

# The Mental Health Promotion Needs of Asylum Seekers and Refugees

A Qualitative Study  
in Direct Provision Centres and  
Private Accommodation in Galway City



**Galway City Development Board**  
Bord Forbartha Cathrach na Gaillimhe



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

# The Mental Health Promotion Needs of Asylum Seekers and Refugees

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## **EXECUTIVE SUMMARY**

Ireland is now a host country for many asylum seekers fleeing persecution in their own countries. The health status of this population group is a concern for the health services as inequalities in health between minority groups and the rest of the population have been highlighted in various studies in Ireland. While there is plenty of evidence to show that there is no health without mental health, few studies on asylum seekers and refugees have adopted a broad view on health that takes into account its social determinants. Mental health promotion is concerned with how individuals, families, organisations and communities feel and the impact of socio-economic, cultural and environmental conditions on well-being. The population of adult asylum seekers and refugees in Galway City reached 1209 in July 2005. The Health Service Executive, Health Promotion Services, in association with Galway City Development Board decided to undertake a study to explore the mental health promotion needs of that population. The findings of the research would inform the development of an action plan for focused interventions around the city.

The study which was qualitative in nature consisted of 23 semi-structured one-to-one interviews with asylum seekers residing in direct provision accommodation and refugees residing in private rented accommodation. Asylum seekers are persons who are fleeing persecution and are applying for the protection of the Irish State through the asylum process. Refugees have completed the asylum process and have been granted the protection of the Irish State.

The findings showed that experiences of past traumas and fears for the future, length of time living under the direct provision accommodation system and language barriers had a negative impact on mental health. This contributed to asylum seekers perceiving their overall health to be poor. Emotional stress associated with these experiences was significant. Perceptions on integration, social inclusion and social support were also significant in determining quality of life and ultimately well-being. The findings suggested the need to revisit policies in relation to the reception of asylum seekers in this country, to improve social inclusion and integration by linking with local service providers and institutions and availing of existing social resources in the community. The impact of the physical and social environment on the perception of well-being was highlighted. Access to leisure facilities



and amenities would increase physical and psychological well-being as well as community involvement.

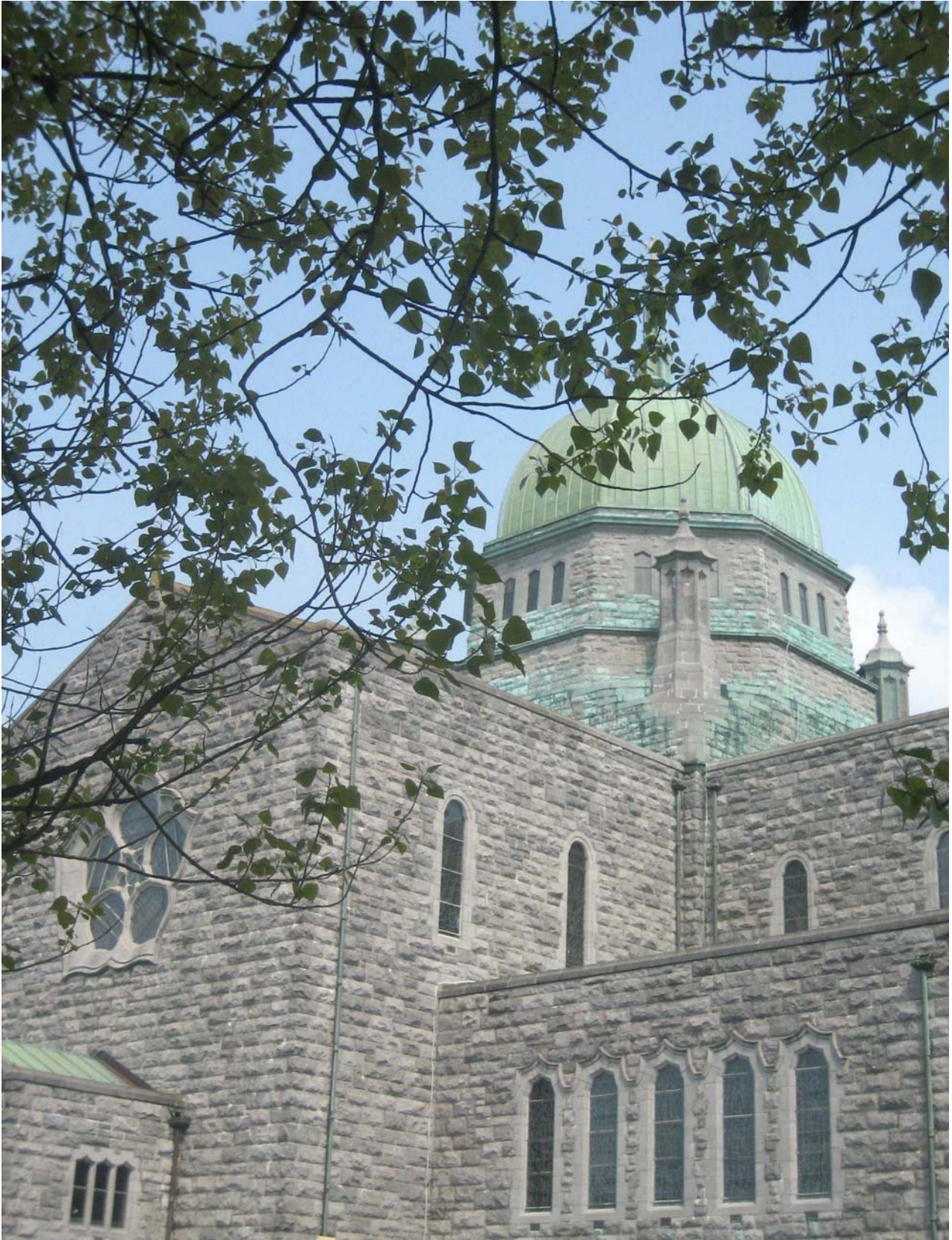
Refugees' perceptions of health were more positive as a result of their independent lifestyle. Language barriers were still significant in this group as well as lack of employment opportunities. The need to improve on the delivery of language classes was highlighted. The importance of education and training to maintain or upgrade skills while in direct provision accommodation was stressed. Asylum seekers and refugees did not feel socially integrated and included in Irish society. Mental health promotion interventions can enable individuals and communities to improve and maintain well being and to prevent the onset of mental ill health. The key is the integration and coordination of services. However, it is the responsibility of all sectors and agencies to create an environment conducive to a better quality of life for all and therefore health gain.

These findings have implications for local authorities, support groups and health promotion services as well as other agencies in Galway City. The following recommendations were made:

1. The mental health needs of asylum seekers should be assessed when they enter Ireland. This should take account of their circumstances on arrival and will require an in depth understanding of cultures and beliefs.
2. Appropriate and timely psychological support should be made available for asylum seekers on arrival in Ireland.
3. Policies within direct provision centres should be reviewed with a view to promoting a more independent lifestyle, building capacity among residents and reducing institutionalisation. This should include an assessment of the need to create training and employment opportunities.
4. Access to language resources should be improved. Targets to reduce waiting lists for courses should be set and reviewed on an ongoing basis.
5. Intersectional programmes to involve the Department of Health and Children, the Department of the Environment, Heritage and Local Government, the Department of Education and Science, the Department of Community, Rural and Gaeltacht Affairs

- should be promoted in partnership with existing support groups for the integration of asylum seekers and refugees.
6. Consideration should be given to enabling transition year students to act as mentors to asylum seekers and refugees in developing links with the Irish community and culture.
  7. Training and education should be provided to enable asylum seekers to learn new skills or to maintain and/or upgrade existing skills while in direct provision accommodation.
  8. A peer-volunteer system within the hostel should be created whereby long-term residents would provide support in relation to information about services and entitlements, translation of documents and interpretation.
  9. Client-focused independent services should be set up to give impartial advice to asylum seekers about the asylum process.
  10. Information on available services in the community, entitlements and job opportunities should be disseminated in a culturally sensitive and appropriate manner.
  11. Newsletters and newspapers that are relevant to asylum seekers lives should be made available at direct provision centres.
  12. Communication between managers of direct provision centres and residents needs to be improved. The possibility of organising regular meetings to act as a forum where concerns can be voiced should be explored.
  13. A feasibility study should be undertaken by the Environmental Health Department (Galway) in collaboration with the managers of direct provision centres in Galway to establish whether supervised cooking opportunities can be created, ensuring that food safety requirements are satisfied.
  14. Consideration should be given to changing travel regulations for asylum seekers to facilitate visits to family and friends residing in other parts of Ireland.

15. When reviewing future planning applications for developing new housing estates, Galway City Council should give consideration to the provision of playground facilities.
16. Access to sporting facilities should be improved. There is a need to negotiate with the managers of various leisure centres around the city in order to set special rates for asylum seekers and refugees.



# **CHAPTER 1**

---

## **INTRODUCTION**

### **1.1 Historical context of refugees in Ireland**

The indigenous people of Ireland tend to think of themselves as a homogenous race but this is quite far from reality. This state has experienced waves of immigration from different sources since the beginning of time: Celts, Vikings, Normans, English, Scottish, Spanish, Huguenots and Jews, to name a few (Cullen, 2000). Ireland's first experience of programme refugees was in 1956 with the arrival of 530 Hungarians. Then in 1973, 120 Chileans, forced to flee their country following the overthrow of the Allende regime, arrived on our shores. Then came 212 Vietnamese 'boat people' in 1979 who developed into 125 family groups comprising over 600 people at the beginning of 1996. The break up of Yugoslavia resulted in the first Bosnians to arrive here in July 1992, followed by 1,000 ethnic Albanian refugees from Kosovo in 1999 (Cullen, 2000).

Throughout the 1970s' and 1980s' the number of applications for asylum under the 1951 Convention was very small. By the mid-1980s' however, the instability of the post-Cold War world led millions to flee their country of origin. In 1986 the total number of applicants to European states almost doubled to nearly 200,000 - from 100,000 in the early 1980s - and by 1992 the number of asylum seekers in Europe had reached a peak of 696,000. In Ireland, there were just 39 applications for asylum in 1992. Western countries reacted to the increase in numbers seeking asylum in the early 1990s in a variety of ways to limit access as much as possible. For the first time, the EU took major steps towards coordinating the asylum policies of its member states which acted as deterrents to asylum seekers (Cullen, 2000).

### **1.2. Asylum seeking in Ireland**

Governments, under the terms of the 1951 Geneva Convention - which was translated into Irish Law through the Irish Refugee Act in 1996 - accept that refugees, unlike other migrants, are deserving of special consideration (Galvin, 2004). Refugees are forced migrants unable to



reside in their countries of origin and they require residence in and protection from host countries.

### **1.2.1 The asylum seeking population**

We are witnessing multi-ethnic, heterogeneous and complex populations trying to integrate into Irish society. There is a huge diversity of needs, ethnic groups and languages, political and religious beliefs. *'Ethnic groups possess their own cultural identity, language, customs and practices, while every individual will possess his or her own unique life experiences and health, social, emotional and psychological needs'* (Eastern Regional Health Authority, 2003).

The numbers applying for asylum in Ireland are decreasing, from 12,000 in 2002-2003 to 7,900 in 2003-2004 (Cullen, 2000). From January to May 2005, the top five countries for applications for a declaration to be a refugee in Ireland were: Nigeria, Somalia, Romania, Afghanistan and Sudan (Irish Refugee Council, 2005). The total number of asylum applicants recognised as refugees from 2000 up to 31<sup>st</sup> May 2005 was 6,303. Before the implementation of the Refugee Act 1996 (as amended), 1,533 individuals were recognised as refugees which brings the overall total to 7,836 (Irish Refugee Council, 2005).

### **1.2.2 The dispersal and direct provision policy**

The Irish Government has had to develop immigration policies on an ad hoc basis to deal with the arrival of asylum seekers, to put in place infrastructures and to deploy services. According to the Irish Refugee Council, we had the third highest number of asylum seekers per capita in Europe in 2000 (Foley Nolan, 2002).

The Government introduced the 'dispersal and direct provision policy' in 1999 to deal with asylum seekers during their asylum determination process. The National Dispersal Programme for asylum seekers was implemented in April 2000 through the Reception and Integration Agency (RIA) which is responsible for the provision of full board accommodation for asylum seekers within the dispersal and direct provision reception programme (Galvin, 2004). There are four reception centres, 65 direct provision centres and 12 self-catering centres throughout Ireland (Irish Refugee Council, 2005).

## **1.3 Rationale**

There were two direct provision centres in Galway City at the start of the study. The July 2005 statistics issued by the Community Welfare

Office of the Health Service Executive, Western Area, showed that 1209 adult asylum seekers were living in Galway City at that time in both direct provision hostels and private rented accommodation. It was not possible to establish from these figures the specific numbers in each category - asylum seeker, refugee or residency status - as all people on the database were categorised as 'asylum seekers'. Table 1 presents an overall picture of the numbers of asylum seekers, refugees and their children and those with residency status residing in Galway City in August 2005. Experiences will vary as one individual moves along the asylum application process and this will be reflected in the study.

**Table 1      Numbers of asylum seekers and refugees in Galway City, August 2005**

<b>Asylum Seekers Galway City</b>	Single Persons	Childless Couples	1 Parent Family	2 Parent Family		No. of Adults	No. of Children	Totals
Total	282	10	199	354		1209	1127	2336

*Adapted from Asylum Seekers Combined Statistics Report, Week ending 26<sup>th</sup> August 2005, SCWO, HSE West (2005)*

This large population of asylum seekers and refugees is a vulnerable group in our society and yet we know little about their health needs from a health promotion perspective. It is generally acknowledged that persons from ethnic minority groups experience a greater level of psychological distress than the local population (Eastern Regional Health Authority, 2003). Studies have focused on physical health and nutritional needs but have not taken a broad view of health. A holistic approach must focus on all aspects of health including the physical, mental, emotional, social and environmental well-being.

Mental health promotion is concerned with how individuals, families, organisations and communities feel, the factors which influence how they feel and the impact that this has on overall health and well-being. It is concerned with action and advocacy to address the full range of potentially modifiable determinants of health.

It was agreed that an exploration of the experiences and perceptions of asylum seekers and refugees in relation to the major determinants of health would provide understanding and knowledge to inform an action plan for focused interventions. These determinants are not only

those which are related to the actions of individuals, such as health behaviours and lifestyles, but also factors such as income and social status, education, living circumstances, employment and working conditions, access to appropriate health services, and the physical environment (Victorian Health Promotion Foundation, 1999).

The Health Service Executive Health Promotion Services in association with Galway City Development Board decided to undertake this study to explore the mental health promotion needs of asylum seekers and refugees. This initiative was funded by the Department of Community, Rural and Gaeltacht Affairs under Proposals for Improved Cohesion and an Integrated Targeted Plan and the Health Service Executive.

#### **1.4. Aim and objectives**

The aim of the proposed research is to gain an understanding of the mental health promotion needs of asylum seekers and refugees residing in direct provision and in private rented accommodation in Galway City. More specifically it intends to:

1. Explore perceptions and experiences of asylum seekers and refugees in relation to their health and well-being
2. Identify the factors that have a positive/negative impact on well-being
3. Identify mechanisms used for coping with stressors
4. Compare the perceptions and experiences of people who live in direct provision with those residing in private rented accommodation
5. Explore potential areas for improvements





## CHAPTER 2

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### LITERATURE REVIEW

#### 2.1 Introduction

Sources for this review were wide-ranging and included recent newspaper articles, information leaflets, newsletters from support groups, published and unpublished reports, national and international studies and articles in peer reviewed journals and national health strategy reports.

#### 2.2 Immigration in Ireland

The early 1990s' levels of economic growth brought Ireland forward as one of the most successful economies in Europe. As a result, unprecedented levels of migrants reached our shores full of hope and expectations. The distinction must be made at this point between migrants, asylum seekers and refugees.

*Migrant worker:* Person who has permission to live and work in Ireland. The legal status varies according to place of origin and type and duration of permit /visa/work authorisation.

*Asylum seeker:* Person fleeing persecution and forced to leave their homeland because they fear for their life. This is the legal status of anyone who is applying for the protection of the Irish State, through the asylum process, under the terms of the 1951 UN Convention on the Status of Refugees as defined in the Refugee Act, 1996.

*Refugee:* This is the legal status of anyone who has completed the asylum process and has been allowed the protection of the Irish State and can now live, work and remain in the State as 'refugee' with the same rights as an Irish citizen (Comhlamh, 2005).

According to the Geneva Convention, a refugee is:

*A person who, owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.*

(1951 Geneva Convention)

*Asylum seekers with Irish born children:* An asylum seeker whose child(ren) is/are born in Ireland has the legal right to apply for residency/permission to remain in the state until his/her children reach the age of 18. When such permission is granted, he/she is entitled to work, claim Unemployment Assistance and qualify for Community Welfare Services on the same basis as any other individual (Galvin, 2004).

## **2.3 Social environment**

As minority groups, asylum seekers and refugees experience difficulties and are vulnerable to a wide range of psychological and social problems (Begley, 1999, Sherlock, 2002, ERHA, 2003). Within the literature a number of themes emerged in relation to the social environment and its impact on mental health.

### ***2.3.1 Barriers to services***

A number of barriers to accessing services have been highlighted in various studies.

*Lack of information* on how the Irish Health Service operates exacerbates the difficulty in accessing services. It can lead to the perception of being discriminated against. Information about services must be made available in a culturally sensitive manner and in all relevant languages. *Information* is a key aspect of accessing health community services (Galway Refugee Support Group, 2005, Sherlock, 2002, Galvin 2004). In 2004, the Galway Refugee Support Group published a multilingual pocket guide to local services and support groups available in Galway City.

*Language barriers* and difficulties, in some instances, in providing adequate translating and interpreting services have been highlighted in all studies (Foley Nolan et al, 2002, Galvin, 2004). Literacy difficulties can also exacerbate poor access to services.

The literature highlighted the fact that capacity building among health staff is essential to deliver quality service. It was argued that knowledge on the background and culture of asylum seekers would enable staff to deal with patients in a more appropriate manner. (Foley Nolan et al, 2002, Sherlock, 2002, Galvin 2004). There is a call for the '*delivery of a culturally sensitive and competent service while at the same time empowering ethnic clients to voice their own needs*'

(Access Ireland, 2004). Training and discussions should include the subject of racism and anti-racist practice (Sherlock, 2002).

### **2.3.2 Supportive environment**

The prerequisites and prospects for health cannot be ensured by the health sector alone. Other agencies and services have an indirect impact on health. Creating a healthy environment may require different forms of action at national and local level. Imparting information and *knowledge* about other cultures in the host community to promote inclusion is important. Elbert Ransom, a civil rights activist, recently on a visit to Dublin Institute of Technology to host a conference, was interviewed by Metro Eireann and stressed the importance of preparing the host population about immigration: '*...the indigenous population of these countries (host countries) has to be informed and educated in the cultures and ways of the immigrants*'. This requires structures for teachers and trainers and also the design of a broad school curriculum that is inclusive of other cultures (Metro Eireann, March 2005). He stressed the importance of informing the host population about the reasons why people migrate, and to tackle the myths and negative attitudes around asylum seekers and refugees. The influence of the *media* in conveying messages on public perceptions and attitudes should not be underestimated. In its second National Mental Health Plan, the Commonwealth Department of Health and Aged Care (CDHAC, 2000) in Australia suggested involving the media in a coordinated, multi-strategic approach by integrating key mental health messages that promote mental health, reduce stigma and encourage early recognition of mental problems and mental disorders.

Marginalised groups within the population experience barriers that affect participation in the *formal and informal education system*. These barriers have implications for achieving good health (Department of Health and Children, 2000). Under the direct provision system, during the processing of their applications, asylum seekers are denied access to third level education and are not allowed to take up employment (Irish Refugee Council, 2005).

*Transport facilities, lack of child care facilities and location* of direct provision centres and in particular those in remote rural areas can hinder access to hospital and specialist care services. For asylum seekers on supplementary welfare, this is an extra burden to cope with in the midst of difficult circumstances (Galvin, 2004).

The importance of the availability of *playgrounds and safe places* for

communities is significant. Children can informally meet other children and learn to deal with conflict. It can also facilitate communication between parents and is conducive to building social support networks (Irish Times Health Supplement, 2005).

## **2.4 Health status of asylum seekers**

The health status of asylum seekers and refugees has been well researched in this country.

*'...it is nevertheless acknowledged that ethnic minorities tend to be a socially excluded, vulnerable group whose health needs should receive special attention. Within this context, it is accepted that the group of asylum seekers is especially vulnerable'* (Eastern Regional Health Authority, 2003).

In the context of asylum seeking in a host country, migrants face many dilemmas. Some recent Irish studies have reported on asylum seekers health needs in terms of their medical needs and health promotion needs and the availability and accessibility of health services to meet those needs (Foley Nolan et al, 2002, Cave et al, 2003, Collins, 2002, Galvin, 2004).

Internationally, there is increasing recognition of the need to prioritise and tackle issues to improve and enhance the life and circumstances of the most deprived and marginalised people in society in order to address inequalities in health (Department of Health, Social Services and Public Safety, 2003, Victorian Health Promotion Foundation, 1999, Commonwealth Department of Health and Aged Care, 2000). The National Institute for Mental Health in England commissioned a report last year on the mental health and mental health promotion needs of Black and ethnic minorities (Department of Health, 2004) which is the follow-up to another report based on consultations with Black and ethnic minorities (Department of Health 2003). The report stressed that while much good mental health promotion with Black and minority ethnic communities was already underway these communities were still experiencing high levels of discrimination and mental ill health. A more targeted approach was needed to ensure that the specific needs of different groups were met.

#### **2.4.1 Physical health**

It is difficult to determine what are the specific medical needs or conditions of asylum seekers and refugees as no research specifically on medical needs has been undertaken (Sherlock, 2002). Research published in the British Medical Journal has asserted that the basic needs of both populations are broadly similar to those of the host population (Burnett and Peel, 2001). More recent research has highlighted the impact of living in direct provision accommodation for long periods (Foley Nolan, 2002, Cave et al, 2003) on physical and mental health.

In England, research carried out in direct provision centres suggests that overcrowding and lack of facilities can lead to poor hygiene that may induce illnesses. The same study reports how asylum seekers arrive with long-standing illnesses or develop new illnesses. They may have been treated for the former but not for the latter. Some may avail of unofficial and self medication to alleviate symptoms (Woodhead, 2000).

Some of the physical ill health experienced by asylum-seekers and refugees may also be stress related, in particular heart disease, infection and gastrointestinal disturbances (Department of Health, 2004).

In a recent study carried out in Cork (Foley Nolan et al, 2002), it was argued that while GPs did not report any major illnesses in their patients, the complaints prevented patients from carrying out basic daily tasks. These findings may suggest general unhappiness and emotional rather than physical difficulties (Foley Nolan et al, 2002).

Health screening is voluntary on arrival in Ireland. The system seems to be working well with a good uptake. Unfortunately, flow of information can be slow once asylum seekers are dispersed (ERHA, 2003). Some asylum seekers may not avail of screening on the grounds that it might compromise their asylum application, even though this is a confidential and independent service (Galvin, 2004). Delays in receiving test results can postpone treatment and induce duplication, particularly when persons are dispersed. It was suggested that consideration should be given to broadening the current screening process to form a general needs assessment (ERHA, 2003).

The relatively young average age of the asylum seeking/refugee population, between 25 and 35, places a high demand on maternity, paediatric and reproductive health services (Jones, 1999). There is

however a high level of satisfaction with the maternity services delivered by the Public Health Nurse services according to a study carried out in County Roscommon (Galvin, 2004). Cultural differences and religious beliefs can make access to health services difficult. Some female patients, for instance, do not want to be treated by a male doctor (Sherlock, 2002, Galvin, 2004).

#### **2.4.2. Lifestyle/Health behaviours**

Asylum seekers and refugees may have limited control over their lifestyle choices due to their exceptional living circumstances.

In studies carried out in Cork and Kerry, findings revealed that three quarters of the participants who *smoked* were from Eastern Europe and 70% were male. Africans are less likely to use alcohol than their Eastern counterparts (Foley Nolan et al, 2002, Cave et al, 2003). It has been advised that health promotion messages must be delivered to encourage females and the African group not to smoke and to maintain low *alcohol intake* as over time, refugees are more likely to adopt our habits (Foley Nolan et al, 2002). It is likely that these habits may be taken up as a stress relief method and a way of coping with stress and underlying problems (Foley Nolan et al, 2002).

A recent survey on the *food experiences* of asylum seekers living in both direct provision centres and in private rented accommodation was carried out by a team from the Health Service Executive North West (Manandhar, 2004). According to this research, for those living in private rented accommodation, food poverty in the community derived from the unavailability of ethnic foods in the retail sector, high prices and transport difficulties in accessing outlets. Refugees relied on what was locally available to them but there was a lack of knowledge about western food preparation. The multi-ethnic nature of direct provision implied that it was difficult for catering services within these centres to provide for the different population groups (Foley Nolan et al, 2002, Galvin, 2004). As most of these centres (65 in the whole of Ireland) were not equipped with catering facilities, families did not always eat the meals that were served and resorted to buying cheap foods of low nutritional value with a high fat content.

*Breastfeeding* practice among the asylum seeker population should be encouraged. However, lack of privacy in direct provision centres often prevents women from breastfeeding their babies comfortably (Manandhar, 2004).

There is a need to increase participation in regular, moderate *physical*

*activity* as there are many physical and mental benefits (Department of Health and Children, 2000). Recommendations were made for the delivery of physical activity programmes within direct provision accommodation centres that could alleviate boredom and encourage integration into Irish society (Cave et al, 2003). The same study highlights other research findings (Collins, 2002) where respondents stated they would like to engage in physical activity.

#### **2.4.3 Mental health**

Asylum seekers and refugees experience multiple problems relating to their mental health and well-being (Woodhead, 2000). Symptoms of mental distress are common but one should be careful not to interpret as mental illness what may be a natural response to a highly abnormal situation (Burnett and Fassil, 2002). In this instance cultural factors should also be taken into consideration (ERHA, 2003). Mental health needs vary according to past experiences, cultural backgrounds, gender, education and age.

*Serious mental ill health* may have developed following traumatic experiences associated with conflicts in countries of origin (torture, war, wounds). Post Traumatic Stress Disorder (PTSD) is common in this population group. Symptoms of depression that can lead to psychosomatic disorders are also common (Foley Nolan et al, 2002, Cave et al, 2003). Persons from ethnic minority communities will also experience mental issues identical to the indigenous population, unrelated to torture, dislocation and so on (ERHA, 2003).

There are difficulties in assessing mental illnesses as certain complaints may not necessarily fall within the remit of the GP nor meet established criteria for psychiatric intervention (Galvin, 2004).

*Victims of violence* do not easily report because they may not see past events as being the reason for their illness. They sometimes treat themselves to cope with the psychological effects of torture and war (Woodhead, 2000).

*Diagnosis of mental illness* is inconsistent due to language barriers and lack of understanding and pre-knowledge of cultural backgrounds and differences (Galvin, 2004, Woodhead, 2000). Cultural beliefs and ethnic customs of individuals add to the difficulty in diagnosing/treating mental symptoms because of different medical practices between western countries and country of origin.

The Regional Health Strategy for Ethnic Minorities recommends the



development of training programmes for frontline personnel specifically aimed at promoting knowledge of cultural practices and perceptions in relation to mental health, facilitating awareness of the needs and barriers faced by members of this group (ERHA, 2003).

The *psychological effects of long-term stays* in direct provision centres, sometimes over two years (Irish Refugee Council, 2005), can have devastating long-term consequences for the quality of life of asylum seekers and their families. Lack of privacy, lack of a place for worship and overall lack of control can lead to feelings of insecurity and isolation that can result in depression, anxiety, frustration, aggression, anger and social withdrawal (Department of Health, 2004). There is also evidence in international research that some minority groups living in the community still experience the same psychological effects particularly if they live in deprived neighbourhoods and if they are poor and unemployed (Department of Health, 2004, CDHAC, 2000). There is no research evidence in Ireland to suggest that this is the case in this country.

*Boredom and idleness* can induce low self-esteem and isolation. Men may experience difficulties relating to change in role and cultural identity and the perception of empowerment with implications for mental health (ERHA, 2003).

A *sense of loss* may include loss of homeland, loss of family and friends, and loss of personal identity. Once safety is assured, most exiles will begin to feel the grief of the losses they have experienced (Eisenbruch, 1990).

*Racism and discrimination* may be additional factors leading to social exclusion, eroding positive identity and leading to much poorer mental health. The experience of everyday minor acts of discrimination acts as a chronic stressor (Department of Health, 2004). Reducing *stress* was ranked in the top three requirements for better health by respondents in the Slán Survey (Kelleher et al, 2003). During the processing of their asylum application, asylum seekers are not allowed to take up employment and are denied access to third level education, which may cause stress (Irish Refugee Council 2005). This can have a serious effect on mental health (Cave et al, 2003).

*Poverty* is widely recognised as having a negative effect on health and people classified as poor suffer from greater psychological distress and have lower self-esteem and less confidence than those classified as non-poor (Department of Health and Children, 2000). *'Poverty is the*

*greatest threat to health'* (WHO, 1997). Asylum seekers in direct provision accommodation centres receive an allowance of 19.10 euro per week. Those who arrived in Ireland after May 1<sup>st</sup> 2004 do not receive child benefit while those already in receipt continue to receive it (Irish Refugee Council, 2005).

However, rather than assuming that these experiences lead to mental health problems, there is a need to identify the strengths, resilience, skills and coping mechanisms that so many individuals, families and communities have. What is needed is a positive definition of mental health that recognises social, economic, political and cultural needs (Department of Health, 2004).

In a recent review of Irish research to date on asylum seekers and refugees, recommendations were made for further research on the psychological and emotional needs of this population (Cotter, 2004).

There is increasing recognition that there is no health without mental health and that there is a combination of factors that influence an individual's mental health. Mental health and emotional well-being depend both on our internal psychological processes and on the values and resources of the outside world. They result in a sense of being in control of oneself and able to cope with events in the outside world. (Department of Health, Social Services and Public Safety, 2003).

While there is plenty of research evidence to date in Ireland on the difficulties experienced by asylum seekers and refugees due to their past traumas and living circumstances, little evaluative research is available that reports on successful transferable interventions.

## **2.5 Mental Health Promotion**

Mental health promotion aims to achieve better mental health and well-being across populations by:

1. Focusing on improving the social, physical and economic environments that determine the mental health of populations and individuals
2. Focusing on enhancing protective factors such as coping capacity, resilience and connectedness of individuals and communities in order to improve emotional and social well-being
3. Identifying the whole population as the target group although

- different interventions may focus on specific population sub-groups
4. Measuring outcomes in terms of public policy, organisational practices, and organisation of social factors and health literacy (Commonwealth Department of Health and Aged Care, 2000).

Effective mental health promotion interventions should ideally include some or all of the following principles: reducing anxiety, enhancing control, facilitating participation and promoting social inclusion (International Union for Health Promotion and Education, 1999).

Interventions may focus on strengthening factors to protect mental health, such as social support, and/or to reduce factors known to increase risk, such as discrimination and violence on three levels: individual, community and structural (Department of Health, 2004). In Ireland, peer-led initiatives and self-help groups have adopted some of the above principles. Such initiatives include:

1. Traveller Community Primary Health Care Workers trained with the Galway Traveller Support Group (Department of Health and Children, 2000)
2. Community Mothers (Johnson et al, 1995, 2000)
3. MÁRTA (Galway Refugee Support Group, 2005)
4. Refugee Community Organisations (Irish Refugee Council, 2004a) or Immigrant/Minority Ethnic Led Organisations (ILO) such as ARAK (Irish Refugee Council, 2004b), SPIRASI (Support service for asylum seekers and refugees)

Some recent publications aiming to challenge discrimination and promote social inclusion in Ireland include 'The National Plan against Racism' (2005) and 'Towards a City of Equals' (Galway City Partnership, 2005).

Mental Health Promotion is most effective when departments and agencies work together to provide information and support. Messages can be reinforced in a wide range of settings including the *media*, the *workplace*, *primary care*, *schools*, *libraries* and *places of worship*, *leisure centres* and other *community settings*. This applies to mainstream services that will also take account of the specific needs of minority ethnic groups (Department of Health, Social Services and Public Safety, 2003).

## **2.6 Summary**

In Ireland, the arrival of asylum seekers and refugees in cities and rural areas is relatively recent. International and Irish research findings to date suggest that individuals and families may be experiencing difficulties related to their legal status circumstances, social exclusion and discrimination in the community. The impact of these factors on mental health is well established and documented. However, research conducted at local and national level in Ireland has focused on the medical aspects of health. We must adopt a more holistic view on health in order to assess the impact of socio-economic, cultural and environmental conditions on mental health and overall health gain. Mental health promotion acts at the individual, community and structural level. Mental health promotion interventions should therefore be focused on specific minority groups but also aimed at whole communities. Evaluations should be undertaken to ensure effectiveness and transferability.

This literature review has identified some gaps in knowledge in relation to the personal experiences and perspectives of asylum seekers and refugees residing in direct provision accommodation centres and in private rented accommodation in Galway City on issues that may have an impact on their overall well-being and quality of life. Knowledge around such issues would enable local authorities and agencies to prioritise actions based on evidence.



## **CHAPTER 3**

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### **METHODOLOGY**

#### **3.1 Introduction**

The research methodology consisted of a series of one to one interviews with asylum seekers and refugees residing in both direct provision and private rented accommodation.

#### **3.2 Research design**

The choice of qualitative methods to conduct this research was influenced by the desire to gain an understanding of the experiences, thoughts and feelings of asylum seekers and refugees. Such an area of interest calls for a constructivist paradigm where interpretation of experiences and perceptions is the key. With the qualitative approach, participants use their own words as opposed to the response categories used in the quantitative questionnaire. It can provide decision makers with the critical information for correcting the problem (Crabtree, Miller, 1992).

The methodology was also influenced by the challenges in collecting data with this population group. The use of questionnaires was not considered appropriate due to a high number in this group who did not use English as their first language. Some interviews were conducted in the French language by the researcher who is a native French speaker.

The approach to designing the questionnaire was guided by a broad definition of health to include external determinants such as social, economic and environmental factors. This research used semi-structured one to one interviews.

### 3.3 Selection of participants

At the start of the research, two direct provision hostels were currently running in Galway City, providing accommodation and board for asylum seekers. It was agreed that asylum seekers would be recruited from those two centres, namely the Great Western Hostel and the Eglinton Hotel. After careful consideration, the researcher successfully accessed participants through local refugee support groups such as Minority Association Services (MAS). Participants from the MÁRTA group (Migrants, Asylum Seekers and Refugees Training for Action) were accessed through the Galway Refugee Support Group.

Refugee participants residing in private rented accommodation were all recruited through a local support group, the SORUSSI group (Russian nationals support group).

The study team agreed to put in place an incentive for participants to enable the researcher to carry out the recruitment successfully, in the form of a 20 euro voucher redeemable in a popular shopping centre chain around the city.

Initial contact was made with managers, staff and members of the groups. All parties were informed of the aim of the research, the length and the style of the interview procedure. Contact numbers were exchanged to enable recruitment and organise a schedule that would be convenient.

### 3.4 Sample characteristics

Twenty-three participants were selected and were interviewed in various locations as displayed in Table 2.

**Table 2 Participants in direct provision and private rented accommodation**

	Direct provision	Private rented accommodation	Total
Males	11	2	13
Females	6	4	10

As the sample was a convenience one, the selection criteria were that interviewees should hold the status of asylum seeker/refugee/residency and be residents in Galway City. The age and marital status of participants is displayed in Table 3.

**Table 3 Age and marital status of participants**

	Age	No	Single	Married	Widowed
Direct provision	18-24	0	9	7	1
	25-34	12			
	35-44	5			
Private rented accommodation	18-24	0	1	5	0
	25-34	5			
	35-44	0			
	45-54	0			
	55-64	1			

### 3.5 Data collection

The data collection took place over a period of one month from the end of October to the end of November 2005. Most interviews were conducted at the place of residence of participants at a date and time convenient to both participant and researcher.

### 3.6 Interview schedule

A quantitative questionnaire was designed to establish demographics such as age, gender, marital status and former occupation, country of origin and length of stay in Ireland. Additional closed questions were asked to complement the qualitative questionnaire and to provide the researcher with relevant information for analysis. The same questionnaire was used for both asylum seekers and refugees.

The approach in designing the qualitative questionnaire was guided by a broad definition of health to include external determinants such as social, economic and environmental factors. The design was intended to elicit experiences and perceptions from asylum seekers and refugees about the impact that these factors have on all aspects of their health.



The broad themes and sub-themes were developed as follows:

1. Life prior to arrival in Ireland

The interview questions were designed to elicit reasons for coming to Ireland in the first place and to gain relevant information on educational and professional background in the home country.

2. Life as an asylum seeker/refugee in Ireland.

The aim of the questions was to explore and illustrate the reality of living on a daily basis in direct provision centres/private rented accommodation and to gain an understanding of the psychological consequences/needs linked to the situation. Questions focused on socio-environmental context, sense of control and independence, personal needs and access to services.

3. Potential areas for improvement.

The questions were designed to elicit answers that would enable the researcher to identify the unmet needs of the participant.

A copy of the interview schedule is available in Appendix 1.

### **3.7 Pilot study**

The questionnaire was piloted in a direct provision centre in Clifden, Co. Galway on the 24th October 2005 and involved 6 participants. The manager of the centre was informed about the study and agreed to recruit the participants for the purpose of the pilot study. Length of interview, appropriateness of questions, difficulty in wording and overlapping questions were monitored and amended accordingly.

The researcher conducted the interviews while the researcher's assistant took notes and monitored the various aspects of the interview.

As a result of the pilot study a few changes were made to the wording of some of the questions, the sequence in which the questions were asked, and care was taken to eliminate overlapping questions within the different sections.

### **3.8 Interview procedure**

All interviews were completed over a four-week period in the place of residence of most participants. Each interview lasted from 40 to 60 minutes. All 11 interviews in the Great Western Hostel were carried out in a quiet room that was made available. In some other instances, a quiet room was not readily available and the interviews took place where it was most convenient for participants.

At the start of each interview, the researcher introduced herself and made the participant feel at ease. She explained the background and purpose of the research. The confidentiality of the interview was made clear to participants at the start of the interview and reiterated at the end. Their consent to recording the interview was obtained. It was also suggested that the transcript could be made available to them if they so wished. Five participants did not wish the interview to be recorded, in which cases the interviews were recorded manually by the researcher.

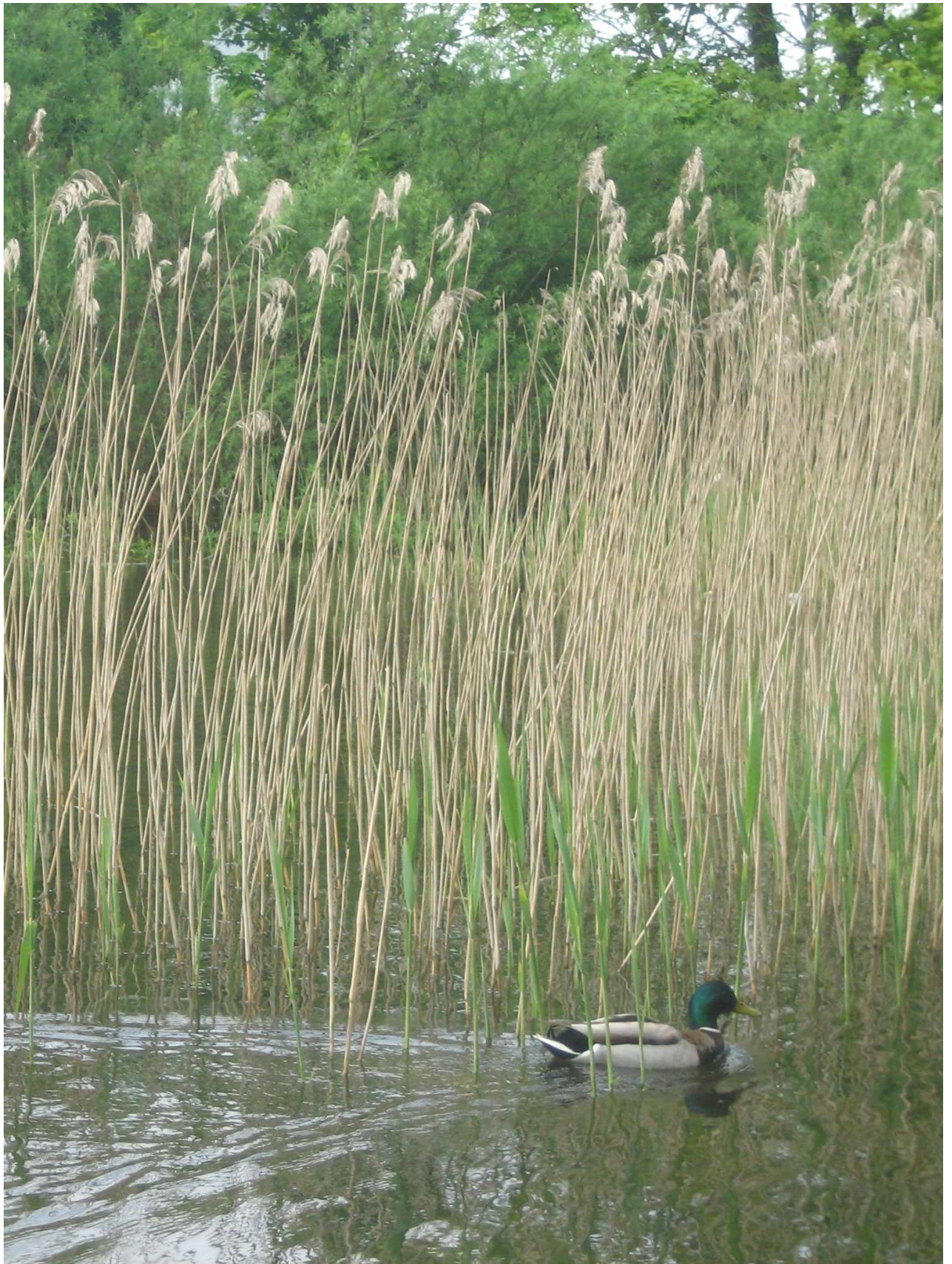
As stated above, no participants in this research were native English speakers. Two interviews were administered through an interpreter; six interviews were conducted in French. In all cases, the content of the interviews was recorded verbatim, therefore the content analysis should retain its high validity.

At the end of each interview, the researcher offered a list of agencies and organisations available in Galway City that can offer psychological support. The pocket guide published by Comhairle was also made available.

### **3.9 Data analysis**

Qualitative data were analysed using content analysis. The audiotape recordings were transcribed manually onto paper by the researcher. Each transcribed interview was accompanied by field notes and observations relating to the circumstances and personality traits of participants and to particular events that happened during the course of the interview. The researcher became totally immersed and thus familiar with the data, and remained flexible and open to change: every day brought more insights into the contents, and data were reorganised.

The category development followed broadly on key themes developed through the design of the questionnaire. Within those themes, sub-categories were created and labelled as they emerged from the transcripts. Coding, which relates sections of the data to the categories, was carried out using numbers and notes on the raw material and then 'cut and pasted' into the developed categories. Verbatim quotes were included to illustrate categories.



## CHAPTER 4

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### INTERVIEWS WITH ASYLUM SEEKERS

#### 4.1 Introduction

Interviews with asylum seekers living in direct provision accommodation were carried out to gain an understanding of their mental health promotion needs. The interviews took place at the two direct provision centres in Galway City. The findings are outlined in this chapter.

#### 4.2 Demographics

The quantitative questionnaire provided useful demographic information on the participants such as age, gender, country of origin, marital status, length of stay in Ireland, children of participants residing with parents in Ireland or in country of origin.

##### ***4.2.1 Age, gender and marital status***

As displayed in Table 4 below, the total number of participants (n=17) was divided as follows: 65% male (n=11) and 35% female (n=6). The sample was a convenience sample which made it difficult to ensure an equal number of male and female participants. The majority (71%) (n=12) were young men and women between the ages of 25 and 34 years. Twenty-nine percent (n=5) were aged between 35 and 44 years. Other studies have similar findings which reflect a relatively young population of asylum seekers.

The majority (53%) of people interviewed were single while 41% were married. If we divide the figures by gender, 55% (n=6) of men were single and 45% (n=5) were married while 50% of females were single and 50% married. All respondents lived without their partners at their place of residence.



**Table 4 Gender, age group and marital status of asylum seekers**

		No.	%
Gender	Male	11	65
	Female	6	35
Age group	18-24	0	0
	25-34	12	71
	35-44	5	29
	45-54	0	0
Marital status	Single	9	53
	Married	7	41
	Separated	0	0
	Divorced	0	0
	Widowed	1	6

#### ***4.2.2 Place of residence of children of asylum seekers***

Over half of participants (n=10) had children. Among the male participants, 45% were fathers (n=5) whose children were living in their country of origin. Eighty-three percent (n=5) of females were mothers but only 60% (n=3) had their children residing with them in Ireland and 40% had their children living in their country of origin. Table 5 displays the data collected regarding the place of residence of children of participants which shows that 70% (n=7) of parents interviewed were living separated from their children.

**Table 5 Place of residence of children of asylum seekers**

	Males	Females	No	%
Participants living in Ireland with children	0	3	3	30
Participants whose children live in home country	5	2	7	70

#### ***4.2.3 Country of origin of asylum seekers***

Table 6 displays the country of origin of participants. All participants came from the continent of Africa, representing 9 countries. When

asked if they spoke English, 90% (n=16) stated that they could speak English but the level of fluency varied according to the country of origin, professional background and the length of stay in Ireland. One participant who had recently arrived in this country required an interpreter for the interview. Thirty-five percent of the interviews (n=6) were conducted in the French language. Fifty-three percent (n=9) were attending or had attended English classes.

**Table 6 Country of origin of asylum seekers**

Country of origin	No of participants
Angola	2
Malawi	1
Somalia	2
Eritrea	1
Nigeria	2
Kenya	1
DR Congo	5
Cameroon	2
Zimbabwe	1

#### ***4.2.4 Length of stay in direct provision accommodation***

Table 7 shows that 41% of participants had spent over 2 years in direct provision accommodation while another 41% had arrived less than one year ago. After combining the figures, 47% of participants had been residing in direct provision in Galway City for over 2 years. These figures were significant in relation to the findings on the impact of length of stay on psychological health.

**Table 7 Length of stay in direct provision accommodation**

No. of years in direct provision	Males	Females	No	%
Over 3 years	0	1	1	6
2 years and over	5	2	7	41
1 year and over	2	0	2	12
Less than 1 year	4	3	7	41

#### ***4.2.5 Professional background of participants***

Most participants (88%) were employed in their home country. Professions and trades were categorised within the following social classes:

- SC1: Professional workers
- SC2: Managerial and technical
- SC3: Non-manual
- SC4: Skilled manual
- SC5: Semi-skilled
- SC6: Unskilled

Table 8 presents the social class of participants before leaving their country. The combined percentage of participants between social class 2 and social class 5 was 65% (n=11). Those who were self-employed, students or had no profession were categorised in social class 6. The breakdown within that class shows that 67% were self-employed, 17% were students and 17% had no profession

**Table 8 Social class of asylum seekers**

Social class	Male	Female	No	%
SC1	0	0	0	0
SC2	3	2	5	29
SC3	0	1	1	6
SC4	2	1	3	18
SC5	1	1	2	12
SC6	5	1	6	35



### 4.3 Background to exile

All participants experienced persecution in their native countries and felt they were left with no choice but to flee. The journey to Ireland had been organised by a third party but the destination was unknown to them prior to departure.

Persecution had its roots in ethnic discrimination, religious beliefs and practice of religion, membership of or connection to a political party and war.

Eighty-eight percent of participants had a career or a trade in their home country prior to their departure for Europe or prior to experiencing difficulties.

*'...I was a nurse in hospital and I was second chief in the Department of Pharmacy...'*

### 4.4 Adapting to a new way of life

All participants felt that their personal safety was assured in Ireland, which was their first preoccupation. However, 88% were still dealing with past traumas, had left family and friends behind and worried about the uncertainties that the future would bring.

*'...I am blindfolded...I do not see what's going to happen tomorrow, it's not easy to make plans...'*

All participants experienced anxiety and stress when they thought about what could happen in the event of a negative outcome to their application for refugee status.

*'...when one stays like this, I don't know what decision the government will take one day for me, that's why I feel frightened every day...'*

Some enjoyed the freedom to practice their religion in a democratic country where there was no threat to their lives.

Fear of deportation was real for some residents who had experienced the evacuation of fellow residents from the hostel by immigration officials.

*'...anytime the minister can take a decision to deport me so, for me, the safety I came here to find, I have not found it yet....'*

Forty-one percent of participants had been residing in direct provision accommodation for over 2 years and 12% over a year while 6% had been here for over 3 years.

Ninety-four percent said they had no opportunities to get to know people. Twenty-six per cent still experienced a longing for their cultural values, community life and support structures.

*'...you know, back home, like us Africans, we have, where we are living, we have a community life, that interact with brothers and sisters and with friends...but here, it's a different thing, you come here, you don't know anyone, if you know they are far from you....'*

The differences in lifestyle were quite dramatic for most participants. For a few, this was their very first experience of living abroad. The most difficult things to adapt to were the climate, food and living circumstances in direct provision, the language and unfamiliar surroundings.

*'...it's not difficult to adapt to a new culture but the problem is adapting to a culture when you don't have a say, you're forced to adapt...'*

## 4.5 Social integration

This section explores and illustrates, through the experiences and perceptions of residents, the reality of living in direct provision and identifies the factors that most impact on psychological well-being.

### 4.5.1 Employment

Eighty-eight percent of participants (91% of men and 60% of women) said that their wish was to be integrated into Irish society. Asylum seekers do not have access to employment in this country. Participants felt very strongly that as long as they were denied the right to work, they would not be able to integrate fully.

*'...we all want to integrate into Irish society but the state does not allow us to do so...'*

Twenty-nine percent declared that they were ready to take on voluntary work while 50% were already involved in voluntary work around the city once a week. Financial reward was an important factor in getting the motivation to work. The majority were prepared to learn new skills and to work part time if necessary to complement their weekly allowance of 19.10 euro.

Twenty-four percent believed that through employment one would get to meet people and acquire knowledge of cultural issues. This would facilitate integration.

Thirty-five percent wished to participate in Irish life by contributing their skills and expertise and by paying their share of taxes. Most participants held a professional qualification or had a trade and felt their skills were not being put to good use.

*'...we are useless the way we are at the moment but we can be useful if we're given the opportunity...'*

*'...what I don't like is to be idle...I am not given the opportunity to express myself, to show my qualities, my abilities....'*

One particular participant was surprised that asylum seekers were not asked to contribute to Irish society even in some small way.

*'...I am an asylum seeker and my case is not decided and on the other hand, I do not see anybody who is telling me to do something...you know...'*

On a personal level, the majority felt inadequate and guilty for not being able to contribute to their host society and share the knowledge they had in their area of expertise.

*'... I like it to help because to do medicine, to be a nurse is to help, I help people in my country, giving injections, I teach people for health, too many things, now I stay, you know, just to stay...for me...'*

Twenty-three percent had a fear of seeing their intellectual capacity, memory and self-confidence diminish. They felt the world of knowledge was changing rapidly and that it was important to keep up with those changes.

*'...I am afraid to lose my intellectual competences because I have no opportunity to apply them...'*

Eighty-eight percent of participants expressed the belief that they could, through employment, preserve their human dignity with freedom of choice and expression, confidence and financial reward. Ninety-one percent of men felt they had lost their sense of identity and status.

*'...if you don't have work, you have nothing...''*

*'...what I was, what people they was to me in my country, you know, this man is a medicine man, you know, some people they come to me in the morning at 5 o'clock, hey my son is this, I have a daughter....ok, we do this, I do everything, I inject,*

*go to the hospital quickly, you know....every these things...'*

Participants described the boredom, idleness and lack of challenges day after day and the negative impact this had on their lives. Most men talked about feeling tired all the time, not being able to sleep at night but yet spending too much time in bed during the day because there was nothing to look forward to. Feelings of isolation and withdrawal from the world were a common aspect of life in the hostel.

*'...the life of a man... a man has to work, doesn't he? I was a carpenter but here...I have nothing to do, it is very difficult....'*

One male resident explained how he felt that integration could help prevent some asylum seekers from opting for a life of crime and becoming 'dropouts'.

*'...it could prevent some people from becoming marginalised, which would lead them to do just anything to this country...'*

#### **4.5.2 Lifestyle**

The direct provision system provides accommodation and board for asylum seekers pending the outcome of their application for refugee status.

Ninety-four percent of participants felt very unhappy with the conditions they were living in which impinged on privacy and freedom of choice and offered a reduced living space. Accommodation was shared in all cases. The numbers per room ranged from 2 to 6.

*'...people are on top of each other...'*

Conducting activities such as reading, watching television, leaving the light on at night, meeting friends or practising religious rites was difficult in those circumstances.

*'...it's terrible, terrible, because we're all different in one way or another...there are some people who like to be quiet, some people like to...watch TV,*

*some would like to have music or others like to read...so these different people, maybe you're to do those things at the same time, which is not possible, not possible...'*

One female resident was granted a private room due to her medical circumstances. Another was refused despite her doctor's recommendations.

The majority of participants talked about the difficulties in dealing with cultural differences within the centre. Forty-one percent mentioned the diversity in cultural backgrounds, including beliefs, attitudes, behaviours and the conflicts that may arise within the confines of the room or when residents gathered at the restaurant during mealtimes.

*'...I never have problem in this hotel. The people they want to be problem with me, but I have to do the best to finish this problem...'*

Participants seemed to be aware of the frustration, anger and stress some residents were experiencing, due to their present living conditions and past traumas.

The question of food was raised as an important factor in overall well-being for all respondents.

*'...when I think, oh today is Sunday, I'm going to eat that terrible meal, there is nothing good to eat...I stay in bed...'*

Most participants stated that they were frustrated by the lack of cooking facilities that meant they had no control over the food they ate; they were dissatisfied with the lack of variety in the types of meals served and the preparation of food was not always adequate according to some.

*'...we don't cook. We just have to eat whatever is provided, whatever is provided you have to eat it...'*

Twelve percent were delighted to have access to food and have enough to eat. Some said more thought could be put into providing a better variety of foods to satisfy different ethnic tastes.

*'...it's not that we are African, but we are from different countries, and we have different types of food, so if they are preparing these African foods, they just prepare food for one country, every time, for which there are African but me, I can't eat it...and they won't do anything...'*

Most residents would like to be able to choose their own food and prepare it. One female resident was asked by her GP to follow a special diet for a medical condition but had not been granted cooking facilities. She felt that she was not able to manage her condition in those circumstances.

The most important problem mentioned by most participants was how to cope with idleness. All those interviewed talked about their daily routine and how they found themselves doing the very same thing every day, day after day.

*'...nothing to do outside, nothing to do in the hostel...'*

Half the participants admitted that they preferred to stay in bed in the morning rather than get up for breakfast as there was nothing to look forward to. The majority described how activities revolved around the fixed mealtimes three times a day: sleep, eat, sleep, watch TV, visit each other in rooms, eat, walk around town and come back.

*'...I wake up in the morning at nine o'clock, I eat my breakfast and I play sometimes pool and I wait for the lunch. Sometimes I go to the library and check the internet...that's it and I come back, eat my dinner, then that's my daily routine...'*

Other activities included reading, listening to music and watching DVDs and videos, visiting friends within the centre or around the city. Opportunities to do anything different were limited by the hostel regulations.

*'...I don't have any choice because...I don't have any choice; I have to stay here because apart from this I have nowhere to go...'*

Within the centres, facilities included a pool room, internet rooms and a crèche. Due to internal difficulties, the internet rooms were not always accessible. The playroom was now running as a crèche which opened every day in the morning. Thirty-three percent of female residents with young children found that activities involving themselves and the children were very limited indoors at all times as well as outdoors in wintertime.

Seventy-three percent of male participants felt restricted by weather conditions. Outdoor activities for forty-seven percent included playing football during the summer.

*'...football helps you forget, it relaxes your mind...'*

Going to the beach was also a favourite pastime for 24%. Two residents had given up running. The reasons given were the weather and lack of equipment such as proper trainers. There were no sporting activities or places to go to in the wintertime.

*'...to change most of the time being here, starting from morning to evening. To have some of my time to entertainment place or sports place or anything...'*

All residents found winter conditions difficult to adapt to and as a result felt more restricted.

*'...sometimes, I go walking to the city, I come back but that was happening mostly in the summertime, I find I was more busy in the summertime than now, because now, even if I want to...I look at the weather and I say 'no', I am not going out in the cold...'*

Sixty-six percent of female participants with children found the summer months more enjoyable as the Salthill area provided plenty to do such as walking along the beach and going to the nearby playground. However they would like to have more opportunities to be active.

*'...like, some activities like games...games for you know, like, also, somewhere where we can play*



*volleyball, like basketball...like children, they also are very idle, and also have some games for them...'*

Fifty-percent of female residents practised swimming for one month. This had been organised through another course they were attending. All said they would like to keep up swimming.

*'...I am only learning, not that I know how...it's something I would like to. Because it keeps me...busy and it feels nice to be in the water, even if I am just to sit here...'*

Summer festivals included African drumming and parties. Generally Galway City provides street events and entertainment during the summer months.

Free access to public facilities for all residents included the public library. Other facilities such as leisure centres, swimming pools and cinemas and the pub were not a choice for most residents as the cost involved was prohibitive.

The majority of female participants got involved in language training, computer classes, lectures and conferences from time to time. Refugee support groups organised special training courses such as the Walking Leader training. Barriers to participation in those activities included the weather, child minding and transport difficulties. Eighty-three percent claimed they could not do the activities they used to enjoy because of lack of facilities and opportunities. Male participants on the other hand did not mention participating in the same activities as the female participants, except for language training.

Travel to and visiting other cities or counties in Ireland was not a possibility as regulations did not allow residents to stay more than one night away from the hostel.

*'...I have friends in Dublin, I want to visit them, for maybe two days, three days, but they won't allow you to go...'*

#### **4.5.3 Education and training**

All participants emphasised the importance to them of education and training and that they would like to see more opportunities for learning while their application was being processed.

*'...I would like to participate in different activities like to take some course rather than staying here because we are wasting our time doing nothing here...'*

Learning new skills and upgrading existing skills would provide challenges and raise morale. Some viewed their stay in Ireland as a good opportunity to get an education as this would not have been possible in their country.

*'...I want to learn something from here, something like school, it is important to speak English nicely, to write it also...'*

One participant made the point that education should be made available to everyone.

*'...Everybody should get education, it should be a public good for everyone rather than people they have different backgrounds, some of them don't have an education background, so it's good for them to bring adult education, but for those who got some academic...they should have something, you know, like 6 months to improve. I think it would be better...'*

Sixty-four percent of male participants felt that vocational training in carpentry, welding and art would be a way to keep busy and prevent the distress caused by idleness and lack of challenges. Twenty-four percent of all interviewed would like to have access to third level education to improve their existing knowledge.

Those with poor spoken English were anxious to improve their language skills and said that they were unhappy about the delivery of English classes.

*'...we should be taught the language properly, at a 100%, every day, I say the problem is the language, it's the language...'*

At the time of interview, one participant who had been a resident at the hostel for 9 months had not been able to access English classes at all because he did not understand the system.

*...if the authorities were really genuine about enabling us to integrate, they would improve on the delivery of English classes...'*

Fifty percent of all participants attended free English classes twice a week for 2 hours each time. Those who had no English at all found the classes to be inadequate in frequency and quality, in terms of being able to communicate efficiently, and thought that total immersion every day would enable them to learn the basics of the language.

*'...language is the biggest barrier to adapting to this country...'*

Sixty-seven percent of female participants felt that education and training courses should be provided if employment was not allowed. Those with skills would like to be able to keep them or upgrade them.

*'...I like people to come to do their hair...you know this hairdressing; you have to be active...because if you stop doing it, you might forget how to do it...'*

## 4.6 Social inclusion

### 4.6.1 Irish community

All participants felt that there were very few opportunities to meet Irish people.

*'...no, I can't feel part of the community because I am not doing what the community is doing, so I can't feel part of the community...maybe I will in the long run but not now...'*

Those attending mass at the local church and those involved in setting up services and organising events with church committees met Irish people on a regular basis. Other opportunities to meet included the local choir, the library and public places such as the beach and night clubs sometimes. One participant said he met Irish people on a regular basis in shops or walking around the city but that encounters were superficial in general. Language difficulties compounded the isolation for 41% of those interviewed.

Thirty-three percent of female participants talked about the good relationship between teachers and students at the course they attended. Eighteen percent of males felt they got on well with the manager and the staff of the hostel. However, visitors were not allowed in the hostel and there was no venue in town where people could meet informally.

Twenty-four percent felt that the Irish were good people. Twenty-nine percent of all participants perceived that Irish people did not want their presence here.

*'...some Irish people don't have time for us...'*

*'...some people will accept you, some ...you feel like an intruder, they talk to you like 'why have you come to ruin our country?'*

One female participant felt that some Irish people were prejudiced against some African countries and that it showed in their reactions and attitudes towards her. Most interviewees argued that a lack of knowledge and a tendency on the part of the population to make

assumptions on the background of asylum seekers arriving in this country increased xenophobia.

*'...I've met some people that say 'why are you here?'. You see you wouldn't start explaining all this to somebody in the street, it's a long story, you know...*

The cosmopolitan nature of Galway City was mentioned as a positive factor for 50% of all participants.

The overall feeling among participants was that they were not part of the Irish community.

#### **4.6.2 Social support networks**

Participants had their own social networks at the hostel where they resided and within the city. There was a tendency for people of the same nationality to socialise together. However residents of different nationalities who shared accommodation enjoyed good relationships. Opportunities to meet included special occasions such as births, birthdays and christenings with asylum seekers who had been granted residency or refugee status and had now moved to private accommodation around the city.

Twenty-four percent of participants said that restrictions on travel prevented them from socialising with friends residing in other parts of the country or/and discouraged those who would have liked to learn about and discover Ireland.

#### **4.6.3 Environment**

All male participants residing in the hostel located in the city centre appreciated the proximity to amenities which eliminated transport costs. The descriptions given about the centre itself were very succinct.

Eighty-three percent of female participants felt very happy with the location of the hostel.

*'...I think I am one of the privileged to be in Salthill...'*

Thirty-three percent expressed surprise that such an area of Galway City could accommodate asylum seekers.

*'...the feeling you get is they would want to take you out from a nice place like this to some village in Connemara, in the middle of nowhere...'*

One participant expressed her dismay at the conditions in the hostel.

*'...looking from outside, it's a beautiful place...the outside appearance, at the beach, beside the sea...but when you go inside, all that glitters is not gold, the inside is terrible...'*

Fifty percent of female participants with children said that they experienced difficulties in the wintertime because there are no indoor facilities nearby for games or activities.

#### **4.6.4 Services**

Health services were perceived to be adequate for most male participants, who attended their GP regularly for both physical and mental ailments. Those who arrived to Ireland injured or in a very poor state of health were very satisfied with the way they were treated by the health care system.

*'...when I left my country, I was just coming out of prison, and the doctor who cared for me, he saw the state I was in, he took care of me without any difficulty...'*

Twelve percent of participants had experienced some difficulties with the health system such as delays between consultations in the event of continuity of care, waiting time at clinics and disorganisation and problems with hygiene at the hospital.

*'...he (the doctor) did not examine me properly because the machine he was supposed to use was not available, so he gave me another appointment...'*

One male participant stated that he had been referred to SPIRASI, an organisation dealing with victims of torture, by his GP.

Sixty-seven percent of female participants would have liked to have the option to choose their own GP. Thirty-three percent were satisfied with maternity and home help services.

The overall majority of participants found social services to be adequate for providing advice and support for the asylum application, and throughout the asylum application process when they could rely on free legal aid in case of appeals. However, as time went on, they felt that there was no one they could turn to for psychological support and information on the progress of their application. The length of time waiting for the outcome of the application was a great source of stress and anxiety.

*'...I help myself...there are no other places...except for this time that you come here ...at least I have the opportunity to talk with you...'*

*'...if there was someone you can tell all your stuff...'*

Sixty percent perceived that Irish authorities were aware of the difficulties asylum seekers were experiencing within the direct provision system but they did not trust that anything was going to be done about it.

*'...how come a normal person sleep like that during the day? Normally people go about their day doing their business, but us, we don't....they (the authorities) know that these people here have problems, they suffer in this situation...'*

Fifty percent of female participants felt that services did not deal with individual cases with special needs very well. Furthermore, they did not believe that services were delivered equally in different parts of the country.

*'...I thought that everything was centralised from Dublin, you see and that you'd have it filtering down to all counties...'*

The feeling overall was that some injustices and inequalities in the delivery of social services and particularly social welfare services should be addressed. Forty-one percent of all participants felt that

information on services including progress on applications, Irish culture and the political structure of the country should be readily available. Some suggested that independent services could provide such facts. Others felt that a career guidance service would give people information on job opportunities for the future. Twenty-nine percent stated that they had sought help from refugee support groups around the city and were happy with the support and advice these services provided.

Seventeen percent suggested involving interpreters and mentors in the delivery of information. Such a service would enable newcomers to familiarise themselves with their surroundings on arrival and would provide an opportunity to practise and improve their English skills. Participants reported learning a lot by word of mouth but felt that more information could be made available. Dissemination through newsletters and newspapers, magazines, leaflets and brochures in different languages could be improved.

Eighty-three percent of female participants felt that transport was not meeting their needs, particularly on certain routes, in the evening and at the weekend. Their weekly allowance did not permit them to take a taxi to access the hospital, the doctor's surgery or evening lectures/classes.

## **4.7 Perceptions of health**

For all participants good health included physical, mental, emotional and spiritual health.

*'...good health is about freedom, being able to choose your life...'*

*'...to be in good health , it's not only physical health, I would say that it's about how one feels mentally...because when you don't feel well mentally , the whole body falls apart...'*

### **4.7.1 Physical health**

Eighty-eight percent of all participants felt that their physical health was fairly good. Those who had experienced ill health as a result of their persecution in their native country had been well looked after by the Irish health system on arrival in this country. All participants said



they attended their GP when they needed to. Since their arrival in Ireland two female participants had experienced serious medical problems which required appropriate living conditions and support from health services. One of those participants felt that her GP's recommendations had not been met by the social services.

Psychosomatic disorders such as sleeping disturbances, headaches, digestive and skin disorders were associated with high stress levels.

*'...I've been worrying about a headache instead of the cause of that headache...'*

All participants felt comfortable and safe here in terms of physical safety. However their current living circumstances and the uncertainty associated with their refugee application prevented them from feeling good and enjoying life to the full.

#### **4.7.2 Mental health**

All participants described their daily life in direct provision as depressing and boring as they had no control over the planning of their lives on a daily basis.

*'...I think it's very bad to put a normal person...how can a normal person be fed like a child? That is never done...that is never done...'*

They felt that there were no opportunities for decision making and planning for the future was totally outside their control.

*'...it's as if my life is managed by another person...I have no say over what's going to happen tomorrow...'*

Overall, male participants were satisfied with the management and staff of the centre but were very unhappy with the policies of direct provision accommodation. One particular participant who had been a resident here for over two years described how unbearable and unacceptable the situation was and argued that such policies should be abolished.

*'...put an end to the direct provision system and let us prepare our own food...'*

Thirty-three percent of female participants felt that life at the hostel was difficult as their lifestyle within the centre was dictated by rules they felt were not acceptable.

*'...there are children here but these children were born by adults and the same adults live here as well. But they regard everybody as these children...you know, so they give all these rules like, I look at them sometimes and I say 'would they live with such rules in their own homes?...'*

The same participants felt that communication could be encouraged at the hostel by providing a suggestion box for residents. It was suggested that a forum comprising the board of management, staff and residents could be a first step towards raising and discussing concerns.

*'...this is like my home now, this is where I spend most of the time...I think it should start here...then they can air our views to the officers of justice or whatever. Because I don't even know if I walked to the Justice Office, who to approach, I don't know...'*

There were restrictions on travel within Ireland and transfer to other direct provision centres around the country was generally not permitted.

Financial limitations imposed further stress on participants who could not afford a normal lifestyle. One participant said he used the allowance to buy a phone card every week to contact his family in Africa.

Those with language difficulties were further isolated and felt the lack of communication with the rest of the community. Forty-one percent believed that knowledge of the language was absolutely vital in adapting to a new country. One participant noted that language was only part of the problem.

*'...English is very important but it's not enough. Even people who can speak English do not have the opportunity to do anything....'*

Stress brought on by fear and uncertainty about the future was said to cause headaches and sleep disturbances.

*'...there is this void and that means the fear of the unknown, although it's there, I try to pretend I don't feel that there, it's not like I don't care, I do care, but I think it's easier to blank that out as well...*

Most participants were still dealing with past traumas.

*'...all I think about is what I have been through in my country...'*

Those who came alone worried about family and friends who had been left behind. Fifty percent had had no news.

*'...sometimes I wake up and I am just thinking about my mother, my child. And I don't want to do anything...just staying there...and sometimes I do nothing...'*

Idleness and lack of challenges in the day caused withdrawal and isolation. Most participants talked about having to repress feelings of anger and frustration and anxiety.

*'...if I have problems, I keep them in my heart...yes, because who am I going to tell here? And even if I tell someone, who is going to listen to me?...'*

Overall lifestyle in direct provision was perceived to be restrictive and unchallenging. It disengaged asylum seekers from the rest of society, thus preventing an independent lifestyle and integration.

#### **4.7.3 Coping mechanisms**

All participants relied on strong social networks from friends at the hostel and around the city for psychological support.

*'...psychological support is when you're in front of somebody who has been through what you're going*

*through... he says 'you must be strong, I've been through what you're going through, it's not easy but you have to be strong...'*

Mothers found great comfort in looking after each other's children. The support networks among women were very strong and provided emotional and psychological support.

Religion provided relief and was a source of strength for all respondents.

*'...the only thing that makes me happy is practising my religion, I got freedom, I am very happy to practice my religion here...'*

Most participants felt they had the strength to carry on and to stay strong despite the difficulties, because they had no choice. However some were worried about the repercussions of these experiences on their lives in the future.

Some activities reported to help relieve stress were football and swimming. These activities were not sustained over long periods as was noted earlier.



## **CHAPTER 5**

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### **INTERVIEWS WITH REFUGEES**

#### **5.1 Introduction**

Interviews with refugees living in private rented accommodation in Galway City were carried out to gain an understanding of their mental health promotion needs. Most of the interviews were held in the place of residence of participants. The findings concern six refugee participants and the findings are detailed in this chapter.

#### **5.2 Demographics**

The quantitative questionnaire provided useful demographic information on the respondents such as gender, age, marital status, place of residence of children, country of origin, length of stay in Ireland and professional background.

##### ***5.2.1 Age, gender and marital status***

Table 9 displays the number of participants (n=6), which was divided into 33% males and 67% female. The majority (83%) (n=5) were young people and were married at the time of interview. Sixty-seven percent (n=4) were living with their spouse and family in Galway City. Thirty-three percent (n=2) had their husband/partner in their country of origin. Some had arrived alone to this country while others had arrived as a couple. Most of those who had arrived alone had been reunited with their spouse. However, the findings did not provide any information regarding reunification.

**Table 9 Age, gender and marital status of refugees**

		No	%
Gender	Male	2	33
	Female	4	67
Age group	18-24	0	0
	25-34	5	83
	35-44	0	0
	45-54	0	0
	55-64	1	17
Marital status	Single	1	17
	Married	5	83
	Separated	0	0
	Divorced	0	0
	Widowed	0	0

#### ***5.2.2 Place of residence of children***

All participants had children. While 83% (n=5) had their children living with them in Ireland, 17% (n=1) had one daughter living in Ireland and more children living in her country of origin.

#### ***5.2.3 Ages of children and children attending preschool and school***

Table 10 displays the number of children per participant, age bracket and attendance to schools. The total number of children was 17 out of whom 71% (n=12) were under the age of 5. Only 25% (n=4) were attending preschool. The reasons for this were that either children were too young or there was a waiting list at the school at that time.

**Table 10 Number and age bracket of children per participant and children attending preschool or school**

No	Part 1	Part 2	Part 3	Part 4	Part 5	Part 6	No	%
Children under 5	2	2	4	0	1	3	12	71
Children over 5	0	0	0	0	0	0	0	0
Children over 16	0	0	0	1	0	0	1	6
Children attending pre school	2	0	1	0	0	1	4	25
Children attending school	0	0	0	0	0	0	0	0

#### ***5.2.4 Country of origin of refugees***

Table 11 presents the country of origin of participants. The majority of participants (83%) came from Asia and 16% from the African continent.

**Table 11 Country of origin of refugees**

Country of origin	No. of participants
Kazakhstan	1
Ukraine	2
Russia	2
Nigeria	1

#### ***5.2.5 Length of stay in Ireland***

Table 12 shows how long participants have been living in Ireland. Fifty percent have been residing in this country for over 3 years. The majority (66%) received their residency status recently. While 67% had a good level of fluency in the English language, 33% (n=2) needed an interpreter for the interview. The ability to speak English at the time of interview depended on the country of origin, level of education and professional background of participants prior to their arrival in Ireland. Therefore length of stay in Ireland did not determine fully the level of fluency in English.



**Table 12    Length of stay in Ireland**

Years in Ireland	No	%
3 years & over	3	50
2 years & over	2	33
1 year & over	1	17
Less than 1 year	0	0

***5.2.6 Professional background of participants***

All participants were employed in their home country prior to exile. Professions and trades were categorised within the following social classes. Sixty-seven percent of participants (n=4) were categorised between social class 2 and social class 4. Those in social class 6 (n=2) had businesses. Table 13 presents the social class of participants before leaving their country.

SC1: Professional workers  
SC2: Managerial and technical  
SC3: Non-manual  
SC4: Skilled manual  
SC5: Semi-skilled  
SC6: Unskilled

**Table 13 Social class of refugees**

Social class	Male	Female	No	%
SC1	0	0	0	0
SC2	0	2	2	33
SC3	0	1	1	17
SC4	1	0	1	17
SC5	0	0	0	0
SC6	1	1	2	33

### **5.3 Background to exile**

All participants said that they had no choice but to flee their countries because they feared for their families' and their own lives. They left husbands, children and parents behind. Persecution due to ethnic differences, racism and membership of a political party were the reasons given for emigrating.

### **5.4 Adapting to a new way of life**

The majority of participants had found it difficult to adapt to their new way of life initially. They found life in direct provision difficult.

Eighty-three percent had received residency status in recent times and 16% got refugee status. Their safety was assured now in this country and they had peace of mind.

*'...I live a normal life...'*

The main difficulties in adapting included: the medical system, getting used to cultural customs, lack of language skills and the weather.

*'...you don't know the traditions...weather conditions, the lifestyle is different...'*

Thirty-three percent of respondents felt that their language skills were very poor despite the fact that they had been living in this country for more than 2 years.

Sixty-seven percent said that they missed family members and the way of life they had left behind. However they felt very hopeful about the future in this country.

## **5.5 Social integration**

### **5.5.1 Employment**

Fifty percent of participants were actively looking for employment. They felt a job would give them freedom, independence, access to facilities and an opportunity to integrate into Irish society.

*'...when you don't have a job, it's daily routine. I would like to go and do something for myself and we can't afford it...'*

They argued that it was not easy to get employment and that the state should ensure that those who have been given the right to reside in this country could access employment. Language barriers reinforced the difficulties in filling a position.

### **5.5.2 Lifestyle**

For thirty-three percent of participants, life in private accommodation was quite a recent experience. Eighty-three per cent felt happy about their lifestyle. They enjoyed the freedom with their young families and looked forward to the new opportunities open to them. Children attended crèches, playschools or primary schools.

*'...it's like a second motherland. We've got the chance to build a new life. I have access to university. The children have access to schools. For parents, the most important is when children are happy...'*

However thirty-three percent felt that lack of employment restricted them to the house too much and they felt isolated from the rest of the community.

*'...if I take work, I go outside every day, I move, I will speak with people, English language, I will work with staff, I will have new friends...'*

Leisure activities included going to the playground, walking, reading, knitting, cooking, visiting places of interest in Ireland and visiting friends. Access to facilities such as leisure centres and special play centres for children was restricted due to high membership or entry fees. Poor language skills further restricted opportunities for activities such as attending the library. Television and satellite facilities provided programmes in the mother tongue which were means of breaking the isolation.

#### **5.5.3 Education and training**

Sixteen percent of participants were currently attending a third level institution. They felt very happy about this opportunity and were looking forward to obtaining a qualification that would secure future employment. However they were concerned about the length of the studies and the restrictions put on the family's lifestyle as a result. One participant was hopeful that she could adapt her Russian qualification to Irish standards. Access to English classes was slow due to restrictions imposed on the availability of places at the institution. This would postpone entry to a course and delay job opportunities even more.

*'...I don't like the fact that I don't speak English and I can't get into the school...to study it... of course it's difficult to get a job here if one doesn't have English and if you don't know how to read or speak or write in English...'*

## **5.6 Social inclusion**

### **5.6.1 Irish community**

All participants felt happy living in the community. Their perceptions of Irish people were positive.

*'...the people are very friendly. You never feel foreign. I never get something bad from Irish people.'*

Opportunities to meet Irish people were limited due to employment circumstances, poor English skills, no social events and no meeting place where exchanges could take place. Thirty percent of people felt circumstances did not present themselves very often to socialise with Irish people.

*'...it's not easy...Irish people, because they work, they don't have time...'*

### **5.6.2 Social support networks**

In general, all participants socialised with people from their own communities because they could share cultural similarities and common experiences.

*'...mostly, it's Russian people that I know. Mentality... you came with the same problems, you have to support each other. You miss your country...'*

One participant argued that in order to enhance social interaction there could be more places where Russian people could meet to celebrate. Another felt that because of her age, it was even more difficult to get to meet people.

*'...I have no friends. I sometimes miss, you know, I sit all the time, just that problem. I am happy; I just need about friends, about people I can talk to, just about that...'*

### **5.6.3 Environment**

Most participants were satisfied with the location of their homes and described the area where they lived as being pleasant, quiet and in a good neighbourhood. One described the area where she lived as unsafe but she was happy because there were lots of children. Sixty-seven percent lived in estates around the city and 33% closer to amenities. However, all participants said that playgrounds were usually located too far from their homes. Weather conditions restricted them further if they wanted to walk or cycle to the playgrounds. Eighty-three percent had access to a car but would like to see more accessible facilities in their neighbourhoods. Depending on the age and the number of children, some parents experienced difficulties.

*'...you know, he is too small (grandchild), if we walk to playground, we just came to playground, he is tired...'*

The role of playgrounds in facilitating communication and enabling socialisation was highlighted.

*'...playgrounds...It is too far for us to go there. Kids need to communicate with each other...'*

Playgrounds would provide an environment conducive to social inclusion and integration.

*'...if we had a playground here, we would meet more often...'*

All participants had young families. Thirty-three percent expressed their frustration at the inaccessibility of educational facilities in the area.

*'...playgrounds, more community crèches and community playschools. Only one in B....and in B..... Twenty on waiting list. Can only take twenty four children...'*

Sixteen percent suggested that playgrounds could be made more interesting. More organised activities such as workshops would draw children together and help create exchanges.

#### **5.6.4 Services**

Sixty-seven percent of participants said that they found the quality of health care poorer here. Perceptions were varied and based on cultural familiarity and experience of services. Some difficulties included accessing a good GP and waiting times at hospitals. Some participants felt they had no control over the medicine they were prescribed.

*'...in Russia, we actually know that stuff is for what, here I don't know nothing...in Russia, we did not need antibiotics, we just go ourselves, we buy it ourselves...here, I go first to the GP, explain the situation, I don't know English, I need translator, you know, other problems that brings...'*

It was also perceived that good quality of care was expensive.

*'...free medical health here is not very good...but good medical health is very expensive...you have to pay to get good medical health...'*

Fifty percent felt that child minding and after school facilities could be improved. Sixty-seven percent felt they would find it difficult to cope without such facilities.

*'...more facilities for children. There are no places to leave them sometimes for a while. Next year, I'll start full time education. School is until 2.30pm so what will I do with the children? After school childcare facilities and childminding services that you can trust...'*

Most participants found information services to be inadequate particularly in terms of future opportunities for employment, qualifications and access to university courses. It was suggested that better information and advice on available courses and accreditation for degrees obtained in the country of origin would help refugees to integrate better.

*'...I need to study again...maybe to help new direction...help people integrate...'*

One participant perceived that a lack of transparency on how the Irish social welfare system operates can confuse and upset people.

*'...social welfare: we had some problems before. They cut off our payment. People should be informed in advance before they make decisions. Things like that put you in distress. You don't know what's happening. It feels as they are trying to discourage you to study...'*

Sixteen percent with children felt that transport facilities could be improved in estates situated on the outskirts of the city.

*'...bus services are not good. They are on the hour. Every thirty minutes would be ok. There are no buses on Sundays.'*

## **5.7 Perceptions of health**

### **5.7.1 Physical health**

Most rated their health as average to good. The majority were young people aged 26 to 32. One participant was middle-aged and suffered from arthritis and high blood pressure.

### **5.7.2 Mental health**

All participants felt comfortable and safe to raise their families in this country. They described they enjoyed not being threatened any more.

*'...I am happy, I don't have afraid about my life, I am happy about quiet...'*

*'...people. The atmosphere...the feeling in our country. We couldn't feel safe but here we do...'*

Refugee status had given them peace of mind and hope for the future.



*'...we see prospects here. We still have a choice to have a normal life...'*

While some participants were still dealing with past traumas, they were looking forward to a brighter future in this country for themselves and their children.

*'...I am happy enough. At the moment, I am full of positive things. You don't want to think about the past. We're trying to build our new life in this country.'*

### **5.7.3 Coping mechanisms**

Participants felt that they were getting psychological support from immediate family, friends and their religion.

Thirty-three percent said that they had control over their lives and were optimistic about the future.

*'...I would like to get a good education and a good job, that's my main target. I don't want to depend on social payment and I want to be responsible for myself and my family. People think that we are lazy and that we want to get the payment and do nothing. We want to show that this is not true...'*

*'...if I need something, I open the yellow pages and I find things I need...'*



## **CHAPTER 6**

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### **DISCUSSION**

#### **6.1 Introduction**

The research findings have identified key factors in relation to the mental health needs of asylum seekers and refugees and those who held residency status. Throughout the discussion, comparisons between both population groups were made to highlight the needs specific and relevant to them.

#### **6.2 Background to exile**

It was difficult to ascertain, through the country of origin of participants, the nature of events that had triggered and then led to the journey into exile. The findings reflected, in all cases, complex circumstances where asylum seekers had been victims of persecution. The demographics showed a heterogeneous population with cultural traditions and religions and therefore a complex background. Ethnicity and discrimination seemed to work hand in hand in undemocratic countries where political turmoil and corruption ruled. Through the interview discussions, it became clear that participants had left their countries against their will. Those who had experienced imprisonment and torture had arrived in Ireland in a very poor state of physical and mental health. All had left family and friends to escape the threat to their lives. While they felt reassured about their safety in Ireland, both asylum seekers and refugees were still dealing with past experiences that had been extremely traumatic. All participants had experienced the loss of a whole way of life that included community life and strong support networks. Emotional stress coupled with fear and anxiety had threatened good psychological health.

The level of persecution, fear and anxiety when arriving in Ireland calls for real support far beyond food and shelter. This highlights the need to address the mental health needs of asylum seekers when entering the country. Services will have to take into account the circumstances in which they came to this country. This will require a fuller understanding of culture and beliefs, and tailoring of services to make

sure that delivery of care is appropriate and sensitive when addressing mental health issues.

These findings were in line with other research findings that suggest that Post Traumatic Stress Disorder is a very common occurrence in the asylum seeker and refugee population (Woodhead, 2000).

### **6.3 Adapting to a new way of life**

It was clear from the findings that the structures in place for the reception of asylum seekers in this country discouraged independent living. Perceptions and experiences of living in direct provision accommodation were generally negative. The restrictions associated with rules and regulations such as idleness, deprivation and lack of freedom of movement, made adapting very difficult. Those who had just arrived in Ireland were attempting to familiarise themselves with their new surroundings, including the weather and the language. Those who were long term residents had started to fear for their lives again in case their application for refugee status would not be granted. Institutionalised life did not create opportunities for acquiring knowledge of Irish culture and the political and social structures. Overall, asylum seekers felt they were living on the margins of a society that had given them shelter but that prevented them from engaging with it at any level. Rules and regulations need to be reviewed to enable residents to enjoy a more independent lifestyle.

Refugees on the other hand were enjoying the freedom and the peace of mind that they had been looking forward to. However, for half the participants, language barriers made adapting and integrating a struggle. Existing language facilities must be improved to ensure capacity to deliver courses that are adequate in frequency and quality.

### **6.4 Social integration**

The structures in place for the reception of asylum seekers and refugees in Ireland reflect government policies. It was quite clear that once an asylum seeker was granted the status of refugee, legal entitlements and lifestyle were greatly improved to enhance quality of life and overall well-being.

#### **6.4.1 Employment**

When asylum seekers were asked how they felt about their lives now, the majority said that they had not integrated into Irish society because they had no opportunities to do so. The majority held a professional qualification or a trade and they were in gainful employment before they left their country. This has been found to be the case in other studies (Foley Nolan et al, 2002, Cave et al, 2003). They would have liked to be able to use their expertise. They felt that the right to work would enable them to integrate and to live a normal life. The most important benefits associated with employment cited were dignity, pride in their own skills and capacity, fulfilment, financial independence, freedom of expression, participation in and contribution to the host society. Males in particular were distressed by the absence of a meaningful activity in their lives. They missed the challenges and the rewards of going out to work. Males are generally an under-served group (HSE, 2006). Health studies on asylum seekers and refugees have not focused on them as a specific group.

Some female participants were also in employment or previously had a business or a trade back home. Those who had left their children behind were distressed and anxious. They would have liked to have activities provided that would keep their minds occupied. Most participants felt that policies that denied employment to human beings were inappropriate. What's more, they felt that those policies did not serve the country's best interests as people's skills and knowledge could be put to good use for the benefit of the whole community.

Voluntary work was an option that many considered and took part in. However, for those who had been involved in voluntary work for some time, lack of financial reward undermined their goodwill. Some felt that the small allowance they received was restrictive. Although the question of 'spending power' did not arise during the interviews, some participants mentioned that they felt limited in their choices and that, over time, this led to frustration and stress.

It was suggested by some participants that those who demonstrated a willingness to be good citizens of this country could be granted the right to work. This could particularly apply to asylum seekers who had been residents in hostels for a long time. Previous studies have highlighted this issue (Foley Nolan et al, 2002).

Employment opportunities among the refugee population interviewed were limited as language difficulties put them at a disadvantage. As

highlighted earlier, learning the language is a priority on arrival in this country. Services should be adequate in frequency and quality. However, the majority felt they had some control and decision making power over their employment prospects. Some felt excluded from the rest of society as they perceived structures were lacking that would provide employment opportunities for the refugee community. The significance of providing training and education in improving and learning new skills while in direct provision should be stressed. Refugees who are now part of the potential work force in this country may not have the requirements and the skills to suit a job description because they were kept idle for a number of years waiting for their application to be processed.

It was interesting to note that none of the participants expected to receive additional financial support from the government. They wished to be independent earners, not to be a burden on the Irish state. They were grateful for the support they had received since their arrival.

#### ***6.4.2 Lifestyle***

Accommodation and board were predetermined by direct provision regulations. Living conditions in the hostels were difficult due to a lack of privacy, overcrowding in rooms, and limited facilities within the centres for meeting people and for entertainment. Conflicts and tensions between residents were common, arising from cultural differences and the inability to contain feelings of anger, frustration and emotional pain. Similar findings were found in various studies (Woodhead, 2000, Foley Nolan et al, 2002, Cave et al, 2003, Galvin, 2004). Internal regulations in the centres seemed to restrict even further an already regimented lifestyle. It was argued that open communication and understanding between management and residents could help to promote a more flexible and pleasant living environment. This would suggest a need to establish links between management and residents by calling regular meetings to voice concerns, using a partnership approach.

The structure of the day revolved around meals which were served at set times. The question of food raised many negative feelings. The findings showed a general dissatisfaction with quality, variety and preparation. While the hostels attempted to cater for different ethnic tastes, the consensus was that the food always tasted the same. Men and women alike missed preparing their own food. Some got the opportunity to do so when visiting friends in private accommodation. Cooking and eating are simple, pleasurable activities for everyone. We need to try and find a way to let people cook for themselves within the

centres. A feasibility study should be undertaken by the Environmental Health Department in collaboration with the managers of direct provision centres to establish whether supervised cooking opportunities can be created, ensuring that food safety requirements are satisfied.

Refugees said that they felt free to lead a normal life. The majority were kept busy with their young families and were enjoying this.

There were few opportunities to engage in meaningful activities within the hostels during the day to pass the time or to relieve boredom. Imposed idleness created anxiety, stress and isolation which lead most residents to spend too much time in their rooms in bed. They felt they had too much time to think. This shows the need for some form of employment and training. Some of the daily activities included reading, watching television, visiting friends within the centres and around the city and attending the local library. Some female participants perceived that hostel regulations on travelling prevented them from spending time away from the hostel, which increased isolation. However, asylum seekers are allowed to spend time away from the hostel if they notify the manager of the hostel. Authorities feel that leaving a bed idle in a hostel is a waste of state funds and that this practice should be kept to a minimum. There may be a way to agree on a more flexible approach to travel that would enable asylum seekers to visit family members and friends in other parts of the country.

All of those involved in physical activities enjoyed them and would have liked to sustain them. Interviews showed that both asylum seekers and refugees found the weather to be a deterrent to outdoor activities during the winter. The playground was a favourite place for all families with children. However, parents felt restricted by weather conditions when the playgrounds were located too far away from their homes. Sport and exercise were also very much restricted to the summer season. Sport was found useful in combating stress and promoting relaxation among males and females. Most were aware of the positive effects this had on their mood. There is a need to offer a broader choice of activities that everyone can enjoy both within and outside the hostels, all year round. Facilities for children indoors and outdoors should be improved. There are numerous leisure centres within the Galway region that asylum seekers and refugees could be accessing if they had the money. We need to find a way to provide some activities. Consideration could be given to negotiate special rates with leisure facilities to reduce the cost of membership. Some

facilities offer such rates for people over 55 when members use the facilities at a certain time of day. Such a system could be put in place for all age groups.

Access to and participation in sporting activities should be promoted and encouraged to provide an antidote to a sedentary lifestyle and to enhance both physical and mental health. There is plenty of research evidence on the benefits of regular, moderate physical activity (Cave et al, 2003, Kelleher et al, 2003, Department of Health and Children, 2000).

#### ***6.4.3 Education and training***

The majority of asylum seekers felt that if employment was not an option, education and training should be made available. The findings suggested dissatisfaction with the frequency and the quality of English classes among 50% of both the asylum seeker and the refugee population. The importance of language in the ability to lead a normal life was stressed. Many still experienced difficulties in dealing with everyday situations and felt isolated. Some refugees felt that after more than two years in Ireland, they regretted not being able to communicate fully in English. This prevented them from accessing services with confidence and getting to know the culture so that they could integrate. Availability and access to classes could be improved particularly for those who had no English at all. It was suggested that volunteers or mentors could spend time with residents daily to inform them on the social and political structures in place in this country. This would provide total immersion in the English language (Dutch Council for Refugees, 2005). Consideration could be given to setting up transition year students as mentors. This could be a two-way learning process where students, asylum seekers and refugees could familiarise themselves with different cultures and backgrounds. A mentoring programme should be developed by the Department of Education and Science for transition year students and could be piloted in schools within Galway City. The flexibility of the transition year programme could enable transition year students, with the support of the school management, to engage in such worthwhile activities. The system of peer-educators has also proven to be a positive channel in the promotion of physical and mental well-being in disadvantaged communities and minority groups (Johnson et al, 1995, Department of Health and Children, 2002, Access Ireland, 2004). This idea could also be encouraged within hostels where long-term residents could become mentors or tutors for newcomers.



Asylum seekers do not have access to third-level education. However, some suggested that vocational training could be offered. Learning new skills or updating existing skills would be a valuable activity to alleviate stress and boredom and to give a sense of accomplishment. The development of a register of skills would enable residents to participate in activities within or outside the centres and would create opportunities to utilise their abilities. Settings in the community could include hospitals, clinics and schools. Training could be delivered through workshops or as work experience in companies and institutions around the city. There might be opportunities to offer training courses within training centres similar to those that the Health Service Executive currently offers to users of mental health services in Galway City. The refugee population has the right to access third level institutions. While some were already taking courses, others were anxious to obtain accreditation for qualifications they had gained in their country of origin. They expressed the need to access services where they could get information on the validity of their qualifications.

## **6.5 Social inclusion**

### ***6.5.1 Social networks***

Asylum seekers felt that opportunities to meet the Irish community were limited due to living circumstances that were not conducive to participating in social activities. The findings revealed negative experiences associated with feelings of being forgotten, dumped, marginalised, and excluded from the host society. Regulations in the hostels limited freedom of movement and freedom of access to facilities frequented by Irish people. The local church and choir were regular venues which gave them the opportunity to meet Irish people and the wider community. Some had experienced discrimination but the general perception was that Irish people were good people. However messages conveyed through the media and policies on the reception of asylum seekers in Ireland seemed to have reinforced feelings of xenophobia and racism. It would be essential, in an effort to encourage inclusion, to disseminate factual information, increase knowledge and promote communication between different population groups within the communities. Promoting access to settings such as playgrounds, playgroups, community centres, crèches and schools could provide a suitable environment to open communication channels. Support groups already in place around Galway City are providing social support structures for many. Any attempt to improve further communication and support must involve linking and working in partnership with existing organisations and institutions.

Refugees who were now living in the community still felt that opportunities to meet Irish people were limited because everyone was busy. However, they felt welcome in the community. Language barriers were still reducing opportunities for inclusion. It is essential to ensure that all age groups and their specific needs be taken into account when planning activities and interventions.

Social networks among both asylum seekers and refugees were well developed. These networks provided friendship and psychological support in a caring environment where trust and understanding prevailed. For both communities, language, culture and past experiences united them. Support groups around the city provided information and advice which was a lifeline for those with poor English skills. It is therefore essential that these groups are funded adequately to sustain the level of support that they have provided so far.

Asylum seekers who had family and friends residing in other parts of Ireland could not visit them for long periods of time since regulations on travel prevented them from doing so. This was highlighted previously in this study. Consideration could be given to increasing the frequency of travel and to extending the length of visits so that contact with family members is maintained.

#### ***6.5.2 Environment***

Living conditions, as discussed earlier, were determined by direct provision accommodation. The findings suggested that psychological rather than physical well-being was affected in that instance. Living conditions therefore met basic human physical needs but not necessarily mental health needs.

Some difficulties were experienced in relation to transport and the scarcity of indoor and outdoor facilities. One of the hostels was located in the centre of town which meant that transport costs were cut down and the vicinity of shops and services was a positive factor. For other asylum seekers living on the outskirts, the frequency of buses on certain routes did not seem adequate during the weekend and at night. Weather conditions could make freedom of movement difficult particularly where mothers and children were concerned or when people experienced physical impairment due to a medical condition.

Most refugees reported being satisfied with their surroundings and their neighbourhoods. They felt safe in their homes. However, some

may not have had a garden and the proximity to the road prevented children from playing freely outdoors. Most agreed that they would like to see more playgrounds near where they lived, suggesting that these could be made more interesting for children. Some highlighted the importance of playgrounds for both parents and children to promote and enhance inclusion. An article published in the Irish Times highlighted the important role of playgrounds in the community (Irish Times, 2005). The Planning and Development Act 2000 (Government of Ireland, 2000b) specifies the need to allow 10-15% for the provision of open space or amenities in housing estates. However, this open space does not necessarily have to be a playground. The guidelines on social housing stipulate that play spaces for small children should be provided within one minute's walk of each front door and should be overlooked from the dwellings (Department of the Environment and Local Government, 1999). This would need to be considered by Galway City Council when reviewing future planning applications. Guidelines on the content of a play policy should be adhered to for the provision of play facilities in local authorities' areas and the standards reached as set out in 'A Parks Policy for Local Authorities' (National Children's Office, 2004).

### **6.5.3 Services**

Health care services such as hospital and GP services, home help and maternity services were perceived to be adequate for most participants. Those who were not satisfied suggested that the choice of GP should be a personal matter for both asylum seekers and refugees. However, asylum seekers and refugees have the right to choose their GP once they have been registered on the system for a while. A form is available from the social services to that effect. The participants in this study did not have this information. It is essential to provide asylum seekers and refugees with user friendly information on their entitlements. Language difficulties and lack of knowledge on how the system operates exacerbate isolation and create stress. Other difficulties experienced with the health services ranged from waiting times at clinics, delays between consultations in the event of continuity of care, disorganisation and hygiene concerns at hospitals.

Social services were good in providing guidance for the asylum application but some improvement could be made on the support available for special cases. Some argued that those services were not equally delivered around the country, which led some people to feel excluded or unfairly treated. Expectations were high in some instances in relation to what the social services could deliver

particularly regarding the asylum application. The findings suggested that timely psychological support and information on asylum applications were not provided even when asylum seekers had been waiting for a considerable length of time in direct provision. Lack of available information on the application process led to mistrust of the authorities. Some thought that independent services should be put in place to provide such information. A study carried out in Co. Monaghan made recommendations to develop a comprehensive national and regional information service. It would require a coordinated effort between different sectors and agencies (Guerin, 2001). Also, it was felt that information and the dissemination of newsletters and literature regarding the asylum seeker population was not always forthcoming.

Some hostel residents highlighted the need for advocacy services, interpreter and translating services to welcome newcomers and to assist anyone in adapting to their new life. This could create a link between asylum seekers and the wider community. Access Ireland is currently running a cultural mediation project which aims to facilitate and assist minority ethnic users of health and social services. This service consists of a cultural mediator or a 'bicultural' link worker who assists both service providers and users (Access Ireland, 2004). Similar practices have been successful in the Netherlands, Belgium and Denmark where it was felt that personal contact between the refugee and his 'assistant' was not only beneficial for the individual refugee; the involvement of all the volunteers also helped create a more favourable climate for acceptance of refugees in the country, thus promoting integration (Dutch Council for Refugees, 2005).

Refugees have had the experience of social services while in direct provision and were still dependent, at the time of interview, on social welfare payments. They were satisfied with those services overall. However their needs had changed. Some were now accessing university courses and applying for jobs. The majority felt they would like to see more services in place that would provide information on the types of courses on offer, on accreditation for those who held a primary degree from a foreign university, and on employment opportunities.

Social inclusion requires that services meet the needs of the socially marginalised groups in our society. There is a need to prioritise the delivery of services that meet those needs.

## **6.6 Perceptions of health**

Most asylum seekers perceived their overall health to be poor. Other studies have found that perception of health is poor among minority groups (Foley Nolan et al, 2002). Physical complaints included lack of sleep for many and weight loss but they did not report major illnesses since their arrival in Ireland. Male respondents particularly experienced sleep disturbances and called on their GP for sleeping tablets. They felt inactivity and stress were the main reasons for not sleeping. Others suffered from upset stomachs and headaches. Two female participants had serious medical conditions they were concerned about. However, the majority of respondents were more worried about how they felt mentally. Good health was described in broad terms as including freedom, independence and happiness. The most frequently quoted experiences that had an impact on psychological well-being were past traumas, idleness, lack of control over living conditions, fears for the future and feelings of isolation. While no quantitative scale was used to measure levels of satisfaction with life and health, the findings suggested unhappiness and dissatisfaction with life in general. Although there was no mention of particular psychiatric disorders or use of mental health services, the complexities of cultural perceptions and beliefs made it difficult for the researcher to ascertain whether that was the case or not. This study had a limited remit on this issue.

Most refugees did not mention being affected by serious physical illnesses. Some felt that health care was not as good here as in their country. They also felt that good quality health care was expensive and that they could not afford it. The majority, at the time of interview, had recently received their refugee or residency status. They were very happy with the opportunities that were open to them. They considered themselves safe and led independent lives. However barriers to integration had started to emerge for some as time went on. Difficulties experienced by some included limited employment prospects, language difficulties and social isolation.

### ***6.6.1 Coping mechanisms***

In general asylum seekers and refugees seemed to have fairly good coping mechanisms that enabled them to maintain a basic way of life despite the difficulties. Strong informal social networks that included friends and room mates provided psychological support. However it was difficult to assess the level of distress experienced by some of the participants. Some seemed to have good resilience that helped them to cope with life's adversities. Resilience is a quality that enables

human beings to cope and to remain positive despite difficulties (Antonovsky, 1996).

Asylum seekers and some refugees found comfort in the practice of their religion and in caring for their families. Some found relief from boredom and stress in sport. The practice of sport can help promote social interaction and integration. Physical activities conducive to relaxation and well-being alleviate anxiety and stress. They should be encouraged and sustained all year round.

The findings suggested that refugees with young families were happy to be able to make plans for the future. They felt restricted financially but hoped to improve their situation after completing third-level courses and further training.



## **CHAPTER 7**

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### **CONCLUSIONS AND RECOMMENDATIONS**

#### **7.1 Introduction**

It is generally acknowledged that persons from ethnic minority groups experience a greater level of psychological distress than the general population. Asylum seekers and refugees are a vulnerable group in our society. While research to date in Ireland has focused on the physical health and nutritional needs of asylum seekers, a broad view on health is required that takes into account the major determinants of health.

It was therefore agreed to undertake this study to gain a better understanding of the mental health promotion needs of asylum seekers and refugees residing in direct provision and in private rented accommodation in Galway City. More specifically, the study was intended to explore the perceptions and experiences of both groups, to make comparisons and to identify the factors that have an impact on their overall well-being. The study was qualitative in nature and consisted of demographics and semi-structured face-to-face interviews with participants.

All asylum seekers interviewed came from various African countries. This was a heterogeneous sample. Most were relatively young. Male participants lived alone within the direct provision centre but some had left wives and children in their home countries. Some female participants had young children living with them in the hostel; others had left husbands and children at home.

Most refugees interviewed also had young families and most came from the East. Difficulties in recruiting participants led to accessing individuals who came from different parts of the former Soviet Union.

#### **7.2 Conclusions**

Most asylum seekers held a professional qualification or a trade on arrival in Ireland. However they were denied employment, which was the source of much distress and dissatisfaction in their lives. Men



were particularly affected by idleness and inactivity and the lack of an outlet for their skills, which led to boredom and isolation. The majority felt that unemployment was the biggest barrier to integration in this country.

Refugees, however, experienced freedom and independence after being granted the right to reside in Ireland and said that they were enjoying life despite some difficulties such as isolation and lack of employment opportunities.

Direct provision accommodation was found to be very difficult, particularly for those who had been long-term residents. Lack of privacy and independent lifestyle were the main factors identified as having an impact on mental well-being. All said that they were very dissatisfied with the questions of food choice, meal variety and lack of catering facilities. Concerns were raised about the delay in processing asylum applications and the considerable amount of stress this created.

Leisure activities were limited to the hostels where facilities were poor. Outdoor activities were restricted to the summer months because of the bad winter weather.

Refugees were dissatisfied with a lack of amenities close to their place of residence. Crèches and schools were not within walking distance and waiting lists were usually long. The need for trustworthy child minding facilities was highlighted.

Generally, asylum seekers would have liked to be able to access education and training during their stay in direct provision. They were dissatisfied with the availability of courses and classes, particularly English classes. Fifty percent had poor language skills. Poor English skills created barriers to employment opportunities and integration for some refugees who were still attempting to learn the language.

Overall, asylum seekers and refugees did not feel integrated in this country, either because there were few opportunities to meet Irish people or because of language barriers. Some felt discriminated against. However, social networks were strong within various ethnic communities and in the hostels and were reported to provide good psychological support and trusting relationships.

Health services were perceived to be good in general. Social services were perceived positively. However, some participants felt that they

did not trust the authorities to deliver an equitable service. There were gaps in the dissemination of information and the need for the creation of more independent services was highlighted. A lack of knowledge and understanding of how the services operate created more stress. Some argued that the availability of mentors, interpreters and translators would alleviate the stress caused by language difficulties.

Limited transport facilities increased feelings of isolation for those living on the outskirts of the city.

To conclude, asylum seekers perceived their mental health to be poor overall. They experienced high levels of stress and anxiety linked to their social and legal status in Ireland. There were few opportunities to relieve the stress and boredom associated with living in direct provision accommodation.

Refugees' positive experiences were linked to their recent status in Ireland which enabled them to access educational services and to enjoy a more independent lifestyle. However, they still reported not feeling totally integrated in this country.

### **7.3 Recommendations**

This study has provided some useful insights into the lives of asylum seekers residing in direct provision accommodation and refugees living in private accommodation in Galway City. The issues raised in this study prompted the following recommendations:

1. The mental health needs of asylum seekers should be assessed when they enter Ireland. This should take account of their circumstances on arrival and will require an in depth understanding of cultures and beliefs.
2. Appropriate and timely psychological support should be made available for asylum seekers on arrival in Ireland.
3. Policies within direct provision centres should be reviewed with a view to promoting a more independent lifestyle, building capacity among residents and reducing institutionalisation. This

should include an assessment of the need to create training and employment opportunities.

4. Access to language resources should be improved. Targets to reduce waiting lists for courses should be set and reviewed on an ongoing basis.
5. Intersectional programmes to involve the Department of Health and Children, the Department of the Environment, Heritage and Local Government, the Department of Education and Science, the Department of Community, Rural and Gaeltacht Affairs should be promoted in partnership with existing support groups for the integration of asylum seekers and refugees.
6. Consideration should be given to enabling transition year students to act as mentors to asylum seekers and refugees in developing links with the Irish community and culture.
7. Training and education should be provided to enable asylum seekers to learn new skills or to maintain and/or upgrade existing skills while in direct provision accommodation.
8. A peer-volunteer system within the hostel should be created whereby long-term residents would provide support in relation to information about services and entitlements, translation of documents and interpretation.
9. Client-focused independent services should be set up to give impartial advice to asylum seekers about the asylum process.
10. Information on available services in the community, entitlements and job opportunities should be disseminated in a culturally sensitive and appropriate manner.
11. Newsletters and newspapers that are relevant to asylum seekers lives should be made available at direct provision centres.
12. Communication between managers of direct provision centres and residents needs to be improved. The possibility of organising regular meetings to act as a forum where concerns can be voiced should be explored.

13. A feasibility study should be undertaken by the Environmental Health Department (Galway) in collaboration with the managers of direct provision centres in Galway to establish whether supervised cooking opportunities can be created, ensuring that food safety requirements are satisfied.
14. Consideration should be given to changing travel regulations for asylum seekers to facilitate visits to family and friends residing in other parts of Ireland.
15. When reviewing future planning applications for developing new housing estates, Galway City Council should give consideration to the provision of playground facilities.
16. Access to sporting facilities should be improved. There is a need to negotiate with the managers of various leisure centres around the city in order to set special rates for asylum seekers and refugees.

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# **APPENDIX 1**

## INTERVIEW SCHEDULE

Interview No. (for office use)	
Date & Time	
Location	

### Introduction

You are very welcome here today. My name is Régine Stewart and I am conducting this study which consists of a questionnaire. It covers a number of topics requesting information on issues related to your health and well-being. The purpose of the questionnaire is to hear about your views and your experiences as an asylum seeker or refugee in Ireland. This will help us identify what needs to be done to improve the services we provide.

### Confidentiality

I would like to assure you that the information you provide today will be dealt with in the strictest confidence. Under no circumstances will your name be used in connection with anything you tell me.

### Consent for taping

I would like to ask for your consent to record this interview to ensure that I have a complete transcript of what you say. You may wish to access the transcript at a later stage. In this case, please let me know. I would like to reassure you that no one but me will have access to this transcript and your name will not be mentioned in any report connected to this research.

## Section 1 Demographics

**Q.1** Gender

Male	
Female	

**Q.2** Age

.....

**Q.3** What is your marital status?

Single	
Married	
Separated	
Divorced	
Widowed	

**Q.4** What is your legal status?

Asylum Seeker	
Refugee	
Residency	

**Q.5** Where do you live?

Direct Provision	
Private   Rented Accommodation	
Other, specify	

**Q.6** What is your country of birth?

.....

**Q.7** How long have you been living in Galway City?

Years	
Months	

**Q.8** How many people sleep in the same room?

.....

**Q.9** Are those sharing the accommodation with you from the same country?

Yes	
No	

Please specify .....

**Q.10** How many children under 5 live in the household?

State the number .....

**Q.11** Do they attend playschool?

Yes	
No	

**Q.12** How many people aged between 5 and 16 where you live?

State the number.....

**Q.13** Are they attending school?

Yes	
No	

**Q.14** What language do you mainly speak at home?

State one.....

**Q.15** Do you speak English?

Yes	
No	

**Q.16** Have you attended or are you attending classes for speaking English?

Yes	
No	

## **Section 2**

### **2.1 Life prior to arrival in Ireland**

Where were you before coming to Ireland?

What was your occupation?

How did you make the decision to come to Ireland?

Did you come here with the rest of the family?

How do you feel about living here now?

What are the main differences between home and here?  
How difficult is it to adapt to a new culture?

## **2.2 Life as an asylum-seeker/refugee in Ireland**

### ***Socio-environmental context***

Can you describe the area where you live?  
What do you like about living here?  
What do you not like about living here?  
Can you talk about meeting new people at the centre/around here?  
How many people do you know?  
How often do you meet them?  
Where do you go to meet them?  
What makes you feel part of the community?

### ***Sense of control/ independence***

What is it like to share accommodation with other people?  
What is your daily routine?  
Did you do anything different yesterday?  
What plans have you made for tomorrow or the rest of the week?  
Have you taken up any hobbies/activities since you came here?  
What are the things you like to do in your free time?  
Do you get the opportunity to do the things you like to do?  
How do you stay physically active?  
What types of facilities are available around here? Probe if necessary  
How often do you use them?  
How easy do you feel it is to decide what to do for the day?

## **2.3 Personal needs**

What are your main concerns/worries at the moment?  
How do you cope with these difficulties?  
What could help you manage stress better?  
Who can you turn/talk to if you need help?  
How is your health overall?  
What does 'good health' mean to you?  
What puts you in bad form?  
What could improve how you feel?

## **2.4 Access to services**

What types of services do you know in Galway City? Probe if necessary: Health & social services, clinic, playground  
How easy is it to access them?  
Where do you go when you need help?  
How do you find the services?  
What other services would you like to see in Galway City?

## **2.5 Potential areas for improvement**

What things would you like to change and why?  
What changes could help make life better for you and your family here?  
How would these changes make a difference to your life here?

I thank you for your time and your contribution to this research. The results will be very useful. If you have any questions at this time or if you have any concern about what we talked about, please let me know. I would like to reassure you that the information you have given me today is strictly confidential. You may wish to read the transcript at a later stage. In this case you can leave your details with me.

## **Probes for use during the interview**

1. The silent probe
2. The 'Go on, I'm listening' probe
3. Looking for more meaningful information with 'Who? What? When?
4. Why?'
5. The immediate elaboration probe
6. 'Can you tell me more about that?'
7. 'What happened after that?'
8. 'What do you think/feel about that?'
9. 'Why do you think that is?'
10. The retrospective probe
11. 'Can I take you back to something you said earlier? You said: '..... .' Could I ask you a bit more about that?