Translocations: Migration and Social Change

An Inter-Disciplinary Open Access E-Journal

ISSN Number: **2009-0420**

The views and experiences of members of new communities in Ireland: perspectives on mental health and well-being.

Richard Lakeman and Anne Matthews

School of Nursing, Dublin City University, Glasnevin, Dublin 9, Ireland

e-mails: richard.lakeman@dcu.ie; anne.matthews@dcu.ie

Abstract

Ireland has a long history of outward migration but in recent years Ireland has become a destination of choice for migrants from the rest of the world. This has posed a challenge to Irish institutions and Irish society. This paper reports on the findings from a community development project undertaken in partnership between Cairde (a non government resource and advocacy organisation for ethnic minority groups) and Dublin City University. Members of new community groups in Dublin who were affiliated with Cairde took part in focus groups exploring their perceptions regarding mental health, mental ill-health and their experiences of mental health care provision. Participants focused more on their everyday experiences affecting their health and well-being rather than presenting their difficulties from within an illness paradigm. Whilst most participants had experience of accessing health services they had little contact with specialist mental health services. So while the study was designed to focus on conceptions of mental health/ill-health and services, the findings highlight structural inequalities that some migrants face in relation to legal status, accessing educational, occupational opportunities, and social service eligibility; all aspects of their everyday lives that cause them distress and fear.

Key words: mental health and well-being; migrants' perceptions; qualitative focus group research

---

Introduction

In a little over a decade there has been a transformation of Irish society from a relatively homogeneous monoculture, with a population which was 95 percent white and Roman Catholic to a significantly more heterogeneous, multicultural society in which non-native born people made up nearly 11 percent of the population (Central Statistics Office., 2006). People from 188 different countries were living in the State at the time of the census in 2006. Of the 420,000 non-Irish people residing here on census day in April 2006, the largest group were UK nationals, who numbered 112,000. Ireland's historical demographic profile has been one of near continuous population decline and outward migration since the 1840s. From the 1960s the population grew rapidly with large scale inward migration (of both returning Irish nationals and others) and from the 1990s Ireland enjoyed high economic growth and a rapidly expanding labour market. The numbers of people claiming asylum in Ireland also grew from a handful in the early 1990s to over 10000 per year until 2003, drawn largely from Nigeria, the Democratic Republic of Congo, Algeria and more latterly, Romania (Mac Einri & White, 2008).

In Ireland there has been a growing interest and literature concerning psychological aspects of migration particularly to do with refugees and asylum seekers (Ryan, Benson, & Dooley, 2008; Ryan, Dooley, & Benson, 2008). Ryan, Dooley, and Benson (2008, p.16) point out that the human stories and voices of people (refugees) themselves are largely absent from the literature of psychology generally and in Ireland that have only been a handful of community based surveys (Mac Einri & White, 2008) to inform the development of health and welfare services.

This project sought to explore the meaning and determinants of mental health in new communities in Ireland from the perspectives of migrants themselves. Cairde, a non-government community development and advocacy organisation in Ireland working to reduce health inequalities amongst ethnic minorities was a partner in this project. The overall intent of this study was not only to undertake a needs assessment relating to the mental health needs of communities but to build the capacity of communities and community groups to commission, undertake, analyse and report on research of interest and concern to them. Cairde set up an Ethnic Minority Health Forum in 2002 comprised of some 35 groups, with an aim to make a positive impact on the health and wellbeing of ethnic minority communities. At a forum meeting it was agreed that mental health was a shared concern and priority and this research was designed to meet that need. This paper reports on a qualitative analysis of migrants' perceptions on mental health and well-being.

Previous research on the mental health and well-being of migrants has highlighted the need to understand the diversity of experiences of migrants, based on the personal story of the person but also of their experiences of social integration in the country in which they now live. As Murphy (1977) has noted the mental health of migrant groups is determined not only by the psychology of individuals but by factors associated with their country of origin, the migration experience and the country of destination. Understanding these factors is necessary to understanding the adjustment experience of any group. For example, Blomstedt, Johansson and Sundquist (2007) found that the country of birth had a profound influence on self-reported mental health in a Swedish cross-sectional national survey, with Polish and Eastern European immigrants having twice the likelihood of reporting psychiatric illness compared to a Swedish born reference group and some other immigrant groups. Bhugra (2004) proposed that personal and group factors contribute to resilience and vulnerability which can interact to produce psychological distress and the exacerbation of mental ill-health at different stages in the migration process (pre-migration, migration, post-migration and acculturation).

Whilst, the notion that immigrants in general are at greater risk of mental health problems is now disputed or at least seen as a simplification (Silove, 2004), pre-migratory and migratory traumatic experiences do predispose refugees and asylum seekers to post traumatic stress responses and mood disorders. The constellation of depressive, anxious, somatoform and dissociative symptoms seen in many immigrants has been coined the 'Ulysses syndrome' (Carta et al., 2005). This syndrome develops over time in response to multiple stressors, losses or obstacles faced during the migration process, including the individual's reception in the host country. Those who choose to migrate for higher education or economic betterment will face different stressors to those who are forced to flee their homeland as political exiles or refugees.

The relationship between migration, mental health, mental disorder and aspects of social integration is complex. For example, Munk et al. (1997) undertook a large community survey of residents in Oslo (a traditionally low inward migration and mono-cultural city). Not surprisingly they found that immigrants from non-western countries tended to have higher levels of psychological distress than immigrants from other western (and presumably culturally similar) countries. Data derived from the same study was used to examine the differences in psychological distress and a range of psychosocial indices between Pakistani immigrants and Norwegian nationals (Syed et al., 2006). They found that when poor social support and low economic status were controlled for (together) the difference in distress between groups was eliminated. They concluded that social support and economic conditions are important mediators of mental health. These data tend to support a view that social and economic wellbeing and cultural identity are inextricably linked to perceptions of mental health. The collaborative study on the topic of the mental health of migrants aimed to add to this research, based on the stated concerns of the groups affiliated with Cairde for research in this area.

Methods

A qualitative design was chosen as the appropriate way to explore this topic. Focus groups were chosen as the method of data collection for this study. Focus groups are a qualitative research method that is an alternative to individual interviews. The focus group method enables participants to comment, explain, disagree, and share attitudes and experiences (Curtis & Redmond, 2007). Focus groups are concerned with the interactions between members as well as what they say and were deemed particularly useful for exploration of complex social phenomena (Powell & Single, 1996).

Expedited approval was obtained from Dublin City University Human Ethics Committee to undertake this as a low risk project. Ten community leaders from Cairde's Ethnic Minority Forum took part in focus group facilitation training and subsequently facilitated the recruitment and conduct of focus groups exploring mental health in their communities. Focus group questions were developed collaboratively between the community leaders during a training day (See Table 1). Leaders provided verbal explanations regarding the purpose of the focus groups to potential participants, and obtained verbal consent for participants to contribute. Copies of the questions to be discussed in the focus groups were provided to potential participants in their first language and they who were given considerable time (days in most instances) to consider whether or not they wished to be involved.

Participants

Seventy five individuals (44 females and 31 males) took part in ten focus groups carried out over several months in the first half of 2008. Each community leader conducting a focus group recruited members of their own community, as defined by them, for each focus group.

Recruitment was conducted by focus group leaders through their existing social networks, that is, through their involvement with groups who otherwise met together for other purposes e.g. community advocacy, worship, cultural celebration or social activity. Some of the members of these various social and religious groups were invited by the focus group leader to become involved in the present study and those interested then participated in a research focus group. The immigration status of members varied within and between groups. Some members were asylum seekers, or recognised refugees, whilst others had full citizenship or were on working visas. Details of country of origin, languages spoke, gender composition, and religion of participants is outlined in table 2.

Data analysis

The aim of the analysis was to provide a comprehensive and parsimonious representation and rich description of the perceptions and viewpoints of focus group participants. Transcripts were made of the audio recordings of all focus groups and these were imported into the software package QSR N-Vivo (version 9) to facilitate what Miles and Huberman (1994) describe as data reduction, or the process of selecting, focusing, simplifying, abstracting and transforming the data. Three project members reviewed all data using the focus group questions as starting points. Then each sentence of each transcript was allocated one or more codes or labels which best represented the perception, opinion, assertion or expression. When a sufficient number of codes were generated and a unifying concept appeared to emerge, elected codes were aggregated under that concept. Thus a tree like structure grew with the central concept (or top level category) being the question or concept (e.g. components of good mental health) from which various branches emerged (e.g. Having good relationships, occupation etc) which in turn were populated by exemplars and connected back to the transcribed text. The analysts also read the transcripts and coded data with a view to discerning differences within and between groups. The authors of this report read and reviewed coded parts of the transcript independently and met to discuss differences of opinion (these were few and readily resolved through discussion). Finally the narrative account that follows was written ensuring that all content elements were included and higher level categories were illustrated with verbatim examples from the transcribed text.

Results

Components of "good mental health"

Focus group participants discussed the meaning of good mental health. Indicators of positive mental health included positive emotions such as feeling happy, relaxed, and contented, and having positive or optimistic thoughts about the future.

> *When you have a hope that tomorrow day is good, not waiting for bad things to happen, when you are not waiting – just living* (a participant from the 'Slavianka' Russian speaking women's focus group).

Whilst there was an acknowledgement of mental health encompassing rationality, the capacity for judgment and 'normal functioning' of the brain, the emphasis of all focus groups was on extra-psychic factors. The most dominant themes (that is discussed with the most intensity and mentioned most frequently) related to mental health were having security and good relationships with others.

Security had different connotations depending on the phase of migration process of individuals but was considered by all as being an essential component of mental health. Asylum seekers identified insecurity over their immigration status and the constant threat of deportation as being inconsistent with positive health and indeed described negative impacts on mental health. Some participants who had experienced pre-migratory trauma stated that good mental health was not being exposed to war or ongoing violence. More generally good mental health was associated by almost all migrants with having sufficient and secure resources to meet basic needs and being able to build and maintain a home.

> *When I have the necessities in life, like shelter, food, water. To be able to go outside and feel safe, having a home* (a participant from the West African Network, women's focus group).

Having good relationships with friends, family and the wider community were cited as important. This included being able to communicate, being respected by others, being around understanding people and particularly being with family. Being able to provide for ones' family, enjoying leisure activities together and establishing the routines and rhythms of everyday life were construed as important for personal mental health.

Mental health and happiness were tied to having opportunities to work, to learn and to help others. Some cited recognition by others (e.g. employers and professional regulatory bodies) of skills, qualifications and experience as pivotal to realising these opportunities. This was particularly so for those on working visas who felt under-employed. Others had spent time in the State's direct provision accommodation centres. These are places where people are accommodated whilst waiting for their applications for refugee status to be processed (which in some instances can take years). These participants stressed the importance of being able to direct one's own life e.g.

> *(Mental health is…) when you can change you situation, when you are depending on yourself, not on decisions of others* (a participant from the Somali community focus group)

Others spoke of engaging in satisfying activities such as art and creativity and worship and how this helped people feel connected to the wider community.

> *…The church gave me some advice and guidance, I feel more integrated now as a part of the church.* (a participant from the West African men's focus group)

Conceptions of mental ill-health

Some groups (e.g. participants from the Romanian women's focus group) stated that mental ill-health was the opposite of mental health and did not elaborate much further. In some focus groups participants made reference to other people who manifested extremes of distress or unusual behaviour that they considered 'crazy' or ill. However, in the brief discussion of mental ill-health held in each focus group emphasis was on the less extreme, everyday manifestations of distress and psychosocial ill-health, particularly as related to the experiences of migration to Ireland. Anxiety, having interrupted sleep, problems with thought form and content (e.g. obsessions or ruminations), and intrusive recollections of traumatic events were all considered manifestations of ill-health.

> *I think that anxiety is the best defining concept. That constant fear… that you are not*

> *going to get home safe, that you are taking a flight and you are afraid, that tomorrow you will be out of the job, that you won't find any work. You know how it is in Ireland, you work for 7 days and then next week there's no work. And this fear that you may be out of the job, and then the landlord comes and kicks you out of the house.* (a participant from the Romanian community women's focus group)

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

> *(I feel distressed)…when I call home and talk to my other children who are not here. When I have to tell them that I can't bring them here.* (a participant from the 'Slavianka' Russian speaking women's focus group).

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

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

The most important things affecting mental health

Participants were directly asked about the most important things affecting mental health. They responded in relation to their overall well-being and how this was negatively affected by immigration policies and status. Fitting in with Irish society was also a related factor identified by participants. Throughout their discussions, participants vividly described the effects of these various factors in emotive and expressive terms. They described feelings of frustration, worry, feeling "not together", incompleteness, anger, wanting to scream, sadness, isolation, unhappiness, anxiety, stress, disappointment, disempowerment, depression, rejection and worthlessness.

> *It is hard to deal with disappointment and crushing of your dreams and aspirations on psychological level. I feel sometimes that you have made wrong decisions in your life and lives of other people in your family* (a participant from the Russian speaking men's focus group).

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

… being treated differently, not like a human being. This causes hurt, anger, upset. 'I was treated badly at Dublin Airport, I was asked questions for over an hour although I had passport and everything was ok. (a participant from the West African Network – women's focus group)

Participants made reference to dealing with officials in accommodation or immigration and provided accounts of not being believed, treated well or given adequate explanations. Some of the participants within African groups described their perceptions that officials and health professionals did not acknowledge or accept their distress, because they appeared stoic.

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

> … *Talking to Department of Justice about my citizenship is very frustrating. I have been here for a long time, applied for naturalization and now waiting – again. Half of your life spent in waiting for responses from justice* (a participant from the Algerian community focus group).

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

> *I have no job, no nothing, the asylum process makes me unhappy because it prevents me from living normal life like other people* (a participant from the Eritrean community focus group)

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

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

Others stated that they were unhappy at being perceived as wanting benefits when they did not have any opportunity to work. Those who could work expressed their frustration at getting jobs that did not fit their qualifications. Work was described as a means to financial security but also providing a routine and structure as well as fulfilling family roles, for both men and women.

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

> …*Because if you are poor and you don't have any work, you've got no money; and if you've got no money, you cannot take care of your family, you don't have anything to eat, you become anaemic, and then your brain no longer functions properly* (a participant from the Romanian community, men's focus group)

Access to affordable and secure private rental accommodation was cited as problem for others who were undertaking low paid jobs.

The importance of integration and acceptance by Irish people was highlighted. Those in direct provision felt particularly isolated and apart from other people. Experiencing racism also affected the extent to which people felt part of a wider community:

> *You feel like an outsider, discrimination gives you a lack of confidence. Once you have a negative experience, you don't have any hope that you can be a part of the society* (a participant from the West African Network – men's focus group)

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

> *I also frequently have headaches, because I think about home and family - that's hard. You always have this feeling that you are not together, not complete if you worry about your family (when they are not here but somewhere else)* (a participant from the Algerian community focus group)

Participants who suffered in their own countries because of their religion or who had been imprisoned also described suffering further trauma within this isolating environment. Some participants described gambling and alcohol as ways of coping with isolation whilst acknowledging that gambling made the financial situation worse for them. Using alcohol was identified as a way of alleviating distress but to the detriment of mental health.

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

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

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

Discrimination

Discrimination and racism was explored and discussed in depth within all groups (space constraints preclude more than a cursory overview in this paper). Group members varied in their perceptions of the extent of the problem and Europeans on working visas recounted different experiences to asylum seekers and non-European people.

> *We are immigrants, foreigners and new to here – what would you expect? In any country people are very wary of newcomers… That's why they give us low jobs – who else will do them for that money?* (a participant from the Russian speaking men's focus group)

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

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

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

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

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

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

Some participants recounted stories of people not being interviewed or employed because of their names and when employed being treated differently to other workers. Others spoke of racist taunts or being 'set up' by other employees. One woman who attempted to start her own business confronted more overt racism:

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

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

Participants also recounted examples of racism and abuse as they went about their day to day business. Some participants had been taunted by strangers on the street e.g. 'Go back to your own country' or 'monkey show me your tail'. Others reported having doors slammed in their face or people ignoring greetings or spitting at them. Participants also described overtly racist behaviour from officials such as police and general practitioners which was particularly distressing

> *Another time, someone called me a "Paki" and told me to "go back to your country". It was a police sergeant. Because I did not have identification with me, I was arrested,*

> *but I've done nothing wrong. I have been living in Ireland for 12 years, I have fluent English – I have citizenship here and I don't have to carry an identification…They let me go…I go to sleep every night and it stands in front of my eyes.* (a participant from the Algerian community focus group)

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

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

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

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

> *…these insults reach deep inside your soul. Injustice is always frustrating and infuriating* (a participant from the Romanian community women's focus group)

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

> *The way professionals are treated is bad, skills are not recognized. Your gifts and your talents die, your interest dies down. Then you become frustrated and depressed.* (a participant from the West African Network men's focus group)

Other participants described feeling angry…

> *…the aggressiveness grows in you and the psychological stability is affected. You snap out much quicker. You tend to take revenge on others because of what is happening to you, because you think it's only fair that you 'pay back in the same currency'* (a participant from the Romanian community, men's focus group).

However, more usually participants reported feeling hopeless, despairing or suicidal…

> *I had a lot of negative experiences in this country, which brought a lot of anger in me… My family broke down and I only see my children occasionally. I am a young man but have very little hope that anything will be ever good for me here.* (a participant from the Algerian community focus group)

How to improve mental health in new communities

Participants identified a range of structural things that could be changed to improve their experiences of living in Ireland broadly. These included policy changes to secure access to essential services, increasing information about services, and enhancing integration so that they felt they belonged within Irish society.

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

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

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

> *…when you do not have an opportunity to work. I feel disgusted with myself but I can't do anything. It is impossible to survive, to expensive to go to work. I can't even afford to go study – all the same problem – childcare.* (a participant from the Russian speaking women's focus group)

Participants' spoke about access to education in terms of their children's basic education and, also, adults' continuing education:

> *…give the chance for our children to go to school. Give our kids the right to go to school no matter what religion or immigration status they are. Also to give us the chance to study, to work to be like everyone else. We are not different than anyone.* (a participant from the Congo Lisanga focus group)

Being in work and particularly having an adequately paid job was linked to overall wellbeing and happiness by many participants, and demoralization when unable to find work.

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

> *I think that information is the key. And prevention is important. There should be something done before it is too late as like with people who are suicidal. I think that's why there are so many suicides in Ireland – because unless they save you half way through… nobody cares if you are showing symptoms of depression, no health professional will, on their own accord, do something about it. My partner had a depression… GP prescribed Prozac - that was it* (a participant from the Russian speaking men's focus group)

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

> *For ethnic minority communities more skills related to health needed. How to organize around health, having health information about services… We need training courses on how we can change health of our communities, how we can organize ourselves.* (a participant from the Algerian community focus group)

Information about services generally was seen to need improvement:

> *Yes, and to give information to immigrants how to go about the services… I don't know what to do if I feel not together or stressed… I drink and forget about every thing* (a participant from the Russian speaking men's focus group)

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

> *If things – information, leaflets and forms - were in different languages, like in England they are more diverse than Irish society – it would be easier to cope. Also if interpreters were available when going places or accessing services….* (a participant from the Somali community focus group)

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

> *Some feel let down by the conditions they are living in, a lot of people have talents and want to contribute but they are let down by the system or community* (a participant from the Eritrean community focus group).

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

> *We do not get an opportunity to mix with other people, to understand people. We just locked up in direct provision centres and it is expensive for us even to come to the city centre*. (a participant from the Somali community focus group)

There was a need identified for places to meet and interact, and this could include churches, social places, offices and internet access (to assist with employment seeking in particular) as well as a need to talk within communities and with Irish people. This was seen as a way of strengthening communities through developing trust, solidarity, identity and enhanced integration.

Racism and discrimination were seen as obstacles to integration. The need to shift the way ethnic minority groups are perceived by Irish people, the media and officials was also identified.

> *The mentality of how Irish people see us. They think we sleep in the trees or in jungle. In the shops they follow us even if we are getting something for only 5 cent. They think*

we are animals. They have to take this out of their mind (a participant from the Congo Lisanga focus group)

Discussion

This research was descriptive, and a-theoretical rather than conceptual or theoretically grounded. The chosen method did not enable the researchers to return to participants and explore or develop concepts further and this is acknowledged as a weakness of this study. At best these findings might be described as 'displays of perspective' which are negotiated and developed between members (Reed & Payton, 1997). They also present the voices of participants, which has typically been absent from research on migrant mental health and thus presenting these findings may be considered a form of restorative epistemic justice (Fricker, 2007). The composition of the focus groups were fairly heterogenous, representing people at different stages of migration and with quite different pre-migratory experiences. There may have been benefits from focusing on understanding the experiences of particular sub-groups such as asylum seekers or just those with experience of the direct provision system.

Interestingly, despite differences in group composition within and between focus groups there were considerable similarities in the concerns and perspectives of participants. For example in all groups the effects of perceived racism, particularly in interactions with official agencies was vividly described and considered noxious to mental health. Reported experience of racism and institutional discrimination has been found to be related to poor physical and mental health (Karlsen & Nazroo, 2002). A public health approach to addressing the mental health status of minority groups or communities must address personal and institutional racism. Considerations of ethnicity, race and culture need to be central to mental health care provision (Sewell, 2009) if migrants are to engage with mental health services (something that participants were extremely reluctant to do). An emphasis on 'cultural safety' (Papps & Ramsden, 1996) in the education, supervision and regulation of health professionals may provide a means to tackle institutional racism and directly promote positive mental health in the health and welfare sector.

Uncertainty and insecurity were also ubiquitous experiences that were particularly apparent and challenging for those awaiting adjudication of their immigration status in direct provision centres but also for others in relation to having insecure employment and housing tenure. This uncertainty is a source of stress which taxes and challenges people's capacities to cope. Respondents in this research largely described emotion focused efforts to cope. In relation to dealing with the uncertainty of this phase of the migratory experience this may well be the most productive way to cope as there is little that individuals can do to solve the problem. For some the waiting took a considerable toll and some people described losing their sense of personal agency and assuming a hopeless/helpless orientation.

The long term effect on mental health of waiting for immigrations status to be clarified and the associated problems of powerlessness, poverty, prevention from realizing educational and occupational goals and living with the threat of possible deportation has not been explored in great depth in research. Ryan, Benson, and Dooley (2008) undertook a longitudinal study examining levels and predictors of distress amongst a community sample of people seeking asylum in Ireland and found that the only people to show a decrease in distress at 12-24 months follow-up were those who had obtained a secure legal status in that time (e.g. being granted residency or refugee status).

In this study whilst medical or psychological conceptions of mental health were acknowledged by respondents, access to resources (be they social, family, material etc) were more dominant themes and were spoken of as both determinants and indicators of mental health. This is consistent with Ryan, Dooley, and Benson's (2008) theoretical assertions that constraints on the use of or access to resources is a major structural factor associated with post-migration adaptation and well-being. They argue (p.15) that "Negative psychological outcomes are likely to arise when the host environment places constraints on or depletes the migrant's existing resources, while offering few opportunities for resource gain". This was most obvious for people in direct provision who were unable to work, pursue education or pursue goals. However for others who had resolved their immigration status concern about fitting in, accessing work, school, housing and educational resources remained salient. Whilst those who participated in these focus groups may not be 'representative' of migrants generally it was clear that poverty, particularly relative to Irish nationals was perceived as a contributor to poor mental health

An additional branch of this study (not reported here) examined people's experiences with accessing health services. There was a very low level of awareness of and access to formal mental health services of any kind and indeed a suspiciousness of services generally. Of those who accessed psychological support or counselling this was generally highly valued. There was a profound need for access to specialist trauma counselling for some people as well as need for low level/non-specialist psychological support and care, primarily preventative services, particularly delivered in an outreach capacity.

The participants in this study specifically identified what changes could improve their general experiences of living in Ireland. These include structural changes such as facilitating access to education, housing and employment (all fundamentally linked to speedy resolution of immigration and legal status), increased information about health services in general and other social services; and increased opportunities for integration, independence and a chance to contribute to society and be understood and respected.

The data for this study were collected in the first half of 2008. Since then, the global recession and in particular the quite dramatic Irish economic downturn makes achieving such changes unlikely. While migration to Ireland will likely decrease under current conditions, those who have made their lives in Ireland (like those in this study) will face increasing difficulties in this environment. These conditions may also increase the racism reported in this study, at both the social and institutional levels, with a general social sense of discontent. The perceptions and experiences clearly expressed in this research make uncomfortable reading and without structural and attitudinal change, the lives of those who spoke through this research are unlikely to improve.

Acknowledgements

Cairde, participants and focus group leaders who made this work possible. Professor Ronaldo Munck, Muriel Redmond, Tonya Sanders and Jim Walsh who collaborated on analysing the data.

References

Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica, 109*(4), 243-258.

Blomstedt, Y., Johansson, S.-E., & Sundquist, J. (2007). Mental health of immigrants from the former Soviet Bloc: a future problem for primary health care in the enlarged European Union? A cross-sectional study. *BMC Public Health, 7*(1), 27.

Carta, M. G., Bernal, M., Hardoy, M. C., Haro-Abad, J. M., & group., R. o. t. M. H. i. E. w. (2005). Migration and mental health in Europe (the state of the mental health in Europe working group: appendix 1). *Clinical Practice and Epidemiology in Mental Health, 1*(13), 14.

Central Statistics Office. (2006). *Census 2006: Volume 4 - Usual Residence, Migration, Birthplaces and Nationalities*. Dublin, Ireland: Stationary Office.

Council of Europe. (2002). *7th Conference of Ministers Responsible for Migration Affairs*. Helsinki.

Curtis, E., & Redmond, R. (2007). Focus groups in nursing research. *Nurse Researcher, 14*(2), 25-37.

Fricker, M. (2007). *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford: Oxford University Press.

Karlsen, S., & Nazroo, J. Y. (2002). Relation between racial discrimination, social class, and health among ethnic minority groups. *American Journal of Public Health, 92*(4), 624-631.

Mac Einri, P., & White, A. (2008). Immigration into the Republic of Ireland: a bibliography of recent research. *Irish Geography, 41*(2), 151 - 179.

Mathers, C. D., Vos, E. T., Stevenson, C. E., & Begg, S. J. (2001). The burden of disease and injury in Australia. *Bulletin of the World Health Organization, 79*(11), 1076-1084.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

Munk Jorgensen, P., Fink, P., Brevik, J. I., Dalgard, O. S., Engberg, M., Hansson, L., et al. (1997). Psychiatric morbidity in primary public health care: a multicentre investigation. Part II. Hidden morbidity and choice of treatment. *Acta psychiatrica Scandinavica, 95*(1), 6-12.

Murphy, H. B. (1977). Migration, culture and mental health. *Psychological Medicine, 7*(4), 677-684.

Papps, E., & Ramsden, I. (1996). Cultural Safety in Nursing: the New Zealand Experience. *Int J Qual Health Care, 8*(5), 491-497.

Powell, R. A., & Single, H. M. (1996). Focus Groups. *Int J Qual Health Care, 8*(5), 499-504.

Reed, J., & Payton, V. R. (1997). Focus groups: issues of analysis and interpretation. *Journal of Advanced Nursing, 26*, 765-771.

Ryan, D., Benson, C., & Dooley, B. (2008). Psychological distress and the asylum process: A longitudinal study of forced migrants in Ireland. *The Journal of Nervous and Mental Disease, 196*(1), 1-9.

Ryan, D., Dooley, B., & Benson, C. (2008). Theoretical perspectives on post-migration adaptation and psychological well-being among refugees: Towards a resource-based model. *Journal of Refugee Studies, 21*(1), 1-18.

Sewell, H. (2009). *Working with ethnicity, race and culture in mental health*. London: Jessica Kingsley Publishers.

Silove, D. (2004). Mental health problems in migrants and refuges. *Australian Doctor, July 16*, 31-38.

Syed, H. R., Dalgard, O. S., Dalen, I., Claussen, B., Hussain, A., Selmer, R., et al. (2006). Psychosocial factors and distress: a comparison between ethnic Norwegians and ethnic Pakistanis in Oslo, Norway. *BMC Public Health, 6*, 182.

United Nations. (2002). *Number of world's migrants reaches 175 million mark*. New York: Press Release (POP/844).

Table 1: Focus Group Discussion Guide

Introductory questions:	What is “good mental health”? What is “poor or bad mental health”?
1	What do you think are the most important things affecting a person’s mental health here in Ireland? How do you feel (your community) people are treated in Ireland?
2	If you could change anything to improve mental health in your community, what would it be?
3	Do you think discrimination and prejudice affects a person’s mental health and wellbeing? PROBES: How does it do this? Can you give any examples?
4	Think of the last time you had contact with a doctor, health worker or social worker… How did you feel about your experience?
5	If you feel anxious, stressed or unhappy what do you do? PROBE: Would you ever look for help from Irish health or social worker when you feel like this?
6	Any other comments or questions?

Table 2: Focus group composition

Group Name	Country of origin	Language	Religion
Congo Lisanga	Congo	French, Lingala	Christian
Algerian Community of Ireland	Algeria	Arabic/French	Islam
Russian Speaking Women ‘Slavianka’	Ukraine, Estonia, Russia, Estonia, Latvian, Belarus, Moldova	Russian / Ukrainian /Latvian/ Belarusian/ Moldovan	Russian Orthodox:4 N/A: 4
Russian Speaking Men	Moldova, Ukraine, Latvia, Lithuania, Russia	Moldovan, Russian, Ukrainian, Latvian, Lithuanian	Orthodox: 2 N/A: 4
WANET (West African Network)	Angola/Ghana	Portuguese, Twi	Christian
WANET (West African Network)	Morocco, Algeria, Sudan, Syria, Mauritius, Egypt, Saudi Arabia,	Arabic, Creole, Indonesian, Persian, Turkish	Islam

	Indonesia, Iran, Algeria, Turkey		
Eritrean Community	Eritrea, Iraq, Sudan	Arabic	Islam
Somali Community	Somalia	Somali, Swahili, Arabic	Islam
Romanian Community	Romania	Romanian	Orthodox
Romanian Community	Romania	Romanian	Orthodox