health – Your Views⁸ will form the basis for the quality framework in creating a culturally responsive mental health service.

**Service User Involvement**:-
Some factors that facilitate the creation of culturally appropriate mental health services are based on assessed and identified need. The Scottish Executive uses the term “a culturally competent service”⁹ whereby the organisational, structural and clinical barriers are eliminated, and distinctive assessed health needs of minority ethnic groups are addressed.

The single most effective and reliable way to ensure mental health services are culturally appropriate is to promote the full investment and participation of service users, ranging from personal involvement and participation in one’s care plan to including service users in the planning and delivery of services.

**Information and Services Research**:-
Information and research are also key to ensuring that services are based on accurate information, assessed need and best practice. In Ireland, mental health information systems and mental health services’ research are underdeveloped. New information systems should include data on the ethnic profile of service users, thereby, identifying user needs and gaps in the services. The first annual ethnic profile census Count Me In¹⁰ provides a valuable information baseline.¹¹ Other research options should include mapping the provision of mental health services for ethnic minority groups in Ireland.¹²

**Training**:-
Training promotes cultural awareness and enhances knowledge that is imperative to creating a responsive mental health service. Ongoing mandatory in-service equality training programmes for personnel within the mental health services and training programmes that will facilitate the participation of minority ethnic groups in service provision are required.

**Targeted Services Initiatives**:-
Targeted services initiatives to address mental health needs of minority ethnic groups are also required and need to be based on the identified and assessed needs of the service users based on direct consultation including peer group involvement.¹³

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⁹ Defined as “a service which recognises and meets the diverse needs of people of different cultural backgrounds”.
¹¹ The census has shown that Black African and Caribbean people are more likely to go into a psychiatric hospital than the general population and are 44% more likely to be detained under the UK mental health legislation.
¹² A comprehensive mapping exercise conducted in London showed an absence of specialised services, difficulty in accessing mental health services and a general lack of awareness of the distinct complex and multiple needs of refugees and asylum seekers.
¹³ The Pavee Point Primary Health Care of Travellers’ Project is an example of a successful peer lead health initiative and could be replicated in mental health care.
Addressing Stigma and Discrimination:-

Promoting inclusion and empowerment of people with mental health problems is essential. The disparities in mental health care and services for racial and ethnic minorities recounts that racial and ethnic minorities are not less likely than whites to use services for their mental health problems, but are more likely to receive poor quality and inappropriate mental health care.\textsuperscript{14} This compounds and adds to the experiences of stigma and discrimination. Addressing stigma and discrimination, therefore, is an overall priority.

\textsuperscript{14} UK Census and Surgeon General’s Report; Mental Health: Culture, Race and Ethnicity; A Supplement to Mental Health 2003, UK Department of Health and Human Services, 2001.
Ireland is becoming increasingly multi-ethnic. People of many nationalities are coming to Ireland either for work or for asylum. The media and some sectors of the medical profession have been vocal in raising concerns about the possible negative impact this may have on our society or services. Racism has increased since the referendum on citizenship for children born in Ireland of foreign parents.

Travellers, an indigenous minority group, have been shown to suffer from a worse health status than that of the settled population. Irish Travellers’ health is adversely affected by the local environment, lack of amenities at halting sites and racism.

Studies from the UK have shown that asylum seekers and refugees suffer from a significant burden of mental health problems including depression, psychological disturbances and/or post-traumatic stress syndrome. Many of these problems develop and/or increase after arrival due to post-arrival stresses. Their mental health is adversely affected by social isolation, pre and post-arrival trauma, culture shock, language barriers, fear of deportation coupled with a lack of understanding about services, poverty and poor housing.

Irish GPs, in a survey conducted by the Irish College of General Practitioners, have identified the following as key issues: communication difficulties and the need for interpretation and translated materials; asylum seeker expectations; the transfer of asylum seekers to other areas disrupting health care; the need for hand-held medical records and the inequitable involuntary dispersal of asylum seekers around the country.

Mental health services have not yet adjusted to the special needs of ethnic minorities. Western psychological concepts and psychiatry are not necessarily applicable. Health care can be limited by language, cultural barriers and insensitivity to religious needs. Health professionals and service providers need to check out norms and beliefs and to beware of generalisations.

The needs of asylum seekers and refugees overlap with those of other ethnic minorities. Racial harassment is routine in communities. There are many attitudinal barriers such as “prior beliefs”, stereotyping and assumptions.

Ireland now employs a significant number of
medical and nursing personnel who have qualified in developing countries. This may have an adverse impact on the health services in their country of origin.

Immigrant health professionals can suffer from racism and discrimination from indigenous colleagues and some have difficulties in getting recognition of their qualifications.

The Eastern Regional Health Area has developed a mental health policy for ethnic minorities. This has included the training of GPs in multi-cultural health; an interpretation service; a dedicated refugee psychology service in St. Brendan’s Hospital, Dublin and collaboration with Spiritan Refugee and Asylum Seeker Initiative’s (SPIRASI) counselling service.

*A Vision for Change* policy document states that the mental health needs of ethnic minorities should be met by services which are culturally sensitive; follow community development models of mental health; employ professionals from different cultural backgrounds and use professionals who are sensitive to the diversity of human experience.

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**A culturally competent mental health service must:-**

- Carry out ethnic monitoring and ensure access to services
- Promote staff diversity
- Implement equality policies and a cultural sensitive service
- Provide anti-discrimination and cultural competence training
- Provide interpreters and translate relevant information
- Involve ethnic minorities in service planning
- Ensure action against racism in the workforce.

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**There are four key messages to take away from this session:-**

1. We must support the development of cultural competence
2. We must not scapegoat ethnic minority patients
3. We must all guarantee implementation of *A Vision for Change*.
4. Migrants will enrich Ireland as our migrants did other societies.

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15 *Report from the Expert Group on Mental Health Policy.*
“Culture is not like a coat. You cannot take off your own culture when you leave your country and put on someone else’s. Culture is woven into each of us as into a piece of cloth. If we pull out and discard the vital threads of culture, the whole cloth falls apart.”

**Concepts** of health and illness are determined by culture. An understanding of the cultural backgrounds of clients is critical to meeting their needs in an appropriate and responsive manner.

Culture is the learned values, beliefs, norms and way of life that influence an individual’s thinking, decisions and actions in a certain way. It is also something that is learned and shared by a group of people. Culture is often likened to an iceberg in that, like an iceberg, 90% of culture is invisible (known as “deep culture”) while 10% of culture is visible. Visible culture may include language, food, dress or accent while invisible culture may include attitudes, values, beliefs about life, views of time, work or status.

In the Western World we have an allopathic health care system which is a “system of medicine that embraces all methods of proven, that is, empirical science and scientific methodology is used to prove the value in the treatment of diseases”.

A biomedical understanding of health and illness predominates focusing on factors such as bacteria, virus, injury and/or physical condition. Outside of the Western World other health care systems adhere to allopathic medicine as well as additional contributory factors to health and illness. Other contributory factors which are viewed as having significant consequences for health and illness include:

- Disharmony of a person with nature
- Intervention of supernatural being/spirits
- Evil spirits/evil eye
- Human spells
- Imbalance between hot and cold in the body
- Concept of “pain” and “pain management”
- Reincarnation.

“We do not see things as they are, but as we are...”

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17 Henley and Schott; Working in a Multi-ethnic Health Care System; 1999.
18 Spector; Cultural Diversity in Health and Illness; 2004.
19 Immanuel Kant.
When working with patients from different cultures it is important to establish what their belief systems are and how they relate to health and illness. As each person comes from a unique culture and socialisation process it is more effective to treat clients in the context of their belief system rather than in one’s own. It is important to determine cultural clues that will help lead to more accurate diagnosis and more effective outcomes. It may be critical to determine the relationship of the client/service user to the following:

- Faith healers/folk healers
- Cures
- Spiritual healers/leaders
- Concepts of exorcism/deliverance
- Traditional health systems e.g. Ayurvedic (India), Qi gong (China), Curanderismo (Hispanic), Voodoo (West African/Caribbean/U.S.).

- Do not assume when working with patients from different cultures; always ask what differences may exist
- Culture is dynamic and ever evolving; as is the client's relationship to his or her own culture.

"The client teaches, the care-giver learns..."\(^{20}\)

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\(^{20}\) Henley and Schott; Working in a Multi-ethnic Health Care System; 1999.
MEETING THE MENTAL HEALTH NEEDS OF REFUGEES AND ASYLUM SEEKERS INCLUDING VICTIMS OF TORTURE

Dr. Angela Burnett, Sanctuary Practice/Medical Foundation for the Victims of Torture, UK

“When you are a refugee your life is never complete. There is always part of your life that is missing, and that part is home.”

Many factors contribute to a person’s wellbeing; many of these factors are missing in the lives of refugees and asylum seekers. Cultural bereavement from loss of social structures, loss of cultural values and rituals, relationships, material loss, previous experiences such as torture, rape, political repression, separation from family, hostility, racism, loss of social support structures and insecurity all contribute to the complex health problems of refugees and asylum seekers.

In working with refugees and asylum seekers, effective communication is required. Effective communication takes time, empathy and the use of interpreters. To be effective communicators, health workers need training and support; a language and culture broker; an awareness of gender constraints that exist between the interpreter and the refugee. Interpreters and health workers need to be trained; both may be affected by what they hear and may need briefing and debriefing.

Torture has been described as the act of killing a person without their dying. Help to alleviate the effects of torture should take a holistic approach and include considerations of practical, physical and psychological needs. Physical disabilities may need specific support. Rape and sexual violence against both men and women is not uncommon and can lead to feelings of shame, risk of STIs, HIV, pregnancy and sexual difficulties.

Common experiences after torture include sleep disturbance, nightmares, loss of concentration, signs and symptoms of panic, muscle and abdominal pain, fatigue, irritability and jumpiness.

Psychological stress may be caused by both past and present experiences. People may be experiencing normal reactions to highly abnormal situations and it is important not to pathologise their reactions.

Psychiatric referral is rarely needed. However, specialist help for a refugee and/or asylum seeker may be needed if he/she shows difficulty in the function of daily tasks, has suicidal ideas, is self-neglecting or socially withdrawing, has behaviour or talk that is abnormal in his/her own cultural context, or is showing aggression.

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21 Adil, a child refugee from Somalia quoted in Off Limits – Refugee Voices, Double Exposure for C4 Learning.
Supportive listening is essential and needs to be taken slowly over sessions. Through this, health workers can acknowledge injustice, help people cope with memories, bear testimony and earn trust.

Psychological expression is culture bound and this gives rise to the potential for misdiagnosis e.g. black and minority ethnic people are more likely than the majority population to be diagnosed with schizophrenia, sectioned and given anti-psychotic drugs. The factors which most effectively promote well-being for a refugee can be a feeling that he/she is in control and that he/she is able to reclaim the right and ability to rebuild his/her own life.

Effective health care provision should include a welcome, adequate time, effective communication, accurate information, understanding, trust, confidence and cultural appropriateness.

Mental health services need to be accessible and appropriate and should not stigmatise asylum seekers and/or refugees. The role of the voluntary sector in mental health care support is very important.

Medication is used in some circumstances but help for the asylum seeker and/or refugee in addressing his/her practical needs may be the most important treatment initially.

Individual counselling may be effective but may also be an unfamiliar concept. Group work can help to break isolation, help with orientation, help with addressing specific issues such as sleep disturbance and help individuals obtain new skills.

In the UK, there are increasing numbers of adults and children being held in detention centres. These detainees may have had previous experience of detention and torture and now do not know how long their detention will be. This is having a severe effect on their mental health.

It is important that health workers do not set unrealistic expectations; that they do not rescue but instead encourage independence. Building networks with other colleagues enables contact for information, help and support for refugees and/or asylum seekers, and for healthworkers themselves.

Health workers can play a role in advocacy in the writing of medico-legal reports; raising awareness; interacting with and guiding the media, and assisting refugees and asylum seekers in having a voice.

Some refugees are themselves trained health workers. They have valuable skills and experiences to offer but may need help to improve their English, revalidate their qualifications and acculturalise to the health service.

Working with asylum seekers and/or refugees can be rewarding and challenging.

Refugees and asylum seekers have great resilience that should be supported and enhanced, as is illustrated by these two clients from the Medical Foundation.22

“You (the torturer) can break my body but you will never break my will.”23

“Help me to stand up and I will go on fighting.”24

23 Sangul, a Turkish-Kurdish woman.
24 Theresa, a Latin-American woman.
Travellers are a distinct minority group of Irish people. They differ from the general population in many respects including their life-style, culture and treatment by society. The Traveller community continues to experience high levels of social exclusion and disadvantage. This situation requires an urgent, planned response.

According to the last Census there are 24,000 Travellers living in Ireland. They are a small minority group, being only 0.6% of the Irish population. Their health status is much worse than that of the general population with a higher infant mortality rate and Travellers dying younger than the general population.

The Donegal Travellers’ Project this year carried out a detailed survey of Traveller health. The findings are:
- There are 163 Traveller families permanently resident in County Donegal and a further 150 – 250 nomadic families visit the county on a yearly basis
- The survey sample included 64 households and gathered data on the health of 64 adults and 129 children
- The results of the survey highlight the poor mental health of the Traveller community.

The factors which adversely effect the mental health of Travellers include:-
- Uncertainty of tenure (lack of permanent sites, eviction, court proceedings)
- Physical insecurity
- Social isolation
- Social exclusion (racism and discrimination)
- Unsanitary and hazardous conditions
- Overcrowding.

The halting sites are unsatisfactory with no or insufficient amenities provided.

There are also the continual threats and intimidation. As one respondent commented about a fellow Traveller:

“There was a big fire around her mobile, they had petrol…she moved off, the family couldn’t stick it”.

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Report from the NATIONAL CONFERENCE HSE West on ADDRESSING THE MENTAL HEALTH NEEDS OF MINORITY ETHNIC GROUPS AND ASYLUM SEEKERS IN IRELAND

Survey Findings:-
- The mental health of Travellers is very poor with nearly half of respondents suffering from depression; 41% have been diagnosed by a doctor as having depression
- The proportion of people suffering from depression is higher among people living in sites (50%) than for those living in houses (26%)
- In the research, the frequency of travelling does not appear to impact on physical health
- Those that travel more frequently have better mental health
- Over 80% suffer stress in their daily lives
- Stress was not said to be caused by accommodation by Travellers living in a house
- Almost 50% of the Travellers living on sites reported that the accommodation situation was a cause for stress.

Ways Forward:-
- Make ethnicity and mental health a priority agenda item
- Provide services for ethnic minority people that are appropriate and sensitive to their needs at local, regional and national level
- Work towards the elimination of racism and discrimination from the provision of mental health services
- Encourage greater collaboration with Travellers in the planning, development and implementation of mental health services
- Increase the emphasis on appropriate education and training for mental health professionals including the areas of ethnicity, racism and Traveller issues
- Develop systems to measure the success or otherwise of the above action points.

This is the first research carried out in Ireland on the mental health of Travellers. It has identified some of the key issues and it is hoped that the results of the survey can form the basis for future planning.
CÁIRDE is a non-government organisation working to reduce health inequalities among ethnic minority communities. CÁIRDE is committed to supporting the participation of ethnic minority communities in the enhancement of their health through community development.

The work of CÁIRDE is informed by a community development approach to health, by the social determinants of health model and by a health inequalities framework.

The process in the development of the project work of CÁIRDE has involved many stages, outreach work and consultation, the building of trust (many minorities are wary of officials due to past experiences) and the identification of issues and training needs. This was followed by the building of capacity, collective action, support and influencing. A New Communities Partnership (NCP) and an Ethnic Minority Health Forum were formed.

Other activities included women's leadership development for women as leaders, women's health development and women's health action. Childcare and child development were promoted in a childcare centre.

A primary care needs assessment led to a community development and health project and other activities that took into account National Anti-Poverty Strategy (NAPS) objectives. The You Can Make a Difference project (HIV project) was also developed.

Key issues for ethnic minorities were identified as follows:-

- Poor access to services
- Poor access to resources
- Lack of support
- Lack of Information
- Social exclusion
- Inequalities.

It was found that it was important to build community infrastructure to enable communities to come together e.g. a meeting space, support around organisational development and women's fora.

Important, also, was the community development approach that involves building up the analysing skills of the communities to enable them to assess and respond to their own needs.
The Ethnic Minority Health Forum helped to strengthen the collective voice of the ethnic minorities and to engage with policy makers.

Training and capacity building has been a very important component of CÁIRDE’s work. Topics have included collective action, Irish policy system, community development and National Anti-Poverty Strategy (NAPS).

Barriers and challenges included the difficulty of maintaining ongoing participation in trying to demonstrate a community development approach. This method of development is relatively new to Ireland. The development of capacity, the lack of resources, the population dynamics, the political situation and legal situation have led to new and/or changing issues. Time constraints are always a problem.

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**Learning Gained:**

- The importance of the process
- The importance of measuring and recognising of achievements
- The need to adapt to changing environments
- The importance of building partnerships
- The need to demonstrate the community development approach
- The underpinning of work by an understanding of the philosophy of health inequalities
- The moving from a medical model to a social model of health
- The importance of participation.
Migrant workers may come to Ireland on work visas, work permits or as members of EU Accession States. Their spouses may also come to Ireland. Mobile populations are more vulnerable to mental health problems than static communities.

Migrant workers suffer from social isolation, and loss of family and community supports. Even if skilled, they may have to take unskilled work. This leads to a sense of reduced status and disempowerment. Their identity, self-worth and value systems are threatened. Some may come as bonded labourers; many have to work in poor or unsafe working conditions. Unethical contractual procedures may be in place. Migrant workers do not dare to complain.

Women are at particular risk. They may be paid piecework below minimum wages. They may suffer from sexual harassment and sexualised images of migrant women workers. They enter a labour market that is characterised by gender inequality and face greater barriers to integration. Separation from families and children, difficulty in re-unification and/or childcare issues also add to mental stresses.

Comments by women workers include:-

- “...they know they can exploit us, we have no power and no right to complain...”
- “…I feel that I am nothing here…I am not valued as a person…”
- (my employer) “…wanted to keep me as a slave…”
- (because I am foreign) “…they think they can give me the worst jobs to do…”
- “…I used to cry every night…”

Migrant workers have problems in accessing health services in Ireland. The Habitual Residence Rule, the lack of information about rights and entitlements, not knowing how to access health services, not having any knowledge of or contact with the preventative services and the fear of sickness and having to pay for health care contribute to this. Many report difficulty in accessing GPs because GPs say that their lists are full. Migrant workers can be the victims of negative stereotyping. Service providers need to be aware of differences between western psychological concepts and traditional and/or cultural norms.

Many migrant workers do not have any contact with support organisations, are given no information and can
feel very lonely and isolated after arrival. Women do not know how or where to seek help when they are victims of domestic violence. Spouses are forced into dependency on their husbands both financially and socially.

**Good practices have or should include:**

- Community development and empowerment approaches with migrant led organisations. There should be interagency co-ordination and multi-disciplinary approaches, respect for human rights and confidentiality
- Places where employers provide mentoring, support and recognition of skills and/or qualifications
- Partnerships e.g. between trade unions and Migrants Rights Centre and/or Immigrant Council of Ireland
- Training in cultural competence, equality and diversity.

**The health services need to:**

- Focus on equality and anti-racism
- Develop culturally sensitive strategies
- Promote a culture of respect
- Develop partnerships with migrant led organisations
- Ensure that service delivery is focused on prevention and addressing risk situations
- Promote staff training to focus on specific experiences of migrant workers.

**The migration process has a detrimental impact on the mental well-being of migrant workers. Advocacy, support and easier access to culturally competent mental health services are essential if mental health problems of migrant workers are to be prevented from increasing.**

Health services need to take a psycho-social approach to addressing the mental health needs of migrant workers. It is very clear that mental well-being is linked with cultural and social factors and that these factors need to be addressed.
This Project grew out of the need to address issues of mental health and social isolation in male asylum seekers. The Project was funded with help from the Northern Area Health Promotion Service. Funding requirements for the project were as follows: it should promote health, be sustainable, be multi-disciplinary and be based on a partnership and integration model.

Male asylum seekers living in direct service provision hostel accommodation were identified in terms of their mental health needs and the Project aimed to “facilitate a safe, quiet time and relaxation space for male asylum seekers”. This was accomplished through focusing on positive mental health skills, reducing stress and anxiety and developing an overall “holistic” understanding of health and wellbeing.

The identified group of men was multicultural and included men from Algeria, Nigeria, Kurdistan, Iraq, Togo and Sudan. All the men had fair to good English speaking skills. The group was a closed group and ran for ten weeks.

From the start, the group set its own ground rules and suggested the types of activities that would be useful. Additional one to one support was available to individuals, if needed.

Of particular importance was the need for the group to get out from their accommodation:

“...part of our stress is our accommodation...getting out is much better for us...”

Of equal importance was the value of the group being a peer led partnership:

“...thought I would be told what to do...together I discovered what I could do myself...”

Relaxation skills, understanding differences, art and complementary therapies, history and sport were some of the things covered in the ten weeks. Key outcomes for the group participants were social support, confidence and a sense of new possibilities.

“I am better off than when I started. I gained confidence here. I'm very happy and I'm grateful.”

“I feel better now; before if I saw others I just say hello...they are my friends now.”

“To me it was nourishing...I could speak then forget it...to have someone understand can make you feel better.”
INTERVENTIONS WITH YOUNG ASYLUM SEEKERS

Dr. Angela Burnett, Sanctuary Practice/Medical Foundation for the Victims of Torture, UK

Children may have direct experience of torture. They may have witnessed torture or may, as child soldiers, have perpetrated violence themselves. However, they should be regarded as victims. Children react in varying ways to these experiences of trauma; some may act older than their years whilst others may regress. Within families, secrets may pervade with no one quite sure of who knows what; this needs to be sensitively unpicked. It is an important thing for a child to develop a sense of trust, confidence and belonging.

Young people’s perceptions of health relate to their emotional and social well-being. They need more information about health services and in particular, on relationships, sexual health and family planning. Young people living alone often have a poor diet.

Community paediatrician, Dr Ann Lorek and colleagues in Lambeth, carried out a regular follow-up for all unaccompanied children using hand-held records. They revealed a high number of psychological problems; 30% had no educational placement and of those who did attend school or college, 6% reported bullying. No drug use was reported amongst this group.

Unaccompanied children are a particularly vulnerable group with a range of health needs; 33% of the girls and 1% of the boys had experienced rape; 62% had witnessed atrocities; 83% of these young people had lost one or both parents through death. Many of their psychological problems could be helped by strengthening educational and social networks and mentoring or friendship schemes.

Young people are also resilient and can help to shape services. Most are given temporary status until they reach the age of 18; around this age there is much uncertainty about the future.

Befriending schemes can reduce loneliness and isolation and assist young people to negotiate new systems. Befrienders may represent a friend, aunt or uncle and contacts may develop into long-term relationships. Careful selection and screening of befrienders is crucial. Training and easily accessible ongoing support should be provided.

Examples of good practice in providing support in schools are provided by Camden Language and Support Service who provide dedicated support teachers for refugee children and a welcome pack, as well as support for teachers themselves who have refugee children in their class. Buddy systems, where newcomers (who often arrive in the middle of a school term) are befriended, have been shown to be successful in helping refugee children settle in and prevent bullying.
Where there is a dispute concerning a young person’s age, it may be useful to carry out an age assessment. This gives an estimated age based on serial growth measurements, attainment of stages of puberty and dental development. However, it needs to be understood that there is a wide margin of error (several years in each direction) and it should also be noted that nutritional deficiency and illness may delay puberty. X-rays should not be used to assess age.

Increasing numbers of women and young people are trafficked into the sex industry; they are particularly vulnerable as they have no legal immigration status. I do not like to apply the term “illegal” to human beings and it is arguable that people in this situation are “illegalised” by the system. They have no statutory entitlement to health care but may benefit from outreach health services.

PICUM (Platform for International Co-operation on Undocumented Migrants) carries out work to support people in this situation and other undocumented migrants throughout Europe.

The Poppy Project, set up by the Home Office, offers people a way out of the situation but only if they agree to return to their home country and give evidence against the trafficker. However, since they are often in huge debt to the trafficker or their family are under threat, they often end up back in the same situation within the sex industry and thus a “revolving door” is in operation.

Finally, it is important for health workers to encourage their clients’ independence and to build wide networks with social services, education and voluntary organisations e.g. the Red Cross Family Tracing Service who will try to contact missing relatives or friends.
**Background:-**

The Drama Project with foreign national pupils in three Letterkenny primary schools developed from a Family Needs Assessment in 2004. Foreign national children were identified as a key group being most at risk of marginalisation. A partnership between the Health Promotion Department, HSE West and Balor Developmental Community Arts (DCA) Group established the project *All Different, All Equal* to explore some of the key issues affecting these children using the innovative creative methods of the programme.

Balor DCA had previously collaborated with the Health Promotion Department on a number of initiatives with young people using drama to address a range of health issues including bullying, teenage pregnancy, alcohol and suicide. The group had also been funded by Donegal Local Development Company (DLDC) to support a process drama project in primary schools *Playacting/Drama in Action*.

**Aims:-**

The aims of *All Different, All Equal* were to:

- Promote and celebrate cultural diversity in schools
- To empower the children to feel proud of who they are and of their cultural heritage
- To build and consolidate trust for each other within the group.

**Phase 1:-**

The drama facilitator, supported by the language teacher, delivered weekly drama workshops. The group explored stories from around the world to understand what people have in common from varying cultures. The children then scripted simple short plays using puppets and performed these plays for the junior classes. The children’s teachers observed positive changes in the children in terms of confidence and language.

**Phase 2:-**

A play celebrating the cultural richness and diversity within the school was devised and written by the group. *The Journey in Search of a Song* included music, dance and songs from Nigeria, Sudan, Ireland, Poland and India. On the day of the performance the school...
hall was decorated with costumes, pictures and jewellery from around the world. The children’s families brought samples of home cooking and the school experienced a multicultural celebration as the children proudly performed for their friends and families.

“The work that Joanna did along with the language teacher has had such a noticeable and positive effect on the children. This was obvious to see when we held our International Day. I was very pleased that the diversity within the school was recognised and celebrated.”

(School Principal)

**Outcomes:**

- To date, three primary schools and over 70 foreign national children have participated in the programme.

- To celebrate the International Day Against Racism a photographic display and workshop were held in the local library.

- In the participating schools, an additional four drama workshops were held over four weeks with 18 classes involved to explore Rights and Responsibilities. Over 490 pupils were involved. The Rights of the Child were explored on a local and global level.

**Note:**

At the Conference a short DVD was used to present the project. Copies are available from Balor DCA, Balor Theatre, Ballybofey, Co. Donegal.

Tel: 074 - 9131840 or email: info@balordca.ie
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Travellers: Summary of Feedback from Roundtable Discussions
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Asylum Seekers: Summary of Feedback from Roundtable Discussions
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Migrant Workers: Summary of Feedback from Roundtable Discussions
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Drama: Misunderstandings in Language and Culture
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Drama: Summary of Feedback from Roundtable Discussions
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Introduction:-

This part of the programme was designed to give delegates an opportunity to discuss mental health issues pertinent to three specific groups namely Travellers, asylum seekers and migrant workers. The format used was through ten minute Presentations followed by twenty minutes discussions. There were twenty-five roundtable discussions led by facilitators with approximately ten delegates at each table.

The feedback from these specific group discussions is summarised in relation to each minority ethnic group referred to above and incorporates general comments, issues raised and recommendations made.

The programme also included a drama presented by the Balor Theatre Company, Ballybofey, Co. Donegal entitled *Misunderstandings in Language and Culture*. This section concludes with feedback from the discussion surrounding the drama and encompasses issues relating to language, general comments, and proposed recommendations.

Direct quotations have been used from delegates to express their views and to highlight the issues raised and these quotations are illustrated in blue coloured boxes.

Conference Facilitators


Middle Row (L-R) Linda Elliott, Una McGinley, Maura McGettrick, Elaine O’Doherty, Josephine Stewart, Margaret Blockley, Kathleen Barry, Ann Sheridan.

Back Row (L-R) Bernadette Shields, Mags Kerlin, Christine Price, Paddy McBride, Emmet Murray, Kevin Mills, Sean Craven, Martin McMenamin.
**SUMMARY:**

Accommodation is paramount. The most poignant and recurring issue that emerged throughout the roundtable discussion feedback was that of Traveller accommodation. The effect that Travellers’ physical environment has upon them contributes negatively towards their mental health compounding further problems in the area of education, childcare, discrimination and lack of integration, and the accessing of and delivery of health services.

It was highlighted that many halting sites are not properly serviced and do not have good access to services, schools, G.P.s, shops, etc. Halting sites were described as being comparable to concentration camps - are hazardous with poor sanitation, creating major difficulties in everyday living. These living conditions are a fundamental factor in Travellers’ mental health difficulties.

It was recognised that if those Travellers who still had a nomadic way of life were provided with better accommodation facilities mental health problems would be reduced. Travellers should still have the freedom to move.

Issues and concerns surrounding depression, suicide and substance abuse were also raised and need to be tackled.

One commentator stated that 41% of Travellers were diagnosed with depression; yet many health professionals are reporting that Travellers are not taking up treatment due to the stigma attached to needing and/or accessing mental health services. The lack of trust between Travellers and health care workers, discrimination, prejudice and attitude towards Travellers were highlighted as being fundamental impediments to their accessing of services.

“Accommodation is paramount.”

“Halting sites are like cans of sardines.”

“Higher proportion of illness/bad mental health amongst those who don’t travel.”
It was recognised that Ireland does not have a good record on racial tolerance towards Travellers. Much more information, awareness and understanding is needed for both the general public and service providers on Traveller issues. Some negative attitudes towards Travellers were displayed by some of the delegates during the discussions.

Information given to Travellers is not always clear. Services should ensure that information is given in a way that is clear and in a medium that can also be understood by those with literacy difficulties. Concerns were raised about gender differences in the Travelling community and how this may lead to inequity in health.

It was also suggested that there is a difference in culture and attitude between older and younger Travellers; between behaviour and culture; assimilation and integration.

The issue of education was raised and concerns voiced that there was not enough being done to help Travellers in training for skills, education and health needs.

Discussions were also raised about the importance of Travellers taking self and social responsibility.

Government and agencies need to co-ordinate well together.

There was a concern by some that Traveller issues were being subsumed by the issues arising from the increasing numbers of other ethnic minorities.

“Problems with Travellers often based on prejudice.”

“Ethnicity is very important for all Travellers.”

“Traveller issues are being pushed aside as “old new” while migrant workers and immigrants now take the limelight.”
Key Recommendations:-

- Better accommodation/sites for Travellers
- Tackle racism
- Engage with Travellers meaningfully in the design of services
- Medical cards/records should be transferable when travelling
- Training for G.P.s on multi-cultural health
- Training Travellers as health care workers
- More training, awareness raising, anti-racism training and education for the public and services providers
- Treat everyone according to their specific needs - Mental Health Services should go to the Travelling community rather than expecting them (Travellers) to come to us
- Support for Travellers to take more social responsibility
- Provision of childcare facilities
- Need for directory/information centre accessible to professionals
- Clear information for Travellers, which is literacy proofed and user-friendly, should be designed.

“No consultation with Travellers on where they want to live.”

“Not enough being done; no political will.”

“If recognised as ethnic group Travellers would be recognised and respected for who they are.”
Summary:-

Considerable concern about the conditions imposed on asylum seekers after they arrive in Ireland was expressed.

The mental health problems of asylum seekers increase after they arrive in Ireland. This is due to living in direct provision hostels on only €19.10 per week; being socially isolated and ghettoised; dehumanised; overcrowded; not being allowed to cook or to work; losing control over their own lives, and not being able to express their concerns. New mothers can be isolated and depressed.

Asylum seekers are in a state of anxiety due to delays in having their request for asylum processed and due to fears of deportation. Asylum seekers with mental health problems fear being stigmatised and may not seek help.

It was pointed out that some asylum seekers are fleeing from poverty and not from persecution.

Records are often inadequate. If asylum seekers with mental health problems are transferred to another hostel there is no continuation of care. General practitioners and public health nurses are often the first line carers. Practitioners may feel at a loss. They need time to listen.

There is a lack of collaboration between services and agencies trying to care for asylum seekers. There are not enough resources provided and there is insufficient support for integration. Cultural competencies in all areas are very weak and skills in trans-cultural psychiatry are lacking.

There were concerns about the care given to unaccompanied minors.

“Vicarious traumatisation. What has been experienced in asylum seekers’ own country may be traumatic and horrific but their experience as an asylum seeker in Ireland may be nearly as traumatic.”

“Some people spend years in direct provision and their lives are consumed by the application process.”

“Need a robust framework to prevent services from opting out.”
There were grave concerns about family members being used as interpreters. There is a need for a good interpretation service and for more translated health and information materials. The Northern Ireland interpretation service is under-used.

There were concerns about scaremongering and racism. The Irish should have confidence in their own culture and not fear others.

Political issues were raised including the ad hoc Government planning of services; the reactionary approach; the institutional injustice and racism; the absence of services for asylum seekers who leave the hostels and for illegal residents; the lack of consultation with grass roots organisations and asylum seekers, and the sincerity of the Government in poverty proofing its policies relating to asylum seekers. The Non-Government Organisations’ (NGOs) work with asylum seekers was commended.

“**We live in a global village and need meaningful participation.”**

“**We are too quick to label.”**

“The Irish attitude is very hypocritical given their own history of emigration.”
**Key Recommendations:**

- Implement training of service providers in cultural competencies: trans-cultural mental health understanding and management
- Ensure knowledge of international background and asylum seeking system and cultural norms
- Provide training to asylum seekers on the Irish system, Irish culture and on the life skills needed in their new environment
- Provide interpretation services and better access to translated materials; ensure that services and materials are pro-actively promoted
- Improve integration, offer choice, welcome asylum seekers, improve community networks, encourage asylum seekers to join local community activities, give family support, work in partnership with minority ethnic groups
- Promote focused interdisciplinary teams with better input from grass roots to co-ordinate, educate, prevent and/or find gaps in services and promote help for needs identified
- More funding and resources should be provided by the Government for asylum seeker services and support systems
- Develop better advocacy systems
- Improve public awareness and understanding
- End direct provision or improve conditions
- Speed up the asylum process and provide amnesty for all long-term asylum seekers and allow them residence
- Develop a specialised mental health service and appoint cultural diversity officers; learn from the Northern Ireland models
- Stop the transfer of asylum seekers with mental health problems to other hostels after “incidences” to allow continuation of mental health treatment and support
- Ensure that those involved in working with traumatised asylum seekers have access to psychological support, if needed.

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27 Delegates were divided over whether to end direct provision or improve conditions in it.
Summary :-
Employment, employers and employment related issues emerged as being significant and controversial issues which contribute to mental health problems experienced by migrant workers in Ireland.

Exploitation, violation of rights and entitlements and discrimination of migrant workers by employers leads to fear; fear of employers, fear of losing employment, fear of bringing shame on their families, fear of isolation, fear of loneliness; such fear has a detrimental and adverse effect on the mental health of many migrant workers. These factors and associated fears, when compounded, play a major role in encouraging migrant workers to remain a hidden group, therefore, creating further difficulties with integration into Irish society.

It was said that no support networks or groups exist for migrant workers as with other minority ethnic groups. Migrant workers are not aware of their rights and entitlements. There is a lack of accessible information available and language is often a barrier.

There was “outrage” at the levels of injustice. Employers do not always adhere to the law. The issue of employers holding work permits was described as akin to modern day slavery. Migrant workers are “owned” by their employers and are at their mercy. There are not enough work inspectors. Migrant workers are an extremely vulnerable and isolated group.
Migrant workers contribute immensely to Irish society. Many are doing jobs that the Irish simply will not do.

Issues were raised in relation to the Habitual Residence Rule which, it was alleged, imposes a huge barrier for migrant workers and perpetuates inequities within our system. Gender issues are more apparent with migrant workers. The sense of disempowerment in spouses and their dependency can lead to mental health problems.

Lack of co-ordination was seen as a major concern by delegates. Government Departments including the Health Service Executive (HSE) need to work in partnership with other agencies in order to improve the situation for immigrants. Occupational health services should be available for workers.

Some immigrants experience real poverty and practical solutions need to be found to support them. There was concern about the conditions of undocumented immigrants and the difficulty they have in accessing services. It was noted that some immigrants have the opportunity to return to their own countries.

Racism is a problem. It was thought that suspicion of immigrants played a role in this. Delegates strongly recommended further training of service providers to minimise this suspicion and to raise awareness of the rights and actual conditions of migrant workers. School programmes should also be introduced.
"This society is extremely unequal."

"... but migrant workers come here by choice..."

“Change can only be effected through education.”

**Key Recommendations:-**

- Migrant workers should hold their own permits
- Employers should be legally responsible for providing migrant workers with information packs on rights and entitlements
- Legal loopholes need to be addressed
- Spouses should have the opportunity to work
- Migrant workers should be included in the social inclusion brief
- Continue to develop inclusion strategies e.g. recruitment of ethnic minority groups into Gardai
- Need for more work inspectors
- Set up support networks and support groups
- Information should be more accessible and available in different languages
- Need to develop mental health professionals’ understanding of cultural diversities
- Education.
In order to stimulate discussion on communication, the Balor Theatre Company, Ballybofey was commissioned to present a five minute drama on communication issues. The play was in three parts. It was both humorous and thought provoking.

The first part of the drama drew parallels between the Irish who went to England in the 1950s to look for work with the migrants who are now coming to Ireland to look for work. It opened with an Irishman leaving home in 1956 to seek work in England. He described his grief at leaving home and his loved ones and how he tried not to shame himself with tears. He demonstrated the bereavement felt by those who have had to leave their homes.

The Irishman described the difficulties in communicating with the English. He was unsuccessful in buying a train ticket when he pronounced the name of his destination as it was spelt, rather than as it was pronounced locally. The ticket officer did not understand him. By playing around with the terms “take your pick” and “a queer fellow” the drama showed how the same word could have different meanings in different cultures. It also illustrated how this could lead to misunderstandings and how, unintentionally, offence could be given.

The second part of the play shows a doctor/patient interaction. This showed how the use of metaphores and similies can be totally confusing, when used cross-culturally, if neither person is fluent in the other’s language. It illustrated how this can give rise to inadequate understanding and difficulties in patient care. The importance of using clear English with simple words was demonstrated.

The final section of the drama showed a newly arrived immigrant to Ireland being interviewed by an immigration officer and the frustrations that were experienced by both sides. Miscommunication was evident in pronunciation of common words, place names, and in the use of colloquialisms and idioms. The drama was also important in that it pointed out how a foreigner may say that he/she understands out of politeness when clearly he/she does not.
Summary:

The use of drama with humour to demonstrate the misunderstandings in language and culture between Irish people and people from other countries was commended as an excellent method to highlight the key issues and stimulate discussion.

Irish people have a tendency to assume that foreigners will understand Irish colloquialisms and the nuances of the language.

It was pointed out that the Irish need to take time to understand what is being communicated; to think about who they are addressing before speaking; to simplify their language and to check that they are understood. Asking for a yes/no answer is not enough. They should not assume that they always know what is best for non-Irish people.

Body and non-verbal language is important; it can lead to misunderstanding. Service providers may either shout in order to try to clarify what they are saying or they may use an interrogational method of interview. Body language which is acceptable in Irish society may be intimidating to the non-Irish person.

It was stressed that native English speakers need to take time when communicating with a non-English speaking person. Time is needed to develop relationships. Working through an interpreter can be difficult but can also be more successful than struggling with misunderstandings in English. Some psychiatrists may prefer to medicate rather than embarking on in-depth therapy. Some words cannot be directly translated.

It was emphasised how quickly the Irish have forgotten their own history on emigration. They now give unskilled jobs to highly skilled workers from the Eastern block and may consequently have a sense of power over migrants and asylum seekers.

There was some discussion on how the Irish can maintain their own identity.

Irish people have a tendency to make assumptions about non-Irish people who do not have the same verbal language and culture. There is a danger in making such
assumptions. English is the recognised language and therefore, it is expected by some service providers that clients should speak English.

“Even basic greetings have different cultural connotations; not making eye contact in some cultures is a mark of respect.”

“We have a tendency to shout in order to improve clarity.”

“Notice how little we have moved on.”

“Irish people historically were treated badly as emigrants – have we forgotten this now that we are so affluent?”

“Even basic greetings have different cultural connotations; not making eye contact in some cultures is a mark of respect.”

“We have a tendency to shout in order to improve clarity.”

“Notice how little we have moved on.”

“Irish people historically were treated badly as emigrants – have we forgotten this now that we are so affluent?”

Key Recommendations:-

For planners and managers:-

◆ Ongoing intercultural training of service providers needs to take place; this should include training in communication skills and attitudes; personal experiences should be built into training

◆ Drama, art, theatre and humour should be used to raise awareness; schools and teenagers should be targeted

◆ Cluster foreign families in the same area and plan carefully for their arrival

◆ Give classes to asylum seekers and foreign workers

◆ Set up an effective interpretation service with trained interpreters

◆ Train professionals in how to interact with foreign nationals

◆ Carry out cultural/language proofing on information documents/packs.

For all Irish Nationals:-

◆ Be aware of language

◆ Speak slowly

◆ Use simple language; avoid jargon and colloquialism

◆ Clarify that all the important information that has been given has been understood correctly.
QUESTIONS FOR THE PANEL

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QUESTIONS FOR THE PANEL

Introduction:-
There were two Panel Sessions for Questions, morning and afternoon respectively, to enable delegates to pose questions to the Panel in conjunction with the Presentations given and in accordance with the Conference Programme.

A selection from the numerous questions put forward by delegates on the day have been included in order to encompass the main issues raised. Due to time constraints there were many questions that simply could not be answered on the day. Where possible requests for written responses were provided. Some of these questions are included in this chapter.

This chapter has been divided into morning and afternoon sessions of Questions for the Panel for ease of reference.

The following represents a sample selection of questions posed by Conference delegates and the Panel’s response.

QUESTIONS FOR THE PANEL (morning session):

Panel: Bríd Clarke, Chief Executive Officer, Mental Health Commission;
Caoimhe Gleeson, Equality Officer, HSE West;
Dr. Angela Burnett, Sanctuary Practice/Medical Foundation for the Victims of Torture, UK;
Dr. Philip Crowley, Deputy Chief Medical Officer, Department of Health and Children;
Frank Edwards, Director, Reception and Integration Agency, Department of Justice, Equality and Law Reform.
Chair: Alice O’Flynn, Assistant National Director - Social Inclusion, Office of the CEO.

Q. Is there evidence that asylum seekers’ mental health improves/declines on arrival in a foreign country?

A. Work suggests that both physical and mental health of asylum seekers decline on arrival in a foreign country. (Dr. Angela Burnett, Sanctuary Practice/Medical Foundation for Victims of Torture, UK)

Q. Do we have reliable data on mental health and asylum seekers?

A. We do not have any reliable data. Our information systems in mental health are not extensive; we only have inpatient data. The Mental Health Commission is looking into this at present. We are interested in the way that the Mental Health Commission in England used data from their census to highlight needs and gaps in services. (Bríd Clarke, Chief Executive Officer, Mental Health Commission)
Q. Are there any plans to improve the provision of interpreter services?

A. By virtue of the Mental Health Act 2001, the Mental Health Commission is committed to providing interpretation services. Interpreters will be available at mental health tribunal hearings and for consultation meetings with a client and their legal representative.

At a regional level, information will be produced in different languages and in an accessible format. All mental health tribunal participants will receive mandatory training that looks at experiences from a service user’s point of view.

There are now opportunities for the Irish Advocacy Network, Support, Training Education, Employment, Research (STEER) Ireland and other groups to create mutual partnerships to move forward on this agenda.

(Brid Clarke, Chief Executive Officer, Mental Health Commission)

Q. Is it the responsibility of the Health Service Executive to change government policy that is undermining people’s mental health?

A. On one level, it is the responsibility of everybody particularly with regard to some of the more practical issues. However, we need to clarify roles in terms of the Health Service Executive and the Department of Health.

The Department of Health is responsible for legislation and policy; the Health Service Executive is responsible for running the services and the finance thereof within allocated budgets. With regard to the issues of direct provision and mental health I feed into a Senior Officials’ Group on Social Inclusion and will be able to raise these issues at this forum.

(Dr. Philip Crowley, Deputy Chief Medical Officer, Department of Health and Children)

Q. What is in place to help people integrate in terms of applying their skills and qualifications into the workforce; for instance people with foreign medical qualifications gained outside of the European Union?

A. This issue is very complex. There is a very strict legal framework within the Medical Practitioners Act 1978 that determines the basis...
on which a medical practitioner can practice in Ireland. It is extremely
difficult to alter this.

(Dr. Philip Crowley, Deputy Chief Medical Officer, Department of Health and
Children)

Q. If people are in “direct provision” accommodation for 3/4/5 years
surely this must prevent them from integrating. Therefore, is it policy only
to “integrate” those whose asylum applications are approved?

A. There is no published policy about integration. The aim is to deal
with people’s claims much quicker than this. However, delays persist.
It is clearly an obstacle to integration to be living in a hostel.

(Dr. Philip Crowley, Deputy Chief Medical Officer, Department of Health and
Children)

Q. Direct provision accommodation for asylum seekers and refugees in
hostels seems to contribute to mental health problems. Is there any
attempt to change this policy?

A. This is a complex situation. In 1999, the Government took a
decision to provide accommodation for asylum seekers by “direct
provision”. At that time, there was no suitable accommodation
available in the State so they had to acquire accommodation wherever
possible to meet the huge influx of asylum seekers; some of this
accommodation was not suitable for use on a long-term basis. Living
in such accommodation has an adverse impact on people’s mental
health and in particular where people cannot cook for themselves. We
are currently working hard to try to move people into self-catering
accommodation wherever possible. The Reception and Integration
Agency (RIA) is undergoing a huge process of re-calibrating its
accommodation facilities across the country to try and address this
problem.

(Frank Edwards, Director, Reception and Integration Agency, Department of
Justice, Equality and Law Reform)
Q. Is there any evidence of how an asylum seeker’s mental health improved or deteriorated on leaving their country of origin to live in Ireland?

A. I am not aware of any work on this issue specifically in the Irish context. However, a recent meta-analysis of the literature on the mental health needs of refugees has shown that forced migrancy confers an overall increase in psychological ill health.\textsuperscript{28} The authors found that this is not an inevitable consequence of conflict and trauma but reflects the socio-political conditions that they face in host countries. Their conclusion is that improving these conditions could improve mental health outcomes.

Self-reporting by asylum seekers and refugees in the UK reveals an increase in the levels of anxiety and depression. Although people may have reached a place of comparative safety, the conditions in which they live as affected by poverty, unemployment, dependence and the fear of being deported, have a detrimental effect on mental health. (Dr. Angela Burnett, Sanctuary Practice/Medical Foundation for the Victims of Torture, UK)

Q. Would you say it would be a better idea to give asylum seekers the choice of direct provision; they could work and pay their own rent if it were an option?

A. Most asylum seekers want to work, to become independent, and to contribute to the economy. (Dr. Angela Burnett, Sanctuary Practice/Medical Foundation for the Victims of Torture, UK)

Q. What is the Panel’s view on the impact of the segregated direct accommodation provision and the denial of right to work policy on the long-term mental health needs of asylum seekers?

A. Most asylum seekers want to work, to become independent and to contribute to the economy. Indeed, many are very well qualified to do so. There is already an extensive body of evidence on the detrimental effects of unemployment and poverty on mental health. There is nothing to suggest that people seeking asylum are affected any differently. The resultant dependence and lack of control is damaging to people’s long-term mental health. Segregated direct accommodation has the effect of isolating asylum seekers from the local community, increasing division and reducing the likelihood of contact and mutual understanding. (Dr. Angela Burnett, Sanctuary Practice/Medical Foundation for the Victims of Torture, UK)

\textsuperscript{28} Porter M and Haslam N; Pre-displacement and Post-displacement Factors Associated with the Mental Health of Refugees and Internally Displaced Persons: A Meta-Analysis; 2005; JAMA 294: 602-12.
Q. What is the current standard of training/education for health professionals in trans-cultural health?

A. The training of health professionals in trans-cultural health is generally minimal or non-existent. This is a key problem that needs to be addressed as a matter of urgency. Some training and support is happening across the country but is lacking in co-ordination. There is an opportunity to begin to develop core competencies and to build this into our training system.

(Alice O’Flynn, Assistant National Director – Social Inclusion, Office of the CEO)

Q. How can we include members of ethnic groups on our health care teams? Is there a possibility that we can select a trained representative from different cultures like “Just Therapy” in New Zealand?

A. I believe that health care teams that reflect the diversity of the population which we serve increase the possibility of offering a service that is culturally appropriate. In the UK, there are many examples of assistance for refugee health workers to have their qualifications revalidated enabling them to work (www.rose.nhs.uk); there are also courses specifically for refugees who want to develop counselling skills (www.refugeetherapy.org.uk); although they face many barriers to work.

However, it is important to be aware that whilst clients and health workers may share language and some aspects of culture, they may still differ in class, gender and other aspects of culture and beliefs. It is also important for refugee health workers and others who have not previously worked in Ireland to be aware of the differences in patients’ expectations between Ireland and their own country.

(Dr. Angela Burnett, Sanctuary Practice/Medical Foundation for the Victims of Torture, UK)

Q. What are the difficulties facing Mental Health Services in Donegal specifically in relation to new communities presenting for treatment?

A. Asylum seekers, Travellers and people from other cultures may present with different symptoms to their mental problems than those of the majority culture. They may have had, or have, stresses on them that are not familiar to local health workers. Health workers may, therefore, need to take a different approach. The mental health service providers in Donegal need to have on-going training in trans-cultural health issues. The use of interpreters also needs to be encouraged. Extra staff are needed to cater for the increased workload on the mental health services.

(Dr. Fiona Hardy, Regional Services Co-ordinator for Refugees and Asylum Seekers, HSE West)
Q. What kind of services are available to staff and/or interpreters regarding debriefing and support?

A. The health service professional using an interpreter has a responsibility to the interpreter to debrief and/or to offer support to the interpreter. In Sligo/Leitrim/Donegal users of interpreters are informed of the process during their interpretation training and the interpreters are also informed that support can be obtained. This should also be explained by the health service professional whilst he/she is explaining the confidentiality commitment. The line manager of the health service provider has a responsibility to ensure that his/her staff member is given the support needed.

(Dr. Fiona Hardy, Regional Services Co-ordinator for Refugees and Asylum Seekers, HSE West)

Q. Is there a publication you would guide people towards to find out more about the cultural concepts for a department to purchase?

A. Henley and Schott; Working in a Multi-ethnic Health Care System; (1999). There is also a very useful and up to date website: www.ethnicityonline.co.uk We are currently working with our partners in the North to publish a multi-cultural handbook for health care staff on the needs of clients and patients which will be available shortly.

(Caoimhe Gleeson, Equality Officer, HSE West)

Q. What do you feel are the primary training needs of asylum seekers and refugees in Ireland? Addressing issues and working with people from different cultures is extremely time consuming. How can we as a health service provider become more effective and/or more efficient to access?

A. Cultural constraints and language are key issues. The first is in training about our system: the supports and opportunities available; the rights and obligations; the civil society and what is needed to survive physically and mentally. The second is communication skills. This involves language, how to talk in English; how to use body language; how to fill in forms; how to maintain one’s own cultural identity but how also to mix and blend. Health service providers need to arrange for extra consultation time to be given to the client for the first and second visits; this will greatly enhance the productivity of, and shorten, the time needed for subsequent visits. Information leaflets in different languages and pictures would help. The use of a relative as interpreter is not recommended.

(Dr. Fiona Hardy, Regional Services Co-ordinator for Refugees and Asylum Seekers, HSE West)
A. These two issues are inextricably linked. Ireland is becoming increasingly multicultural and needs to recognise Travellers' ethnicity, Travellers' rights and Travellers as a minority ethnic group. We are beginning slowly to plan for diversity. Today is a reflection of that. Travellers are essential to that planning for diversity. It is very important that Travellers are included in the planning process as not to do so would be very serious indeed.

(Paula Leonard, Community Health Care Co-ordinator, Donegal Travellers' Project)

Q. Would officially recognising Travellers as a minority ethnic group help to address their needs and does the panel think that the impact of Ireland becoming increasingly multi-cultural should make it easier or more difficult for Travellers to have their needs addressed?

A. These two issues are inextricably linked. Ireland is becoming increasingly multicultural and needs to recognise Travellers' ethnicity, Travellers’ rights and Travellers as a minority ethnic group. We are beginning slowly to plan for diversity. Today is a reflection of that. Travellers are essential to that planning for diversity. It is very important that Travellers are included in the planning process as not to do so would be very serious indeed.

(Paula Leonard, Community Health Care Co-ordinator, Donegal Travellers’ Project)

Q. How do the Panel feel about the recent announcement that the €1,000.00 payment for parents may include workers whose children are back in their native country?

A. It makes no difference whether a child is here in Ireland or at home; parents still have huge financial responsibilities for the upbringing of their children. Massive burdens are placed on families who are
separated because a parent has to migrate to work to ensure their survival. I interviewed several women in my research who spoke about the grief of this separation and the long-term impact of the separation on the family. We now have the term “trans-national parenting”.

(Dr. Jane Pillinger, Independent Policy Advisor and Researcher)

Q. Why can asylum seekers not work?

A. There is an absolute denial of the right to work for all asylum seekers in Ireland with the single exception of a small number of asylum seekers who applied for asylum between July 1998 and July 1999 (approximately 3,500 asylum seekers benefited from the scheme). The latter group were granted the legal right to work while their applications were being processed. December 1999 saw the introduction of a policy of dispersal and the implementation of measures of direct provision to replace the more generous social welfare entitlements to which asylum seekers were previously entitled.

(Cherif Labreche, Liaison Officer, CAIRDE)

Q. What is the legislation that causes persons leaving direct provision accommodation to be deprived of their medical cards and €19.10 allowance?

A. There is no legislation as such. However, S.W.A. Circular no. 04/00 refers. This stipulates that: “Under Direct Provision, asylum seekers will still need a residual income maintenance payment to cover personal requisites. The recommended amounts are €19.10 per week for an adult and €9.60 for a child. Exceptional Needs payments can, of course, be made where appropriate”. Payments can be stopped if a Community Welfare Officer is satisfied that an asylum seeker has left hostel accommodation. This is also applicable to medical cards. Asylum seekers do not have an automatic entitlement to medical card services. Entitlement is based on assessable income being within relevant financial guidelines. If a medical cardholder leaves the Community Service Area in which they reside they no longer have an entitlement to medical card services in that area because they are no longer resident in the area. If an asylum seeker leaves direct provision and continues to

Q. Are there clear recommendations being made to government departments to seek any end to “piece rates” i.e. below minimum wage and to work permits, given the negative impacts that these issues are having on mental health?

A. These issues are not being addressed. There are inadequate labour inspectorates to deal with related potential problems. Trade Unions are slowly addressing such issues. My Research Report highlights these issues and addresses recommendations to government, employers and unions.

(Dr. Jane Pillinger, Independent Researcher & Policy Advisor)
Q. How can one begin to address the way in which we, as health workers, oppress?

A. As health workers we need to be aware of our power and use it wisely. We need to be aware of how institutional racism operates and make sure that our policies are non-discriminatory. We need to be good at listening and at self-examining what we do and on the effects this has by getting feedback. We need to involve asylum seekers themselves in designing, implementing and delivering services.

(Dr. Angela Burnett, Sanctuary Practice/Medical Foundation for the Victims of Torture, UK)

Q. In terms of accessing services does alcohol and drug misuse pose a problem?

A. We provide a psychology and therapy service. If someone has a problem with drugs or alcohol we are active in referring them on to get support with their specific problem in order for them to receive the benefit of therapy.

(Irin McNulty, Psychologist, HSE Refugee Psychology Service)

Q. What formal training in this area is currently available in Ireland for mental health professionals?

A. I am not aware of any specific core curriculum training available in trans-cultural psychiatry in this country. In order for this to develop, it needs to be looked at by the academic institutions to provide optional modules and in-service training. The Health Service Executive has also been looking at this in terms of unitary education and development for health care staff.

(P. J. Boyle, Clinical Nurse Specialist, HSE Balseskin Reception Centre)

Q. How can we include members of ethnic groups on healthcare teams? How can we select and train representatives from different cultural groups?

A. There are some models we could look at e.g. the Health Care Advisors for Traveller Health Care is being used for other ethnic groups in parts of Ireland. There is also Access Ireland and the area of nurse education. Once people have refugee status they may be able to take a health care qualification. It can be a slow process. We need to look at giving recognition to the qualifications they may already have as per the Lisbon Declaration which refers to the issue of migrant workers’ qualifications in Europe.

(P. J. Boyle, Clinical Nurse Specialist, HSE Balseskin Reception Centre)
Q. How were the religious differences taken into account and dealt with prior to selecting/inviting men to the men’s group?

A. Religious beliefs were not an issue; the men were just invited to join. We did not take religion into account and it was not a problem.
(Sr. Breege Keenan, Social Worker, Vincentian Refugee Centre)

Q. Is there a specific language service support and how do we identify language issues?

A. There are translation services across the country. In the East, a nine month language translation pilot project has recently been completed. Once this has been evaluated this will help in the development of these type of services.
(Alice O’Flynn, Assistant National Director – Social Inclusion, Office of the CEO)

Q. Could we begin to use the “ethnic identifier” question as piloted in the Rotunda and Tallaght Hospital?

A. We are currently in discussions with the Department of Health to see when we can roll out the use of the “ethnic identifier” question in all hospitals.
(Alice O’Flynn, Assistant National Director – Social Inclusion, Office of the CEO)

Q. Why do the families of torture survivors require extra support?

A. There are many reasons. The impact of torture on one family member can effect the dynamics of the whole family; some family members may have experienced rape and are now having sexual and relationship difficulties; some children may have experienced violence or been a witness to acts of violence and this may not be talked about in the family; there may be secrets that need to be acknowledged and addressed in time.
(Dr. Angela Burnett, Sanctuary Practice/Medical Foundation for the Victims of Torture, UK)

Q. Can you give more information on dealing with young people who are keeping secrets and also on programmes to support young people particularly unaccompanied minors?

A. This is similar to the response needed when there is evidence of a child experiencing sex abuse; it is all about building up trust and developing trust. Log on to http://intl-bjsw.oxfordjournals.org/cgi/content/abstract/36/5/707 “The Sound of Silence: Listening to What Unaccompanied Asylum-Seeking Children Say and Do Not Say” by Ravi Kohli and www.ncb.org.uk/arc
(Dr. Angela Burnett, Sanctuary Practice/Medical Foundation for the Victims of Torture, UK)
Q. What is the HSE doing to educate staff against racism?

A. Training and support on this is happening across the country, but there is a lack of coordination on this. There is an opportunity to begin to develop core competencies and build this into the training system.

(Alice O’Flynn, Assistant National Director – Social Inclusion, Office of the CEO)

Q. What can be done to address the religious and belief systems on child possession?

A. This is a complicated child protection issue. It must be remembered that the child’s needs are paramount. Children have been in extremely dangerous situations. We need to address the statutory framework on child protection as delivered by social services and also aim to involve the whole community. This is important if we want to change practices and stop them going underground. This same type of approach is important for other issues like female genital mutilation.

(Dr. Angela Burnett, Sanctuary Practice/Medical Foundation for the Victims of Torture, UK)

Q. Can you recommend strategies for alleviating stress as encountered by health workers?

A. Do not take your work home. Make sure you have networks of support; have informal support groups to talk about stress. We found that sometimes it is the “systems” which we work in that can cause as much stress as the clients’ stories, although these can be very stressful to hear. Get relaxation for yourself, do what you need to do to look after yourself so that you can be a good carer for others.

(Dr. Angela Burnett, Sanctuary Practice/Medical Foundation for the Victims of Torture, UK)

Q. Where can we get DVD of Drama in Action?

A. Please contact Balor DCA, Balor Theatre, Ballybofey, Co. Donegal. Tel: 074 - 9131840 or email: info@balordca.ie

(Anne McAteer, Health Promotion Department, HSE West)
SUMMARY OF KEY QUESTIONS FOR THE PANEL:

The following is an overview of the key issues arising from, questions posed and comments made in response to the Questions for the Panel sessions of the Conference:

- Traveller accommodation
- The need to officially recognise Travellers as a minority ethnic group
- The system of direct provision for asylum seekers
- The withdrawal of medical cards for those asylum seekers who leave the system
- Work conditions of immigrants, the basic minimum wage and child benefits
- Recognition of overseas training
- The need to have mental health workers from ethnic minorities
- Training in cultural competencies
- Support for ethnic minority children who hold on to secrets and/or who become psychotic
- The importance of promoting the need for a mental health service for ethnic minorities
- Interpretation services and interpreters
- Funding
- Provision and support of services
- Availability of services and the related planning process
- The enactment of policies and progress made
- Need for references and cultural support materials.

Note: All requests for written responses have been acceded to where possible.
RECOMMENDATIONS

Travellers
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Asylum Seekers
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Migrant Workers
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Language and Culture
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Constructive Recommendations from Evaluation
page 57
RECOMMENDATIONS

Introduction:
The Conference Presentations stimulated animated discussions and the recommendations made by the delegates were constructive and practical.

The recommendations below have been compiled from the main body of the Report and there are many crosscutting issues highlighted in the recommendations.

These recommendations should be of great value to those planning services for and inclusive of ethnic minorities and for those organisations and individuals offering support.

Travellers:
- Better accommodation/sites for Travellers
- Tackle racism
- Engage with Travellers meaningfully in the design of services
- Medical cards/records should be transferable when travelling
- Training for G.P.s on multi-cultural health
- Training Travellers as health care workers
- More training, awareness raising, anti-racism training and education for the public and services providers
- Treat everyone according to their specific needs - mental Health Services should go to Travelling community rather than expecting them (Travellers) to come to us
- Support for Travellers to take more social responsibility
- Provision of childcare facilities
- Need for directory/information centre accessible to professionals
- Clear information for Travellers, which is literacy proofed and user-friendly, should be designed.

Asylum Seekers:
- Implement training of service providers in cultural competencies; trans-cultural mental health understanding and management
- Ensure knowledge of international background and asylum seeking system and cultural norms
- Provide training to asylum seekers on the Irish system, Irish culture and on the life skills needed in their new environment
- Provide interpretation services and better access to translated materials; ensure that services and materials are pro-actively promoted
- Improve integration, offer choice, welcome asylum seekers, improve community networks, encourage asylum seekers to join local community activities, give family support, work in partnership with minority ethnic groups
- Promote focused interdisciplinary teams with input from grass roots to co-ordinate, educate, prevent, find gaps in services, promote help for needs identified
Asylum Seekers (continued)

- More funding and resources should be provided by the Government for asylum seeker services and support systems
- Develop better advocacy systems
- Improve public awareness and understanding
- End direct provision or improve conditions
- Speed up the asylum process and provide amnesty for all long-term asylum seekers and allow them residence
- Develop a specialised mental health service and appoint cultural diversity officers; learn from the Northern Ireland models
- Stop the transfer of asylum seekers with mental health problems to other hostels after “incidences” to allow continuation of mental health treatment and support
- Ensure that those involved in working with traumatised asylum seekers have access to psychological support, if needed.

Migrant Workers:-

- Migrant workers should hold their own permits
- Employers should be legally responsible for providing migrant workers with information packs on rights and entitlements
- Legal loopholes need to be addressed
- Spouses should have the opportunity to work
- Migrant workers should be included in the social inclusion brief
- Continue to develop inclusion strategies e.g. recruitment of ethnic minority groups into Gardai
- Need for more work inspectors
- Set up support networks and support groups
- Information should be more accessible and available in different languages.
- Need to develop mental health professionals’ understanding of cultural diversities
- Education.

Delegate were divided over whether to end direct provision or improve conditions in it.
**Language and Culture**:-

*For planners and managers*:-

- Ongoing intercultural training of service providers needs to take place; this should include training in communication skills and attitudes; personal experiences should be built into training.
- Drama, art, theatre and humour should be used to raise awareness; schools and teenagers should be targeted.
- Cluster foreign families in the same area and plan carefully for their arrival.
- Give classes to asylum seekers and foreign workers.
- Set up an effective interpretation service with trained interpreters.
- Train professionals in how to interact with foreign nationals.
- Carry out cultural/language proofing on information documents/packs.

*For all Irish Nationals*:-

- Be aware of language.
- Speak slowly.
- Use simple language; avoid jargon and local dialects.
- Clarify that all the important information that has been given has been understood correctly.

**Evaluation**:-

- Issues raised and recommendations made during the Conference should be actively pursued, policies should be implemented and follow-on Conferences and/or Seminars should be held.
- Cultural awareness and information training should be mandatory for all Health Service Executive staff and should be available for those working with minority groups.
- References should be made available and there should be a directory of resources.
- A bookstall at the Conference would have been useful.
- There need to be more examples of good practice.
- There needs to be more baseline data.
- There needs to be a more creative approach to information dissemination.
- Non-mental health professionals working with minority groups with aggressive behaviour need to know how to manage the situation.
- Government, voluntary and community groups need to work more closely together.
EVALUATION

Conference Organisation

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Conference Evaluation

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Conference Organisation:-

The Conference was arranged in response to an expressed need by many people who work in departments or organisations with or for minority ethnic groups and asylum seekers.

The Conference Committee was aware of the need to present sufficient, relevant and useful information; as well as to allow time for discussion and the sharing of experiences and ideas. The Committee was also aware that most delegates would only be able to commit one day to the Conference; it was believed that most delegates would like an opportunity to discuss all the topics and so parallel workshops would not be an option.

The Committee decided that the Conference would need to be organised in such a way that these elements could be met and therefore took the following planning decisions:-

◆ **Time keeping:-** The speakers were all informed in advance that time-keeping was going to be rigorous. A time-keeper independent of the Chair was appointed.

◆ **Tables:-** Each table was allocated a trained facilitator and reporter so that all participants would have the opportunity to have their ideas and recommendations summarised and recorded.

◆ **Panel sessions:-** There were no spoken questions from the floor, only written questions for the Panel which were given to the facilitators by delegates; the Conference Committee then sorted questions by subject matter which were delegated by the Chairperson to individual Panel members for a response. If delegates’ questions were not answered during the panel sessions they were given the opportunity to request written responses.

◆ **Graveyard session:-** It was decided that a short and punchy drama straight after lunch would bring delegates back to their seats in good time and stimulate lively discussions.

◆ **Minority visibility:-** As well as having some key speakers from minority groups, some locally based asylum seekers offered to help during registration and to join the discussions at the tables.

◆ **Workshop alternative:-** Instead of having three parallel workshops, three short presentations were given, each followed by a brief round-table discussion. It was planned that the results of the discussions would be in the final report.

◆ **Speakers’ Presentations:-** It was decided not to use the speakers’ power-point slides in the report but to summarise their presentations instead.

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**EVALUATION**

![Conference Committee](image-url)

Conference Committee (L-R): John Meehan, Regional Mental Health Officer; Dr. Fiona Hardy, Regional Services Co-ordinator for Refugees and Asylum Seekers; Mike Rainsford, Health Promotion; Tom Quinn, Assistant Director of Mental Health Nursing; Caoimhe Gleeson, Equality Officer; Raymond Guthrie, Assistant Director of Mental Health Nursing and Fiona Campbell, LLB (Hons), Conference Co-ordinator.
Conference Evaluation:-
The Conference Committee would like to thank the participants for their supportive and constructive comments in the evaluation. The overall rating of the Conference was: excellent 52.0%; good 38.0%; fair 2.5%; poor 0.7% and no comment 6.8% as illustrated in the following pie chart. A breakdown of this overall rating is illustrated further in the bar chart below:

The main strengths in the practical management of the Conference were identified as: the independent time keeper, facilitated round-table discussions, excellence of the key speakers, drama, variety of participants, method of organising questions for the panel, display tables and organisation.
The main weaknesses cited were that the Conference was too rushed; there were no references; not enough mental health workers present; some presentations were in monotone; not enough time to discuss each of the three minority groups; not enough visibility of members of the main minority groups or the Department of Justice; Travellers were under-represented; it was assumed that all participants understood the definitions around asylum seeking issues; the room was too cold and the acoustics at the back of the room were poor.

The programme content was commended. The issues around the mental health needs of asylum seekers and members of other ethnic minorities were thought to be highly relevant in the changing cultural identity of Ireland. Many participants commented on how much they learnt from it; how their attitudes had changed and how their practices could now be improved. The issues around the children of ethnic minorities were highlighted.

Participants said that they learnt more about Travellers and their mental health needs; gained a better understanding of mental health; were shocked by some of the information given; realised how little they knew; realised how easy it is for native Irish to inadvertently display hostility, and that their awareness was raised.

Information needs required by participants included more on the law regarding the asylum seeking process; the definitions around different terminologies used; a snapshot of cultural issues; more on entitlements and allowances for migrant workers; more references to follow up on the issues raised.

**Constructive Recommendations from Evaluation:-**
- Issues raised and recommendations made during the Conference should be actively pursued, policies should be implemented and follow-on Conferences and/or Seminars should be held
- Cultural awareness and information training should be mandatory for all Health Service Executive staff, and should be available for those working with minority groups
- References should be made available and there should be a directory of resources
- A bookstall at the Conference would have been useful
- There need to be more examples of good practice
- There needs to be more baseline data
- There needs to be a more creative approach to information dissemination.
- Non-mental health professionals working with minority groups with aggressive behaviour need to know how to manage the situation
- Government, voluntary and community groups need to work more closely together.

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Speakers included a refugee, a Traveller and a representative from the Reception and Integration Agency, Department of Justice, Equality and Law Reform. Asylum seekers supported registration and organisation.

The Conference was highly valued by most of the participants who now look forward, with hope, that the momentum shall be continued.
CONFERENCE SUMMARY AND CLOSE

Conference Summary
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Conference Close
page 65
Conference Proceedings’ Key Themes

**Partnership:**
Concerns around partnership emerged. Partnership is about the integration of services. It is about co-ordination. It is about us co-ordinating ourselves as a Health Service Executive in terms of not just primary care but hospital care also. It is about us working in partnership with people who use our services; with the community and voluntary sector; the Non Governmental Organisation (NGO) sector. Equally important are the statutory agencies working together and looking at what the common pieces of work are; and indeed respecting and looking at the differences. Some of those differences are going to be a challenge for us. Clearly accommodation and direct provision is a challenge. It is a challenge for the Health Service Executive. It is a challenge for the Department of Justice. There are very different approaches to it. That whole sense of partnership, that sense about how we integrate our services and how we co-ordinate ourselves, is a very big challenge for us.

**Training:**
Another important theme that emerged is how we educate, support, train and resource people who are delivering services to actually deliver them in a multicultural Ireland. As a unitary body we can make some significant progress on this. Some work has been done around this and we are very near the stage of actually looking at how that can be rolled out. In terms of partnership, one of the things we need to be looking at is how we can share that training and do co-training across the community voluntary sector and indeed the statutory sector.

**Injustice:**
Equally important is the injustice that people feel about the current policies that we have in this country and the impact that that has on people’s health and mental health. We talked about isolation and loneliness. We just heard again about the impact on people not being able to work in this country who have got training, who are skilled, who are qualified; the impact on people’s self esteem of not being able to utilise those resources and skills that they have got is very significant. That sense of injustice that people feel is very palpable.
**Children:**
Another important issue is the impact on children. Most people come into this country with their children. The impact on children is clearly significant in terms of living in accommodation that is inappropriate; schools that are finding it difficult to respond to people’s individual cultural experiences; the haphazard nature sometimes of children attending school and lack of continuity and consistency in terms of their education at such a young age makes children very vulnerable. Sometimes the education process and our own policies actually let children down.

**Moving Forward**

**Equality:**
Another issue that emerged is how we ensure that in responding and looking at the needs of one group we do not exclude and disenfranchise other groups that are themselves very marginalised. The Travelling community, in terms of ethnic minority communities, for some time in this country have being striving hard to get the same rights as everybody else. As we go forward we need to make sure that we do not exclude any particular group. We need to look at people’s needs both on an individual level and on a group level. People have different needs. We need to be respectful and mindful of the individual needs of different groups. Accommodation for people from ethnic minority communities, for migrant workers and for Travellers is a central issue. The poor state of halting sites is a central issue that has been ongoing in this country for a long time and by addressing issues of accommodation across different groups I think we can make some kind of leeway. I think that this was very important in terms of the feedback.

**Information:**
Another issue raised is how we can ensure that there is information available for people; information that is relevant, in the languages that people need, and is culturally appropriate. Many find it impossible to get basic information. It was suggested that we need to have a central bank of information; a website which is constantly updated and has a feedback mechanism. Certainly, I think if we could do something on the information aspect then we will begin to address some of the other critical issues that have been emerging.

**Conclusion:**
Finally, I know that Professor Drumm is very serious in relation to the reform of the Health Services and having one unitary body; it is about simplifying the system for people. Professor Drumm states with absolute conviction and determination that the people who use the health services in this country will be the central spine in terms of how the services in the future will be designed, shaped and delivered.

*It is fantastic to have such a turnout at a National Conference like this. Thank you.*
Under the new health reforms and HSE structures, one of the concerns raised here in the North West, is the potential to become subsumed within the change process as we have always been renowned for driving positive change in the past. However, we have decided that we are going to continue to shape the national agenda and use the energy in the North West to both support and actively participate in what happens at a national level.

There have been many Speakers. I think that the quality of Presentations, the comments, etc., speak for themselves. I would ask you to put your hands together and thank them personally.

Thanks to the Conference Committee for such a comprehensive agenda. There is a lot of background work that goes on to bring a Conference like this together and they deserve tremendous credit for the drive and commitment shown in relation to today’s proceedings.

The Project was very much initiated by Dr. Fiona Hardy, Regional Services Co-ordinator for Asylum Seekers and Refugees, HSE West and Conference Committee Chairperson. Dr. Hardy brings much clinical expertise, organising ability and personal commitment to doing something for people who are on the receiving end of challenging experiences. It is part of that personal commitment and drive that will ensure that this agenda is very much kept to the fore of the HSE as we go forward.

Thanks to the Radisson Hotel staff, technical support, cameraman, photographer and Balor Theatre Group, Ballybofey, Co. Donegal.

I would like to thank Alice O’Flynn for chairing this morning’s session. Alice will have a particular interest in and responsibility for taking forward some of the agenda items at a national level. Alice’s commitment is illustrated by her presence today.

Finally, I would like to thank you all for coming. I think your presence certainly illustrates the interest there is in this topic. We, at the outset, could not have envisaged that we would have so many people wanting to attend today’s Conference. It illustrates the goodwill there is to engage with the challenging agenda that faces us all as a society.

As we are in Yeats’ country, I would like to reflect on the aims and objectives of today’s Conference and conclude by saying that, in the shadow of bare Benbulben, we hope to plant a seed which will hopefully one day grow into a mighty mighty oak.

Thank you very much and safe home.
APPENDICES

I. Programme
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II. Biodata of Speakers
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III. Conference Quiz – Myths and Facts
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IV. Cultural Differences
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V. Displays and Stands
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VI. References
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# NATIONAL CONFERENCE
## ADDRESSING THE MENTAL HEALTH NEEDS OF MINORITY ETHNIC GROUPS AND ASYLUM SEEKERS IN IRELAND
### Radisson Hotel, Sligo, 31st January 2006
#### Conference Programme

### a.m.

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<th>Time</th>
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<tr>
<td>8.30</td>
<td>Registration</td>
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<tr>
<td>9.15</td>
<td>Table Introduction with Facilitators</td>
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<tr>
<td>9.25</td>
<td>Housekeeping:&lt;br&gt;<strong>Dr. Fiona Hardy,</strong>&lt;br&gt;Regional Co-ordinator for Refugees and Asylum Seekers, HSE – NW; Conference Committee</td>
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<tr>
<td>9.30</td>
<td>Chairperson:&lt;br&gt;&lt;br&gt;<strong>Alice O’Flynn,</strong>&lt;br&gt;National Care Group Manager for Social Inclusion, HSE</td>
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<tr>
<td>9.35</td>
<td>Opening Address:&lt;br&gt;&lt;br&gt;<strong>Brid Clarke,</strong> C.E.O.&lt;br&gt;Mental Health Commission</td>
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<tr>
<td>9.45</td>
<td>Setting the National Context:&lt;br&gt;<strong>Dr. Philip Crowley,</strong>&lt;br&gt;Deputy Chief Medical Officer, Department of Health and Children</td>
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<td>10.05</td>
<td>Cultural Concepts of Health:&lt;br&gt;<strong>Caoimhe Gleeson,</strong>&lt;br&gt;Equality Officer, HSE</td>
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<td>10.20</td>
<td>Mental Health Experiences of Refugees and Asylum Seekers:&lt;br&gt;<strong>Dr. Angela Burnett,</strong> Sanctuary Practice/&lt;br&gt;Medical Foundation for the Victims of Torture, UK</td>
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<td>10.45</td>
<td>Tea/Coffee</td>
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### p.m.

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<tr>
<td>1.00</td>
<td>Luncheon</td>
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<tr>
<td>2.00</td>
<td>Chair: <strong>John Hayes, Local Health Officer, HSE-NW</strong></td>
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<tr>
<td>2.05</td>
<td>Drama: “Misunderstandings in Language and Culture”&lt;br&gt;Balor Theatre Company, Ballybofey, Co. Donegal Followed by discussion</td>
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<td>2.25</td>
<td>Key Interventions/Best Practices:-&lt;br&gt;- Men’s Mental Health Project - Asylum Seekers - in conjunction with H.S.E. Psychology Services for Refugees and Asylum Seekers, Balseskin Reception Centre and Vincentian Refugee Centre&lt;br&gt;- Interventions with Young Asylum Seekers – Dr. Angela Burnett&lt;br&gt;- “Drama in Action” School Project – Anne McAteer and Joanna Parkes, Health Promotion Department, HSE-NW</td>
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<tr>
<td>3.10</td>
<td>Refreshments</td>
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<td>3.30</td>
<td>Question and Answer Panel</td>
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<tr>
<td>4.00</td>
<td>Summary:&lt;br&gt;<strong>Alice O’Flynn,</strong> National Care Group Manager for Social Inclusion</td>
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<tr>
<td>4.25</td>
<td>Closing: <strong>John Hayes, Local Health Officer, HSE-NW</strong></td>
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<td>4.30</td>
<td>Close</td>
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- Migrant Workers and Mental Health- Experiences and Perspectives - Dr. Jane Pillinger, Independent Policy Advisor and Researcher
- Men’s Mental Health Project - Asylum Seekers - in conjunction with H.S.E. Psychology Services for Refugees and Asylum Seekers, Balseskin Reception Centre and Vincentian Refugee Centre
- Interventions with Young Asylum Seekers – Dr. Angela Burnett
- “Drama in Action” School Project – Anne McAteer and Joanna Parkes, Health Promotion Department, HSE-NW

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**APPENDIX I: Programme**
BIODATA OF SPEAKERS

Dr Fiona Hardy, Regional Services Co-ordinator for Refugees and Asylum Seekers, HSE West, qualified as a doctor in 1970, and in 1984 qualified in International Public Health at the London School of Hygiene and Tropical Medicine. She undertook an MPhil in Social Anthropology in 1993. Dr. Hardy has worked extensively overseas in Mother and Child Care in health development and as a clinician; she has worked for organisations such as the Red Cross and Save the Children; on DFID Projects as a Health and Social Development Adviser. Her work has always been focussed towards the most disadvantaged members of society and looking at ways to address the socio-economic factors that militate against health and well-being.

Alice O’Flynn, Assistant National Director - Social Inclusion, Office of the CEO, worked in London and Scotland within the Social Services/Social Care field in both the statutory and NGO sector until 2001 when she returned to Ireland to take up a post with the Health Services as Director of Homelessness. Her primary degree is in Social Science and she is also a qualified social worker. She has developed and managed a wide range of mental health, childcare and homeless services.

Ms. Bríd Clarke, Chief Executive Officer, Mental Health Commission, is a former psychiatric social worker. She has worked in the Adult Mental Health Services and Child and Adolescent Mental Health Services in Dublin and the former Eastern Health Board as Director of Child Care and Family Services and Programme Manager for Services for Children and Families Mental Health Services. In 2000, Bríd moved to the South Western Area Health Board as Assistant Chief Executive Officer and was appointed as the first Chief Executive Officer of the Mental Health Commission in December 2002.

Dr. Philip Crowley, Deputy Chief Medical Officer, Department of Health and Children, qualified from medical school in 1984 and worked for several years in Nicaragua and Central America in public health development work. Whilst working in Newcastle-upon-Tyne, he developed the Community Action on Health Project using a community development approach to creating links between marginalised communities, minority groups and the health service with a view to tackling health inequalities. He has trained in public health medicine and has worked with the Institute of Public Health in Ireland; he was Project Director for the General Practice in a Multi-cultural Society Project and the General Practice Health Inequalities Project with the Irish College of General Practitioners. He recently left general practice in the north inner city of Dublin to take up his current appointment.
Caoimhe Gleeson, Equality Officer, HSE West, is currently the only Equality Officer employed in any health service body in the Republic of Ireland. Since her appointment in 2001, her work involves policy development, equality information dissemination and training, and development of new and innovative practices in employment and health service delivery to diverse groups. She has also worked on projects relating to gender equality, youth work, intercultural education, development of civil society and citizenship rights in El Salvador, Ghana, United States, Croatia and Bosnia-Herzegovina.

Dr. Angela Burnett, G.P., Medical Foundation for the Care of Victims of Torture and Sanctuary Practice in Hackney, East London provides primary care for asylum seekers and refugees. She also provides training on the health care of refugees and torture survivors, and has assisted in the development of health services. Previously, she worked in Zambia providing health care for people affected by HIV/AIDS and their families. She has also worked in Macedonia and with Oxfam in Ethiopia. She writes on the health of refugees and of survivors of torture; she has written a series in the British Medical Journal, several book chapters, guidelines and a resource pack for health workers published by the Department of Health.

Angela O’Leary and Paula Leonard, Donegal Travellers’ Primary Health Care Project Donegal Travellers Project is a partnership of both Travellers and settled people committed to social justice, equality and improving the quality of life for Travellers in County Donegal and in the wider northwest region. Paula Leonard and Angela O’Leary both work with the Donegal Travellers’ Primary Health Care Project, which, in 2005, commissioned the first Health Impact Analysis (HIA) of the effects of accommodation on the health status of the Traveller Community. A key finding of the research (forthcoming, 2006) focuses on the mental health of the Traveller community and explores the links to accommodation issues.

Cherif Labreche, Liaison Officer, CÁIRDE, works in this non-government organisation working to reduce health inequalities amongst minority ethnic communities. Cherif has been responsible for facilitating the development of the Ethnic Minority Health Forum adopting a community development approach. CÁIRDE’s aim is to tackle health inequality experienced by minority ethnic communities and individuals, by working through community development to build the capacity of minority ethnic communities and individuals, to realise their rights by engaging directly with and influencing the policy system.

Dr. Jane Pillinger, Independent Researcher and Policy Advisor, works on health and equality issues both in Ireland and globally. She has been involved in a number of research projects concerning labour migration and has recently

APPENDIX II: Biodata of Speakers
completed a research study for the Equality Authority on the Situation and Experiences of Women Migrant Workers in Ireland. She is currently writing a paper for the International Office for Migration on the social policy implications of migration to Ireland and is a member of the Immigrant Council of Ireland’s research and policy group.

Sr. Breege Keenan is a professional social worker and Director of the Vincentian Refugee Centre, Phibsboro, Dublin.

Ms. Irín Mc Nulty is a psychologist working with the HSE Refugee Psychology Service as part of the team in Balseskin Refugee Reception Centre, Dublin.

P.J. Boyle is a Clinical Nurse Specialist in Asylum Seekers’ Health and works as part of the team in Balseskin Refugee Reception Centre, Dublin.

Joanna Parkes is a drama facilitator currently working with the Balor Developmental Community Arts Group in Ballybofey. She works throughout primary schools across Donegal delivering the Drama In Action Educational Drama Programme. She previously worked as a Programme Officer for the Outreach/Education Programme at the Abbey Theatre working with Community Groups and Older People. In the All Different All Equal Project Joanna has worked with groups of children from international families in three schools in the Letterkenny area.

Anne McAteer is the Education Officer for primary schools in Donegal, Sligo and Leitrim and works as a member of the Youth and Children team in the Health Promotion Department, HSE West in Letterkenny, Co. Donegal. Anne carried out the research with children in Letterkenny as part of a Family Needs Assessment.

John Hayes, Donegal Local Health Manager (LHM), HSE West, a native of Co. Limerick, is a qualified Environmental Health Officer and has a Master degree in Health Care Management. Formerly General Manager of both Sligo and Donegal Community Services, and Manager of the former NWHB General Practice Unit, John became the first General Manager of Regional Mental Health Services in the North West in 2003. In September 2005, he was appointed Local Health Office Manager (LHM) for Donegal and the lead Local Health Manager (LHM) for Mental Health in the HSE West Region.
### CONFERENCE QUIZ

Note: some questions may have debatable answers

#### MYTHS AND FACTS

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>True</th>
<th>False</th>
<th>Facilitators guide</th>
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<tr>
<td>1</td>
<td>Most asylum seekers are given a mobile phone by the HSE.</td>
<td></td>
<td>FALSE</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Asylum seekers are not allowed to work.</td>
<td>TRUE</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td>Interpretation services are available in most areas to help asylum seekers when they use the health services.</td>
<td>TRUE</td>
<td></td>
<td>In some.</td>
</tr>
<tr>
<td>4</td>
<td>An adult asylum seeker in direct provision accommodation receives €100 per week.</td>
<td>FALSE</td>
<td></td>
<td>€19.10 per week.</td>
</tr>
<tr>
<td>5</td>
<td>The mental health status of refugees improves once they become resident in Ireland.</td>
<td></td>
<td></td>
<td>Not known.</td>
</tr>
<tr>
<td>6</td>
<td>Frontline health professionals working with ethnic minorities have all received cultural awareness and anti-racism training.</td>
<td>FALSE</td>
<td></td>
<td></td>
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<tr>
<td>7</td>
<td>In some cultures, avoiding eye contact is a sign of respect.</td>
<td>TRUE</td>
<td></td>
<td></td>
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<tr>
<td>8</td>
<td>Male circumcision in Ireland by a non-health professional is legal.</td>
<td>TRUE</td>
<td></td>
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<tr>
<td>9</td>
<td>In the “Citizen Traveller” survey 2000, 93% of Irish settled people said they would accept a traveller as a member of their family.</td>
<td>FALSE</td>
<td></td>
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<tr>
<td>10</td>
<td>The life expectancy of a traveller woman is 12 years less than that of a settled woman.</td>
<td>TRUE</td>
<td></td>
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</tr>
<tr>
<td>11</td>
<td>People who are subjected to racism experience mental stress.</td>
<td>TRUE</td>
<td></td>
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<tr>
<td>12</td>
<td>Every HSE area has mental health workers experienced in dealing with cross cultural mental health problems.</td>
<td>FALSE</td>
<td></td>
<td></td>
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<tr>
<td>Question</td>
<td>Answer</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>Using a family member as an interpreter is not always a good idea.</td>
<td>Privacy; inappropriate information; can upset the social structure of the family.</td>
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<tr>
<td>Why?</td>
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<tr>
<td>What are the other possible meanings of the word “YES”?</td>
<td>I hear you; I want to agree with you; I don’t understand.</td>
<td></td>
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<tr>
<td>How is silence interpreted in the Japanese culture?</td>
<td>I am honouring what you are saying; I am decoding what you are saying; I am showing you deference and respect by not speaking.</td>
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<tr>
<td>If a Muslim patient dies in hospital, what request might the family make?</td>
<td>The family would like a burial within 24 hours; the body to face Mecca; the family may wish to handle and/or wash the body themselves.</td>
<td></td>
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<tr>
<td>How can Ramadan affect health care for Muslim patients?</td>
<td>The patient may wish to take nothing by mouth between sunrise and sunset and may also refuse injections.</td>
<td></td>
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</tr>
<tr>
<td>Why is it important to ask about a patient’s/ client’s cultural identity?</td>
<td>To help early diagnosis of metabolic conditions such as sickle cell and G6DH. Also to identify need for an interpreter and to be aware of cultural constraints.</td>
<td></td>
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<tr>
<td>Why are some non-Irish Nationals reluctant to access health care?</td>
<td>They may not be sure if they are eligible for treatment; they may be worried about cost; they may fear racial discrimination; they may have been the victims of torture by authorities including health professionals in their own countries; they may have no fixed address.</td>
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<tr>
<td>Some clients will have a belief in the “hot/cold” balance in life and nature. What could be the significance of this?</td>
<td>Disbelief at the explanations given by health professionals; refusal to take treatment/change diet because it goes against their hot/cold beliefs.</td>
<td></td>
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<tr>
<td>What may some patients believe is the cause of their mental health problem?</td>
<td>Some action that they took earlier which has displeased the spirits; the evil eye.</td>
<td></td>
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</tr>
<tr>
<td>If a patient from a non-Irish culture smiles during history taking, what could it mean?</td>
<td>Anger, frustration, sorrow, embarrassment, disappointment, lack of knowledge, not being able to understand, politeness and/or fear.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DISPLAYS AND STANDS

1. The Taste Project; Susan McDonnell and Anna Reitberger.

2. Richard Wayman; Photographic Display of Kurdish Refugees.

3. Partnership, HSE West.


5. Equality Authority.

6. N.C.C.R.I. (National Consultative Committee on Racism and Interculturalism).

7. Equality, HSE West.


9. Mental Health Service Information, HSE West.

10. Irish Refugee Council.

11. La Touche Bond Solon Training Limited.
## REFERENCES

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>TITLE OF WEBSITE OR DOCUMENT</th>
<th>NAME OF ORGANISATION/DETAILS</th>
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<tbody>
<tr>
<td>TORTURE</td>
<td><a href="http://www.torturecare.org.uk">www.torturecare.org.uk</a></td>
<td>Medical Foundation for the Care of Victims of Torture. Provides care and rehabilitation to survivors of torture and other forms of organised violence.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.ccst.ie">www.ccst.ie</a></td>
<td>Centre for the Care of the Survivors of Torture. Provides medical examination, counselling and complimentary therapies.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.hrw.org">www.hrw.org</a></td>
<td>Human Rights Watch. Dedicated to protecting the human rights of people around the world to prevent discrimination, uphold political freedom, protect people from inhumane conduct in wartime and to bring offenders to justice. Human Rights Watch investigates and exposes human rights violations and holds abusers accountable.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.amnesty.org">www.amnesty.org</a></td>
<td>Amnesty International.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.amnesty.ie">www.amnesty.ie</a></td>
<td>Amnesty Ireland. Campaigns for internationally recognised human rights and against abuses of the rights to physical and mental integrity. Provides relevant country profiles.</td>
</tr>
<tr>
<td></td>
<td>Meeting the Needs of Refugees and Asylum Seekers in the UK</td>
<td>Dr. Angela Burnett and Johannes Fassil; Department of Health, UK; 2002. Practical information on recognising and managing the special needs of Refugees and Asylum Seekers. Request from <a href="mailto:dh@prolog.uk.com">dh@prolog.uk.com</a></td>
</tr>
<tr>
<td></td>
<td>The Sound of Silence: Listening to What Unaccompanied Asylum-Seeking Children Say and Do Not Say</td>
<td>Author: Ravi Kohli</td>
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<td>TORTURE (continued)</td>
<td><a href="http://www.Neptsd.va.gov/facts/specific/fs_refugees.html">www.Neptsd.va.gov/facts/specific/fs_refugees.html</a></td>
<td>United States Department of Veteran Affairs, National Centre for PTSD. Useful article on Post-Traumatic Stress Disorder plus references.</td>
</tr>
<tr>
<td>GENERAL INFORMATION ON REFUGEES/ASYLUM SEEKERS</td>
<td><a href="http://www.irishrefugeecouncil.ie">www.irishrefugeecouncil.ie</a></td>
<td>Irish Refugee Council (IRC) is an independent non-governmental organisation (NGO). Promotes the human rights of Refugees and Asylum Seekers in Ireland providing information and fact sheets, researching and advocating.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.integratingireland.ie">www.integratingireland.ie</a></td>
<td>Integrating Ireland is an independent network of community and voluntary groups working in mutual solidarity to promote and realise the human rights, equality and full integration in Irish society of asylum seekers, refugees and immigrants.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.cadic.com">www.cadic.com</a></td>
<td>Coalition Against the Deportation of Irish Children. Also source through <a href="http://www.integratinginireland.ie/cadic">www.integratinginireland.ie/cadic</a></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.mrci.ie">www.mrci.ie</a></td>
<td>Migrant Rights Centre Ireland (MRCI). Works for the human rights of migrant workers and their families; provides information leaflets and fact sheets.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.immigrantcouncil.ie">www.immigrantcouncil.ie</a></td>
<td>Immigrant Council of Ireland. Promotes the rights of immigrants through information, advocacy and awareness.</td>
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<td></td>
<td><a href="http://www.mentality.org.uk">www.mentality.org.uk</a></td>
<td>Produces publications including “On Your Doorstep” and “Cultural Sensitivity Audit Tool for Mental Health Services”.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.immunisation.nhs.uk">www.immunisation.nhs.uk</a></td>
<td>The most comprehensive, up-to-date and accurate source of information on vaccines, disease and immunisation in the UK.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.cdc.gov">www.cdc.gov</a></td>
<td>Centre for Disease Control, Atlanta. Practical information on communicable diseases, travellers’ health, etc.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.healthac.org">www.healthac.org</a></td>
<td>Health Awareness Connection. A non-profit corporation providing health education in the prevention of sexually transmitted diseases (STDs) and HIV.</td>
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<td></td>
<td>Celebrating our Cultures</td>
<td>Mental Health Promotion with Refugees and Asylum Seekers.</td>
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### APPENDIX VI: References

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<tr>
<td><strong>TRANSLATED MATERIALS</strong></td>
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<td></td>
<td><a href="http://www.immunize.org">www.immunize.org</a></td>
<td>Immunisation information in 27 languages, dtp, HepB, Men C, hib etc., information on vaccinations including Polish.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.immunisation.nhs.uk">www.immunisation.nhs.uk</a></td>
<td>National Health Service (NHS), UK. Up-to-date user-friendly immunisation information.</td>
</tr>
<tr>
<td><strong>EQUALITY AND GENDER</strong></td>
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</tr>
<tr>
<td></td>
<td><a href="http://www.nccri.ie">www.nccri.ie</a></td>
<td>National Consultative Committee on Racism and Interculturalism (NCCRI). An independent expert body focusing on racism and interculturalism.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.animate-ccd.net">www.animate-ccd.net</a></td>
<td>Action Now to Integrate Minority Access to Equality. NGO in Northern Ireland with activities promoting equality and provision of interpretation services.</td>
</tr>
<tr>
<td></td>
<td>Equality from Theory to Action</td>
<td>Authors: John Baker, Kathleen Lynch, Sara Cantillon and Judy Walsh Publisher: Palgrave MacMillan; 2004. ISBN 1-4039-4429-6</td>
</tr>
<tr>
<td></td>
<td>Challenging the Misconceptions of Violence Against Minority Ethnic Women including Travellers in Ireland</td>
<td>Available from Pavee Point, 46 North Great Charles Street, Dublin 1.</td>
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<tr>
<td>SUBJECT</td>
<td>TITLE OF WEBSITE OR DOCUMENT</td>
<td>NAME OF ORGANISATION/DETAILS</td>
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<tr>
<td>INTER-</td>
<td><a href="http://www.socialinclusion.ie">www.socialinclusion.ie</a></td>
<td>The Office for Social Inclusion.</td>
</tr>
<tr>
<td>CULTURALISM</td>
<td></td>
<td>The Irish Government Office with overall responsibility for developing, co-ordinating and driving Ireland’s National Action Plan against Poverty and Social Exclusion.</td>
</tr>
<tr>
<td>Intercultural Competency;</td>
<td>Authors: Myron W.Lustig and Jolene Koester</td>
<td></td>
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<tr>
<td>Ethnic Variations in Dying, Death and Grief</td>
<td>Authors: Donald P. Irish and Kathleen F. Lundquist</td>
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<tr>
<td></td>
<td>Publisher: Taylor and Francis; 1993.</td>
<td>ISBN 1-56032-278-0</td>
</tr>
<tr>
<td>Culture, Religion and Patient Care in a Multi-Ethnic Society</td>
<td>Authors: Alix Henley and Judith Schott</td>
<td></td>
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<tr>
<td></td>
<td>Publisher: Age Concern England; 1999.</td>
<td>ISBN 0-86242-231-0</td>
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<tr>
<td>Culture, Religion and Childbearing in a Multiracial Society</td>
<td>Authors: Judith Schott and Alix Henley</td>
<td></td>
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<tr>
<td></td>
<td><a href="http://www.paveepoint.ie">www.paveepoint.ie</a></td>
<td>Pavee Point, Ireland.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A partnership of Irish Travellers and settled people working together to improve the lives of Irish Travellers through social justice, solidarity, socio-economic development and human rights.</td>
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<tr>
<td></td>
<td><a href="http://www.qub.ac.uk/schools/school">www.qub.ac.uk/schools/school</a> ofenglish/imperial/ireland. travellers.htm</td>
<td>The Queen’s University of Belfast; Document on Travellers in Ireland.</td>
</tr>
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