LET’S TALK
Mental Health Experiences of Migrant Women
AkiDwA is an ethnic, minority-led, national network of migrant women living in Ireland. The organisation advocates for migrant women’s equal rights in Irish society, free of gender and racial stereotyping. Since March 2018, AkiDwA has been providing informal group sessions using a psychosocial approach, known as Let’s Talk, for migrant and refugee women. In order to inform this work, funding was received from HSE National Office for Social Inclusion to conduct research into the mental health needs of migrant women in Ireland, and their experiences accessing services. The research project was launched with a view to piloting a series of informal psychosocial support sessions in a culturally sensitive manner.

The study adopted a qualitative approach using focus groups and in-depth interviews with 40 migrant women in five locations around Ireland from July to September 2019. In addition, consultations were conducted with key informants, representing professionals from NGOs and statutory services. These data were analysed using coding categorisation and theme formation techniques with the assistance of software coding instruments.

The findings reveal that migrant women experienced significant stressors that have serious implications for their mental health and psychological well-being. The study shows that the women were affected by traumatic experiences in their country of origin or during their journey to Ireland, however at the time of the interview, current stressors, especially for the asylum seekers played a more significant role in determining their mental health. The migrant women’s personal distress was experienced on a daily basis and was inseparable from social, political, and institutional processes and determinants i.e. social suffering. Findings show that the women’s lives were characterised by stressors related to: (1) practical challenges faced daily as asylum seekers and refugees, (2) powerlessness and lack of agency and (3) grief and loss.

The study identified the key barriers to accessing mental health services including: cultural beliefs about mental health involving notions of stigma and shame, language barriers and lack of information and inadequate service provision.

There is no doubt that migrant women in this study encountered a multitude of traumatic and stressful experiences in their lives prior to migration, during the migration journey, and particularly in their post-migration lives. These experiences and situations place them in a position of risk, where their well-being and mental health is threatened by the adversities they encounter. Yet, despite their life difficulties and social suffering, the participants showed remarkable resilience and tried to exert agency in many aspects of their lives. In general, for migrant women in this study the resilience factors that enabled them cope with traumatic experiences and current stressors include: (1) hope – looking to promise of the future, (2) religion – belief system, (3) family support and connections to culture of origin and (4) exercising agency and integrating into Irish society.

Despite the traumatic and stressful events that may precipitate and accompany a migrant woman’s pursuit for refuge, mental health problems are not an inevitable consequence of their experience. Instead, a migrant’s well-being is shaped by a complex interplay between stress and resilience factors. The most important social factors are potentially modifiable and therefore of particular interest to groups who seek to improve migrant women’s well-being, including health professionals, public health, and voluntary sector and policy makers. The recommendations of the research emanated from the changes identified by the participants and were also informed by the literature. These included structural changes, access and support from mental health services, enhancing collaboration among services and promoting integration.

The migrant women also made a number of suggestions to AkiDwA regarding its services to support the mental health of migrant women. These ideas plus the findings of the research study informed the piloting of group and art therapy sessions for migrant women. This phase of the project involved the facilitation of over 20 sessions in four locations, throughout Ireland from October to November 2019. Eighty-seven migrant women participated in the sessions. The approach of the sessions was a short-term group approach for supporting resilience and not an in-depth treatment model for trauma. The combination of psychosocial support and art allowed participants to begin to get a sense of not only who they were and what they had lived through, but potentially who they could become.

ACKNOWLEDGEMENTS

AkiDwA is indebted to the 40 migrant women – refugees and asylum seekers who contributed to the six focus group discussions and individual interviews from July – September 2019. AkiDwA would also like to thank the service providers from NGOs and statutory organisations who agreed to act as key informants and contributed their perspectives.

Our gratitude also goes to Mandisa and Deborah who helped access the migrant women for the project and assisted in organising the ‘Let’s Talk’ sessions.

We are particularly grateful to Aisling Hearns (Spirasi), Anita Daly (Syrian Resettlement Support Worker), Julie Scully (Integration Support Worker, Laois Partnership), Natalya Pestova (Mayo Intercultural Action) and Dr. Hester O’Connor (Principal Psychology Manager, HSE) for their professional input and support for the project.
The number of people forcibly displaced worldwide because of persecution, conflict, generalised violence or human rights violations has increased dramatically in the last 5 years. The UNHCR estimates that there are currently (July 2019) 70.8 million forced migrants around the world. Women and girls represent half of this population. The country data for Ireland shows that, in 2018, there were 6,041 refugees, 7,196 asylum seekers and 99 stateless people, giving a total of 13,336 forced migrants living in Ireland (UNCHR, 2019: 66).

Many migrant women living in Ireland have fled from extreme violence and persecution in their home country. Upon resettlement, they have to deal with the loss of family, support networks, gender-based violence, loss of personal livelihood and sometimes poverty and unemployment. The mental health of migrant women is therefore compounded by complex factors, which make them vulnerable to mental health conditions, including post-traumatic stress disorder (PTSD), depression, and anxiety.

Against this background, since March 2018, AkiDwA has been providing informal group talk therapy using a psychosocial approach, known as Let’s Talk, to support migrant women. In order to advance this work and to implement the strategic plan 2019-2021, AkiDwA received funding from HSE National Office for Social Inclusion, to conduct a research project on the mental health of migrant women in Ireland. The aim of this research was to explore the mental health experiences of a sample of migrant women in Ireland, with a view to piloting a series of informal psychosocial support sessions in a culturally sensitive manner.

The key objectives of the project were to:

1. Explore migrant and refugee women’s lived experiences of wellness and mental health issues from a personal and social perspective
2. Explore migrant and refugee women’s access to mental health services and support
3. Identify the barriers which prevent migrant women from seeking support and engaging with appropriate mental health services and agencies
4. Pilot informal psychosocial sessions for migrant, in a culturally sensitive manner to support their mental health needs
The study employs the World Health Organisation explanation of mental health as: a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community (WHO, 2003:7).

Important in this definition is the positive connection of mental health to individual agency (to realise potential), resilience (withstanding stress) and social bonds (community). While the definition of mental health is premised on agency, resilience and social bonds, mental health is an essential precondition for these three components (Schefl, 2008). Furthermore, the International Covenant on Economic, Social and Cultural Rights (1966), recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

For AkiDwA, the term ‘Migrant Women’ includes not only recent immigrants, asylum seekers and refugees, but also migrant workers, students, trafficked and undocumented women. It also includes those who have acquired Irish citizenship but who still consider themselves to be outside the mainstream society in terms of their linguistic, racial or cultural backgrounds, and who therefore still define themselves as migrants. Participants in this study were women seeking international protection and women under the Refugee Resettlement Programme.

2.2 MIGRANT WOMEN AND MENTAL HEALTH

Gender is acknowledged as a key determinant of health, and migrant women are a particularly vulnerable cohort (Campbell, 2018; Delara, 2016; HSE, 2018; WHO, 2018). Female refugees and asylum seekers are especially at risk of experiencing trauma, depression, anxiety, loss and grief (Jarallah and Baxter, 2019; Lindqvist, 2018). It is widely accepted that women are at a greater risk of experiencing physical abuse and sexual violence. Sexual violence includes such acts as rape, sexual slavery, forced pregnancy, forced abortion and forced sterilisation (Delara, 2016). Such violence also brings the risk of contracting sexually transmitted diseases and other health problems. Gender-related trauma may also stem from culturally sanctioned practices such as female genital mutilation (AkiDwA, 2019).

There is ample evidence to show that risk factors for developing mental disorders are encountered by migrants before, during and after migration. Giacco (2019) in a systemic review of the research identified five critical points on the migration trajectory for the mental health of refugees and asylum seekers. These time points are: (a) before travel; (b) during travel; (c) initial settlement in the host country; (d) integration in the host country; (e) challenges to or revocation of the immigration status. A summary of the risk and protective factors at all of these time points can be found in Figure 3 below which shows that female gender is a key risk factor.

Figure 2. Critical time points for the mental health of asylum seekers and refugees and risk protective factors at play

Source: Giacco, 2019.
In addition, many women who have faced forced migration are mothers. Not only is it likely women in these families have encountered profound and multiple traumas, it is likely their children have too (Perez-Aronsson et al., 2019). Migrant mothers, thus, have a double burden: dealing with their own mental health problems, knowing all too well that their children may be affected, and trying to support their children in adaptation. Delara (2016) in her research concluded that migrant women experience disadvantaged social positions in a new society due to gender roles, racism, socioeconomic status, and victimisation. Migrant women may also face many difficulties in accessing the social and health care system due to cultural, structural, economic, social and psychological barriers.

2.3 IRISH CONTEXT

Applications for International Protection

As of the end November 2019, the Irish Government received 4,487 applications for International Protection for the year to date. This total represents a 34% increase on the same period last year. However, as Figure 3 illustrates this number is minor compared to the numbers of applicants in previous decades. In 2002 applicants peaked at 11,634, the highest level on record before rates continued to decline – with a 92 per cent reduction between then and 2013, in the depths of the economic depression.

Figure 3.
Number of applications for international protection 1994-2019


Asylum Seekers in Ireland

Responsibility for international protection applicants (asylum seekers) is under the remit of the Department of Justice and Equality while their claim for protection is being examined. Accommodation and full board is provided in Direct Provision (DP) centres, which are dispersed around Ireland in former hotels, hostels, and schools. As of June 30th 2019, there were 7,018 occupants in DP including 6,082 in accommodation centres and 936 in emergency accommodation. This figure is forecast to increase to approximately 7,700 for the full year 2019. It is estimated that 58% of residents in Direct Provision are male and 42% are female (IPO, 2019).

International protection applicants in accommodation centres are entitled to mainstream health services. This includes GP medical care, mental health services and children’s health. Children are entitled to mainstream primary and secondary education. Limited third level education supports are in place. Once in accommodation, international protection applicants are entitled to a small payment each week. As of March 2019, each adult receives €38.80 per week while each child receives €29.80 per week.

The Direct Provision system has been subject to a number of reviews and much criticism since its inception. The evidence suggests that the system has a detrimental impact, on multiple levels including mental health, on those who have sought protection from the Irish state (AkiDwA, 2010, 2012; Crumlish and Bracken, 2011; Moran et al., 2019; Ryan et al., 2008). The most significant government review, the McMahon Report (2015) makes specific recommendations to improve asylum seekers’ access to health and other support services. It highlights a key concern about the negative impact of the Direct Provision system on the physical, emotional and mental health of residents, and on the wellbeing and development of children. The report also draws particular attention to the negative effect living in Direct Provision has on ‘vulnerable persons, including victims of torture, rape, FGM, trafficking and other forms of psychological, physical or sexual violence’ (McMahon, 2015: 10).

While there have been a number of changes made to the DP system, particularly since Ireland opted into the EU (recast) Reception Conditions Directive in 2018, many problems remain. The current concerns are well documented (AkiDwA, 2010, 2012; Crumlish and Bracken, 2011; Irish Government, 2019; IRC, 2013; Lentin, 2016; McMahon, 2015; Moran et al., 2019; Ni Raghallaigh et al. 2016; O’Reilly, 2018) but to summarise them briefly:

i. Long processing times leading to lengthy and indefinite delays
ii. Inappropriate and substandard accommodation and social spaces particularly for families
iii. Lack of appropriate services and supports including mental health and childcare
iv. Limited opportunities for employment and education
v. Lack of integration with local communities

The current system relies on short-term contracts with private providers who tend to have little background or expertise in human rights or social care, leaving them frequently unable to meet the complex needs of the people they are accommodating. They also cannot be expected to fulfil what is a public law obligation on the State to support the human rights of people seeking protection in Ireland.

Programme Refugees in Ireland

The Irish Refugee Protection Programme (IRPP) was established in 2015 when the Government committed to accepting up to 4,000 people, as Ireland’s response to the humanitarian crisis in Syria. Refugee resettlement under the auspices of the UNHCR involves the selection and transfer of refugees from a State in which they have sought protection to a third State that has agreed to admit them – as refugees – with permanent residence status. The programme substantially increased the number of refugees resettled in Ireland. By December 2019 there were 3,151, mainly Syrian, refugees accepted under IRPP from the refugee centres in Jordan, Lebanon and Greece (IPO, 2019). The majority (86%) of these refugees have been settled in communities dispersed throughout the State.

The model for resettlement of refugees being used by the IRPP1 has three broad phases:

i. Overseas selection missions in collaboration with the UNHCR.
ii. Placement of refugees in Emergency Response and Orientation Centres (EROCs) for the purposes of acclimatisation and orientation for up to one year.
iii. Settlement in communities in local authority areas, coordinated by an inter-agency working group chaired by the relevant local authority, with refugees supported by an “implementing partner” i.e. NGO procured by the local authority.

The funding for the “implementing partner” is provided by the IRPP and the Asylum, Migration and Integration Fund (AMIF), both under the auspices of Department of Justice and Equality. Local Authorities play a critical role in ensuring the success of each resettlement through outsourcing a resettlement project to a suitable ‘implementing partner’ i.e. NGO with expertise in community integration and relevant supports.

The NGO provides a dedicated early integration support programme for the refugees. This consists of eighteen months support for integration, language learning, gaining access to social services and employment. The NGOs employ Resettlement Support and Intercultural Support workers on short – term (18 month) contracts to deliver the programme. These professionals in conjunction with County Councils and other local agencies provide invaluable assistance to the resettlement and integration of refugee families in local communities throughout Ireland.

The implementation of the resettlement programme requires a high level of coordination among service delivery agencies at both national and local level. Service provision is mainstreamed and all the main statutory service providers such as Government departments, the HSE, Tusla and Local Authorities are represented on the national Taskforce which oversees delivery of the programme. The programme is co-ordinated overall by the IRPP but service provision remains the responsibility of the relevant statutory entity.
3. RESEARCH STUDY

The aim of this research project was to explore the mental health experiences of migrant women in Ireland, with a view to piloting a series of informal psychosocial support and art therapy sessions in a culturally sensitive manner. The key objectives of the project were to:

1. Explore migrant and refugee women’s lived experiences of wellness and mental health issues from a personal and social perspective
2. Explore migrant and refugee women’s access to mental health services and support
3. Identify the barriers which prevent migrant women from seeking support and what can be done to encourage engagement with appropriate mental health services and agencies
4. Pilot informal psycho-social support sessions for migrant women in a culturally sensitive manner to support their mental health needs

The project consisted of the following stages:

- A qualitative study of migrant women was conducted from July – Sept 2019. The study was designed to explore migrant women’s experiences of mental health and well-being, identify sources of help, barriers to accessing services and what kind of support AkiDwA could offer in this area. The researcher conducted focus group discussions and individual interviews with 40 participants from five locations. The results of this study form the main part of this report.
- Consultations with key informants, professionals from NGOs and statutory services, were conducted in order to explore migrant women’s access of mental health services, as well as the existing issues and barriers.
- Piloted group and art therapy sessions for migrant women. This phase included the delivery of over 20 sessions in a culturally sensitive manner to support their mental health needs. 87 migrant women participated in four locations, throughout Ireland from Oct – Nov 2019.

3.1 METHODOLOGY

Due to the exploratory nature of the research, a qualitative study design was employed. The design is appropriate when the researcher wants to understand the life world and lived experiences of participants (Creswell, 2017). This methodology enables researchers to build ‘a migrant centred perspective’ where the diverse narratives recounted by participants are organised to tell their collective story directly. Specifically for this study, focus groups and individual interviews were both used as they are considered the most suitable method of data collection when investigating sensitive topics with refugee populations (De Haene et al., 2017).

During the focus groups and the individual interviews, the researcher followed a loose thematic topic guide to ensure that the discussion was exploratory, fluid and not restricted to a predetermined agenda. This allowed the research to remain structured and focused, but also intuitive in enabling issues to be raised of significance to the study that might not previously have been included.

3.2 ETHICAL CONSIDERATIONS

The EU ethical guidelines for research on refugees, asylum seekers and migrants were adhered to in order to ensure ethical practice was followed (E.C. 2018). The ethical principles of; respect for persons and ethnicity, beneficence, transparency and informed consent were observed in line with these ethical principles. Prior to the interview, participants received information about the purpose of the study and the research method verbally and through information sheets. The participants were also informed about their right to withdraw their consent without consequences at any time and that confidentiality would be maintained.

3.3 INTERVIEW PROCESS

In total five focus groups and four in-depth interviews were conducted with migrant women drawn from a range of communities represented in Waterford; Ballyhaunis, Co Mayo; Mallow; Cork City and Carlow. The interviews were conducted from 24th July to 20th August 2019 in the six locations throughout the country as summarised in Table 1 below.

<table>
<thead>
<tr>
<th>TABLE 1 INTERVIEWS</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus Group Mallow</td>
<td>24th July</td>
</tr>
<tr>
<td>Focus Group Waterford</td>
<td>31st July</td>
</tr>
<tr>
<td>Individual Waterford</td>
<td>31st July</td>
</tr>
<tr>
<td>Focus Group Ballyhaunis, Co Mayo</td>
<td>6th August</td>
</tr>
<tr>
<td>Individual Interview Ballyhaunis</td>
<td>6th August</td>
</tr>
<tr>
<td>Focus Group Carlow</td>
<td>12th August</td>
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<tr>
<td>Focus Group Cork</td>
<td>13th August</td>
</tr>
<tr>
<td>Individual Interviews Mallow</td>
<td>20th August</td>
</tr>
</tbody>
</table>

In four locations, a gatekeeper was identified, via AkiDwA contacts, who recruited a group of migrant women from the local Direct Provision Centre. In the fifth location, the researcher contacted a gatekeeper for the Syrian resettlement project. The researcher met with the gatekeepers in advance in four sites in order to provide information on the project and an invitation for the prospective interviewees. An interpreter was involved in one site in order to include the voices of Syrian women, as they did not speak English.

3.4 ANALYSIS

All interviews were transcribed verbatim, except for names, countries and locations, which were substituted with functional codes to ensure confidentiality. These transcripts were imported into NVivo, qualitative data analysis software, in order to enhance consistency of the coding process and to facilitate thematic analysis. The data was thus analysed according to the themes questioned and any others which emerged during the interview process. The experiences of the women were then compared across all interviews systematically, looking, inter alia, for any commonalities, remarkable differences and recurring patterns. From this process the overarching themes were identified (Creswell, 2018).
3.5 PARTICIPANTS OF THE QUALITATIVE STUDY

The participants of the qualitative study consisted of 40 women aged between 19 and 55 years as shown in Figure 4.

The majority of participants were Asylum Seekers (international protection applicants), seven were under the Refugee Resettlement Programme and four had obtained Leave to Remain i.e. residency status (see Figure 5).

The length of time that participants lived in Ireland varied between 9 months and 18 years. Eighteen participants were from East and West Africa, while eight were from Albania and eight from Syria as represented in Figure 6.

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The participants in this study provided a rich description of how their lived experiences of being refugees and asylum seekers impaired their mental health. The main mental health issues identified were more frequently associated with post-migration stressors than with pre-migration or migration experiences. The migrants reported experiencing distress on a personal level daily when they described, how they missed their families, and how they felt depressed or anxious as a result of leaving their home countries and their way of life in migrating to Ireland. Yet, this personal distress was inseparable from social, political, and institutional processes and determinants which Kleinman et al. (1997) labelled as social suffering. Social suffering is recognised as the product of the political, social, and cultural contexts (Bjertrup et al. 2018).

The refugees spoke of how uncertainty, life disruption, loss of family, social networks and cultural supports caused deep distress and contributed negatively to their wellbeing. The asylum seekers explained how their uncertain legal status, living in a powerless life situation, enduring fear of deportation, affected their mental health. They described feelings, emotions, and states such as anxiety, stress, sadness, loneliness, depression, worrying, fear, insomnia and, in a few extreme cases, suicidal thoughts.

MIGRATION JOURNEY

The migration journey has been described in the literature as involving three major sets of transitions: pre-migration, migration and post-migration resettlement (Kirmayer et al. 2011; Giacco, 2019). Each phase is associated with specific risks and exposures. The pre-migration period often involves war, violence, fear and disruptions to life. During migration, migrants can face uncertainty, hazardous journeys, and extended periods in refugee camps with poor resources and harsh conditions. These experiences can provoke or aggravate distress, fear, depression and other mental health problems. As some of the participants (P) in this study, describe it:

“We still remember, we have these memories about, you know, staying in countries like Greece and also the journey by boat and the suffering we had. All these memories are still, you know, instilled in our memory. We are still remembering all these kind of things we have been through that affected us psychologically because we stayed in tents and it was very hot and the food wasn’t enough. P. 30

The most stressful phase was when – left Syria. Yes, the journey from Syria to – yes I was arrested for some time and had to use the services of these traffickers and use these boats, which very dangerous journey by sea. P. 27

On arrival in a safe country resettlement usually brings hope and optimism, which can have an initially positive effect on well-being.

“You needed protection from whatever you were escaping, you needed it now. So, you come here and you’re so very happy to be here and you’re so very grateful because, I believe that gratitude is the best trait that you could ever have. Then you discover the little unpleasant things in between in your case, in the judicial system, in your living environment. So, it’s a potluck of things, and it’s bitter sweet most of the time. P.14

Disillusionment, demoralisation and depression can occur early as a result of migration associated losses, or later, when initial hopes and expectations are not realised and when migrants and their families face enduring obstacles to resettlement because of structural barriers and inequalities aggravated by exclusionary policies, racism and discrimination (Beiser, 2009).
For the participants in this study the greatest challenge to their mental health was post-migration stressors. In addition to adjusting to new cultural norms and societal expectations once arriving in Ireland, participants discussed a number of aspects of everyday life that may have once been routine in their homeland but became challenges once arriving in Ireland. These stressors included challenges related to language, finances and accommodation. At times, the refugees also linked their distress to past traumatic events experienced in their home countries or during their harrowing journey to Ireland. However, current uncertainty, life disruption, loss of family, community, social networks and livelihood were given prominence as direct causes of distress and mental health difficulties.

The following section will elaborate the key themes that emerged in the study.
The participants indicated that their well-being and mental health were significantly impaired by the practical challenges they faced daily, particularly as asylum seekers, to meet their basic needs, in an institutional setting, with inadequate living conditions and resources.

In this regard, P.4 describes the accumulative effect of these daily stressors:

“It is not only one thing, it is a host of things, a series of things that you have to deal with all at once, and we don’t know how to juggle with this, I don’t. So naturally the end result will be, it taking its toll on your mental state of affairs.”

In particular, for those living in Direct Provision the lack of suitable accommodation for families represented one of the main concerns. Poor living conditions included lack of space, overcrowding, limited facilities for cooking and inadequate communal areas. Participants often expressed feeling “trapped”, controlled, living in an ‘open prison’ with lack of freedom.

“We would often joke amongst ourselves, if you survive Direct Provision you can survive everything and it’s not supposed to be so.”

Sharing living spaces and overcrowding in the bedrooms also highlighted this lack of autonomy over basic and intimate details of everyday life. For instance when talking about her experience of moving from the Reception Centre P. 10 said:

“We left all and moved from our country and when we came in Dublin, I can say that I was happy because these people received us, they put us in Balseskin reception centre. Very nice, I can say that I was happy this time --- But then when we came here and I saw these rooms, we just got two rooms. I have three children, my son is 15, Layla is 8 and Nina was 2 years. I was just crying, I told my husband how we would live here in these two rooms, small rooms. Yes, for me it was most stressful. We lived 6 months trapped in these two rooms.”

The everyday lives of the migrant women in Direct Provision held few activities and consisted of the same routines: cooking in communal spaces, caring for children, and performing household chores. For those living in centres that are located in rural areas, some distance from a town, life was particularly stressful as P. 20 explains:

“I was in Balseskin for two days, lucky me. So, I have got two days then I was taken to----. It was on very outskirt (of town). There was nothing, there was no shops, it was just like, I stayed in a lone place where they put people there. So, if you had to go to the shops you had to travel 30 minutes and there was only one bus. So, my two months was just like, I was so depressed, I couldn’t talk to anyone.”

In addition, living in Direct Provision with many different ethnic groups in confined spaces often precluded making connections with fellow community members.

“I was staying with people from somewhere but not Africa and they were not friendly and they were just like everyone was doing their own business and we had to share the bathroom the 16 of us and mostly women they would just leave the bathroom so dirty.”

Throughout the interviews participants reflected on how their vulnerabilities and experiences impacted on their mental, and to lesser extent, their physical health. Feelings of hopelessness, desperation, lack of self-value and self-esteem were dominant themes during their interviews.

“You have people cooking for you, there’s security everywhere, there’s cameras everywhere and then you have some people that were there before, who were saying if you’re not careful with your kids, they’re going to take your kids away, you know, so a different fear sets in.”
Participants of the study described their daily lives as empty from purpose and full of waiting, thinking, worrying and hoping. The asylum seekers, in particular, who were uncertain about their future in Ireland, reported feelings of constant suspense and even fear. The time of waiting for the results of asylum claims in the Irish asylum system varies considerably, ranging from several months to several years, leading for most to a state of ‘permanent temporariness’ in which waiting and uncertainty become part of everyday life. Most poignant was the feeling of suspense they had to endure based on the fear of not ‘getting their papers’ (being refused refugee status) and facing possible deportation.

As described by the interviewee below:

“Direct Provision, it’s very difficult because at the end of the day we are in a limbo, we don’t know what will happen in a year, in a month and you can’t make like full decisions.”

P.8

Powerlessness was a frequent concern in refugee and asylum seekers’ narratives. Firstly, it related to uncertainty about gaining refugee status and where they would live. Whilst for the programme refugees, family reunification was a major concern.

“I have completed three years here and still facing the problems, and problems. It feels like we are the gypsy people moving here or there all the time, where is our home? For a long time we are searching for, where is our home?”

Yes, I’m still afraid like being here, in the reception centre people come and go but you are still stuck in that place, what are they waiting for, are they sending you back or they are still going to process you?

Secondly, powerlessness was experienced in the lack of control over one’s life and the future. The international protection procedure was a puzzling phenomenon for most participants. It lacked transparency and seemed to work without rationale. Their vague futures combined with the absolute powerlessness in the decision were associated with feelings of anxiety and fear as P. 10 explains:

“What’s going to happen to me, are they sending me back home? So, that was really stress on me, I really got depressed. I was scared as well. So, that limbo just not knowing whether you are, still here or they will send you back.”

This sense of powerlessness was also experienced by programme refugees who had resided in orientation centres and were then dispersed to housing in towns around Ireland. They had no choice where they lived and in the process, families were separated. One woman revealed the impact of the separation from her daughter and her sister who were allocated houses in different provinces. She spoke of the inexplicable loss of her family which had stayed together through camps in Lebanon, the journey to Ireland, the orientation centre and were now split.

For many inactivity, unemployment, with no active role in Irish society, impacted on their sense of identity. They felt they had lost their status as independent adults and parents, unable to take control of their lives, which posed a major threat to their well-being.

“Your way of life, you know, your culture, because your culture is your identity and the language too. The language because there are things that --I can express more when I speak my language when I’m here, so I think that’s another thing. You know, being able to express yourself the way you want ---sometimes some words get lost on the way when you try to express the way you feel.”

For others living in Direct Provision with little contact with the local Irish community increased a sense of isolation and loneliness. This was particularly felt in relation to their children who had limited opportunities to interact with local children.

As P. 3 indicated:

“You feel like you are all alone, the children are not experiencing the full Ireland to be out there and see the whole world.”

It’s like we are closed in Direct Provision, we really don’t have access to their community for the children to get together with the other kids in the Irish community. So, that is a bit of a challenge for us. We still feel like we are in this side on our own, secluding here.

All participants emphasised the lack of affordable and accessible childcare as a major barrier to social integration as it limits opportunities for employment and increases social isolation. As P. 11 highlighted when asked about improvements to services;

“For me top on the list would be like childcare because as a mom by being by myself, I want to do something, and then where do I keep the kids, and if I need to put them in childcare centre, can I afford it?”

Participants believed that the local community did not understand or were not aware of their lived experiences as refugees and asylum seekers and that the Irish media had contributed to negative perceptions of them. As P. 9 describes the role of the media in shaping opinions of migrants:

“And every day, you have to explain yourself to people because even if you walk on the street, people ask why you are here. Why did you leave your country? --- The media was saying a lot of things about us—portraying us as spongers, that we are here spreading diseases and all that. So those are the things that were really frustrating us, because we have noticed that people would not understand why we are here, and we’re not here maybe to take over, but we are here to be part of the community and give back to the community when we’re given a chance to do so.”

In addition, for some participants there is a fear that the Irish community will not accept them as P. 21 articulated:

“Sometimes I think that there’s a fear in me that if I have to go out and to a community where I’m the only African woman how will my child feel amongst other Irish kids.”

Furthermore, P. 1 who has a degree in media studies and a MA from TCD felt that despite her qualifications she was discriminated against in seeking employment:

“You are looking for a job and you can’t get it so, you are stressed. Like for example you apply for jobs and sometimes you don’t even get an answer. So, you start maybe to question yourself, is it my name or maybe there’s something wrong with me.”

Adapting to a new culture and language acquisition, constitute significant factors affecting agency and sense of well-being. As P7 explained: The language hurdle is one of the biggest concerns. This is predominately relevant for women from Syria and Albania, for whom language was a barrier, in terms of their ability to negotiate the system and interact with the local community. As P. 31 describes it:

“Your way of life, you know, your culture, because your culture is your identity and the language too. The language because there are things that --I can express more when I speak my language when I’m here, so I think that’s another thing. You know, being able to express yourself the way you want ---sometimes some words get lost on the way when you try to express the way you feel.”

In addition, language barriers experienced on an everyday basis, contributed to a sense of isolation, exacerbated distress and hindered women in seeking help. Older generation migrants who do not speak English are particularly vulnerable. P. 15 describes the experience of her mother who does not speak English;

“She doesn’t understand. So, they are even scared of who will I explain my problem to, how, in what language? So, that also is bringing a lot of depression on them.”
In varying degrees for all participants, the experience of migration entailed a rupture from their family, community and culture with a forceful relocation and reshaping of their lives. They recounted experiences of many losses, not only the loss of a loved one, but also the loss of homeland, cultural group, employment, housing, and security. It is to be expected that being bereaved is only one of many losses that may affect mental health.

In particular for Syrian refugees there was a profound sense of grief about the loss of family members through death in the war, dislocation or leaving them behind. Some families had been separated during the journey; some had family members in other European countries, while others were still in their home countries. These women reported concern for the safety of their children and are consumed with grief at their loss.

Actually, yes, it is a grief, a sense of grief and sorrow at the same time — because the children who are here, they keep crying most of the time because their siblings are living somewhere else. P. 28

And this feeling and the continuous thinking, about our loved ones all the time, this is affecting our mental health because we can’t concentrate on other things here in Ireland, even if we want to learn the language, for example. P. 29

While adapting to a new life situation was difficult in itself, the actual realisation of the loss of family and key social networks caused additional pain and distress. The implications of displacement, of breaking with the past and reinserting oneself in a new social context may not dawn on the migrant before it becomes an emotional reality (Lindqvist, 2018). Hope in an imagined future where problems will be solved upon arrival in a safe place is crucial for carrying refugees ahead in the process of migrating, but once arrived and settled unexpected obstacles arise. As P. 30 explains:

This is the most stressful because all of a sudden, we discovered that we left our loved ones behind. In Syria, for example, social life is very different from here and you would be surrounded by your extended families. I think it’s very difficult because you have to change the country, and you have no friends and you have no families, you don’t know the language, like you didn’t have nothing at all.

For others it was particularly about leaving elderly parents

For example my parents are older now. Thinking that you will never see again them. That’s very hard — — — They’ll be the only ones for you and I think it’s very difficult to never see them. Because you didn’t have the papers to go back. I think that’s very difficult. P.35

In addition to loss of family, participants highlighted the devastating loss of social identity including profession, social status, community, social networks, cultural ‘way of life’.

— you end up feeling stressed, depressed, thinking like if I was back home I had my loved ones close, my family, those people who support you. Sometime you find that here is hard for you to find those people that will support you in the journey of your life. P.20

To try to show them (Irish people) that we are here to also work — Like to try to show them that you can do something for our self. We can do it, we can make, we can also work. We can do many things here. P. 17
The level of support services available to refugees and asylum seekers varied greatly. The programme refugees spoke of the vital support their families received, from the locally based Resettlement Support Worker and Cultural Worker, in settling and integrating into a new community. The support offered to this group and reported as being effective was a holistic multidimensional approach that considers cultural background and social integration as important when reconstructing a new life. In particular the refugees were appreciative of the psychological support they received to help them rebuild their lives in Ireland. In addition, practical assistance was reported as also having a strong influence on their mental health, when helping them to deal with housing, employment, financial support, learning the new language, children's education and participating in social activities. They also highlighted the assistance they received to navigate the health system and referral to specialist services like Spirasi for mental health support. The asylum seekers based in Direct Provision did not receive the same level of support while in the system or on transitioning from it.

4.1 HEALTH SERVICES

All participants had sought assistance from the local health services. The General Practitioner (GP) service is the first port of call for all health issues for migrant women in this study. Most participants indicated that their G.P. (i.e., family doctor), whom they saw for routine check-ups and for referrals to secondary care including mental health services, was in general supportive and empathetic towards them. For instance, P.7 said that she was able to build a relationship overtime with her G.P. and that she could talk freely about her concerns:

“My GP will be the first person to contact and then maybe friends again, yes, but you know, in friends, you are not going to tell what you are going through. I think the GP will be, but sometimes it’s about having someone professional that you can talk to and listen to you.”

Participants were appreciative of how some GPs had gone out of their way to support them and made it easier to access healthcare, and the importance of this to them.

“My voice was too loud and he (husband) was telling me, “Whoa, you are talking too loud, you’re not okay, what’s happening?” and I went to my GP, I said, “I don’t feel good. So, I act like this, and this,” and the answer was, “Oh yes, I know you have a hard life,” and I said, “Yes.” She didn’t say anything else like, “Okay, I suggest you go to this psychologist or do this or that.” When I came home I said, “Yeah, she knows I have a hard life, but I have to keep strong. And I started myself doing little by little, like when I saw my children doing messy things, okay.”

A lot of people have different problems with GPs, that don’t really treat them like humans, but mine was different and I’m one of the lucky ones and after I go for a check-up, you know when you’re pregnant you go maybe once a month as I have three kids. Sometimes I even find an excuse to go see her (G.P.) because leaving the office I always feel better and then my blood pressure kept going high and she referred me to a counsellor. P.33

But, others highlighted this empathy or compassion among service providers should not be something out of the ordinary; instead it should be a core element of good practice and an obligation to any patient. As one woman P.9, put it: ‘The care and empathy they show is not magic.’

Participants, who sought assistance from GPs for mental health problems, highlighted the role of the GP in monitoring their treatment and referring them to appropriate specialist services.

“It was mostly anxiety, insomnia and sometimes panic attacks. What she (GP) said was maybe because my treatment(psychiatric) stopped at a certain point and I haven’t had it in a while. So that’s what maybe led to the ongoing things that I have. So she (GP) recommended that I talk to SPIRASI because it correlates – treatment and counselling. P.7

The care and empathy they show is not magic.”

Participants who sought assistance from GPs for mental health problems, highlighted the role of the GP in monitoring their treatment and referring them to appropriate specialist services.
Other participants reported negative experiences and encounters with the healthcare system. This related to some who felt that they were not understood and disagreed with the treatment prescribed.

Like come out with your own copying mechanism and deal with your pain by yourself... and you end up going back to the GP and they keep pumping you with anti-depressants and all that. I don’t think that’s the right way to treat somebody that has been through torture and trauma in life.

A common theme in the interviews was the lack of integration between the asylum system and healthcare services. Dispersal had a particular impact on this, where asylum seekers are moved from one Direct Provision centre to another, continuity of care with existing healthcare providers may be disrupted or lost. One participant (P. 18) noted that she had been in receipt of cancer treatment in Dublin but was not referred for follow-up care when she was relocated outside Dublin.

Delays in getting appointments for specialist health services including mental health was a recurrent complaint from participants. Syrian women in particular compared the inefficient system here to the effective health system they had in Syria before the war. Long waiting lists to see psychologists or counsellors was also a widespread experience.

Another problem is appointments. When you go to doctor for appointment to see one of those specialists like psychology it takes one year. So, if somebody wants to die, the person will die before the appointment will come. P. 23

Yes, through my doctor because it’s my GP that will refer, is more than a year now - no appointments, no dates. P. 35

For those few participants who had attended counselling they found it very helpful. It provided them with a listening ear and a ‘safe space to cry’. They also valued the opportunity to talk in confidence to someone about their worries and problems and to receive guidance and advice.

When I first got that post-depression I just found myself, I was crying all day. So, GP made referral to, he gave me anti-depressants but it wasn’t helping. It made me sleep but I was still worried, I was still crying and I was still unhappy and he said, “Maybe we should try something else, would you like talking therapy.” I went into psychotherapy and it helped. P.40

I think the biggest difference, the beginning of my transformation was with my GP and then the counselling and then the education part, I think what education will do to you and actually meeting people outside the walls of Direct Provision makes you grow and then you find yourself. P.11

I went for three months to the psychologist when I came here and I found it really helpful. Not anything that she gave like medicines, but just talking with her…. Just talking with her or with the tips that she gave me. P. 14

The role of voluntary organisations was described by participants as crucial in bridging the gaps left by health services and enabling them to get the support they needed. Participants reported how such organisations supported them, and highlighted the trust and compassion they felt when seeking assistance from this type of service. It was clear this support was widely appreciated.

Sometimes I do call, when I’m really stressed at night, because sometimes you just don’t know what’s going on, you get lost. So what I do is there’s a number that I have called, the Samaritans that I call. P.1

The Migrant Centre helps. …. Like you can tell them what’s your problem, they can help you, like give you hope. Give you a choice also. P.38

4.2 BARRIERS TO ACCESSING SERVICES

The participants in this study faced a number of barriers to accessing mental health care and support. These included cultural beliefs of mental health, gender roles and marriage, communication problems and lack of appropriate services.

Cultural Beliefs and Mental Health

The refugees and asylum seekers in this study were a heterogeneous group with varying cultural beliefs. Some participants revealed how cultural understandings of mental difficulties involve notions of taboo, stigma and shame. In addition, psychological distress is associated with abnormal behaviour, ‘craziness / madness’ or ‘supernatural spirits’.

No, there’s no classification for, “Oh, I’m nervous, I’m anxious,” everything is madness or you have spiritual attack, and then you are subjected to the ritualistic things and stuff like that. While here there’s a name for, if you’re shaking, they say you are in panic attack. If you can’t sleep they say, it’s insomnia, if you can’t do this is schizophrenia, is this, is that. While in my country we don’t have those specific names. P. 23

These cultural beliefs influence the likelihood of detecting mental ill health, as well as attitudes to treatment. In cultures where taboo or stigma is particularly strong, many migrant women feel ashamed and hide their illness. The negative views about mental health makes them reluctant to step outside of the beliefs of their family or community to seek help.

I think among us Africans, most women are depressed but they are hiding it. As I said to you --- It is a taboo like to believe that you have mental illness, so, we hide. P.5

If you want something you can find it, I know I can find (help) but sometimes, you feel so, “How do I go there, if somebody sees me, they will say oh she is ---” because even here (ireland) it is the thing that, she is crazy, she is something like that and you just feel, okay, I can’t go (for help). P.21

In addition, for some migrant women religious beliefs discouraged and deterred them from seeking medical treatment and directed them instead to seek help from ethnic or religious leaders.

We don’t want to accept the fact that you have mental illness instead we cover it --- because we believe too much in religion. Some people instead of going to hospital they go to the church. P. 11

Gender roles and Marriage

For some migrant women, their gender role as defined within their culture was a barrier to seeking help. They felt they should be able to cope as otherwise, they are viewed as vulnerable.

So, it’s hard to speak up because if you speak up then you feel like you are vulnerable or you are weak that you don’t know what you are doing, like you are not a woman, like a woman should be able to handle everything. Being a mother, being a wife, being a friend and a supporter. So, always speak out somehow, we don’t feel like anyone is listening to us as women. P. 30

Participants also revealed how cultural beliefs about marriage and the role of women within marriage obligated women to remain silent and stay in abusive relationships or ‘bad marriages’. It is evident from the accounts of the women in this study that marriage ‘failure’ is associated with stigmatisation and shame. Thus the shame of abusive and ‘failed marriages’ is a determinant of mental health and also a barrier to seeking professional help.
A lot of women honestly even here (in Ireland), they are still going through a lot of abuse from their husbands but they still stay. So, that abuse is also causing a lot of mental health issues. So, a lot of them say, “I’m married.” They are not, the marriage is not there. There’s no happiness. The man will have left the woman maybe to go to another county and keep another girlfriend there … what will the wife do, she’s married. P. 9

Most of the people that are going through this depression are people in marriages. People stay in bad marriages because they are scared of the shame of my marriage failed. P. 2

Participants indicated that migrant women often seek support and counsel from ‘church pastors’ in relation to abusive marriage. However many perceived the ‘church pastor’ in this role as reinforcing the traditional role of women within marriages and failing to refer the women for professional help.

The church, I think it’s most of the pastors, they need to empower when it comes to abuse because there’s this thing that a man is the head of the house. They use it through the bible to oppress women and sometimes even if like advising women to seek help. The only thing they will tell them is keep on praying, fasting and praying, when they are going through an abuse situation. P. 12

So, people stay there and then again the church gets involved. So, when you go to church, the pastor will tell you that’s what the word of God say, you need to stay in that marriage. They will keep on praying for you. Instead of saying that you go look for help outside there. P. 5

Cultural understandings of mental ill health, involving stigma and shame, can be significant barriers to migrant women accessing mental healthcare. This was particularly the case in seeking mental health care, where the diagnostic process is almost entirely based on oral communication, as are many interventions (e.g. psychological and counselling). Some participants found it difficult to talk about their problems, therefore resorting to the use of subtle terms to describe symptoms as P. 22 explains;

So, sometimes when you go to your GP or go to your psychologist they don’t have a clear understanding of what you are trying to say because you will say it in a different way while another person will just bluntly say, “Look I’m depressed.”

Others felt it was important that health care providers were culturally aware and had training to be culturally sensitive.

I think migrant women to have maybe a counsellor or a GP who is from almost the same background, or the counsellors or psychologist or GP having a bit of study or education of African women of how African women will deal with depression, to understand it.

Participants also perceived that they are not given enough information about services and what they do get is not easily accessible (both in terms of language and where and how information can be found). Being able to negotiate and access health care services independently required not only language ability but also functional aspects of health literacy such as being able to make appointments, read appointment letters and navigate travel to specialist services, which are mainly Dublin-centred.

4.3 SERVICE PROVIDERS PERSPECTIVE

The views of service providers were obtained by interviewing four key informants (KI) representing a range of professionals working with services for refugees and asylum seekers, including migrant women. They had specific professional experience of; refugee support organisations; community organisations working with migrant groups; services for migrants who had experienced torture and psychological services. The service providers and healthcare professionals who contributed had experience of working with refugees and/or asylum seekers, so had a particularly good understanding of their mental health needs.

Overall, service providers perceived that the mental health concerns of refugees and asylum-seekers are more complex than those of the general population. They were cognisant of the myriad of mental health risks, as discussed in Section 1, that refugees and asylum-seekers encounter throughout their migration journey and on resettlement. Collectively, narratives highlighted that the most concerning mental health issues associated with the refugee and asylum-seeker population in Ireland include PTSD, trauma, depression, anxiety, isolation, separation from families, loss and grief.

What seems to affect women the most would be complex PTSD... So they have all the PTSD symptoms, the intrusion, the hypervigilance, the avoidance, but they also have negative self-concept, disturbed relationships, affect dysregulation, so difficulty regulating emotions and mood, and this all causes a strong functional impairment. So it can affect them being able to study, being able to work, being able to manage their family life, being able to build relationships. KI 1

The potential for mental health issues in Syrian women is separation from their families and isolation. Suddenly they come from Syria where they had engaged in extended family networks and had high support. Now in a nuclear family, they don’t have same connections they used to have, and find it hard to build them again. Woman have the potential to present with low mood, isolated and trying to settle into new culture, a new system. Also they worry about families back home and not being able to support them. KI 2

Service providers perceived the system of Direct Provision as a major contributor to mental health difficulties in asylum seekers. Some providers revealed how they witnessed within Direct Provision migrant women become progressively disempowered and depressed, as the system takes away their autonomy and engenders fear and anxiety.

Significant depression comes from numerous sources for asylum seekers related to the system, length of stay in DP and when it will end. Letters of refusal, deportation orders and refusal of family reunification - these all cause significant distress points. They don’t know the system. They rely on hearsay from others in Direct Provision, micro environment, feed off each other in terms of negativity about centre, management etc. KI 4

Feeling fearful is present all the time and a lack of safety is there. So especially with clients who are in the asylum process when they’re completely in limbo and they don’t have that safety of knowing that they can stay, that’s exacerbated. KI 1

In addition, the denial of the right of work for some asylum seekers has caused distress and a sense of unfairness amongst residents in DP.
Service providers viewed language skills as vital for migrant women to adjust and integrate into a new country and culture. A lack of language skills can lead to social isolation and dependence on others. Service providers explained how language barriers could make it difficult to communicate critical health information, sometimes compounded by inadequate interpreting services. This could lead to misunderstandings about diagnosis or treatment. Service providers also talked about the logistical challenges in making adequate translation services available. The need for interpretation extends beyond primary care services. It can affect how easily migrant women can access mental healthcare they need from counselling and psychotherapy services.

Furthermore, some service providers asserted that many migrant women are unaware of their fundamental rights to healthcare.

"Women do not know of services, they may not have not accessed counselling as need referral from GP. Women do not think that they are entitled to services." KI 4

This, coupled with the lack of legal status in Ireland, has undermined migrant women's ability to voice or seek formal recourse for any problems they may face throughout the healthcare seeking experience. As a result of poor awareness, the lack of health literacy and awareness of one's rights, refugees and asylum-seekers can become particularly vulnerable to further health risks.

Service providers highlighted cultural beliefs and stigma about mental health problems, as significant barriers to migrant women accessing mental health care. Shame and lack of trust were identified as key issues. They iterated that public health services are rarely tailored to consider the cultural beliefs of refugee and asylum-seekers. For instance, many are unaccustomed to verbalising personal feelings and emotions and may somatise their symptoms.

"They come from a medical model, Syrians come from environment where they somatise problems, want tablets, medicine to cure problems, talk therapy is not something they would think of. They need culturally sensitive services." KI 3

"It's a lack of understanding about mental health versus physical health and what you find is that a lot of people from different cultures, they will somatise symptoms a lot because they're not used to experiencing mental health as a purely psychological thing. So you’ll find that they might present with a lot of stomach aches, headaches, pain throughout their body, which could be physical, but you know, when we look a bit deeper, there's definitely a psychological component to a lot of it." KI 1

In addition, many refugees and asylum-seekers are used to a different system often based on their ethnic and cultural practices. Providers considered it vital that services recognise the difficulties migrant women experience in navigating the Irish healthcare and social system. Mainstream mental health services commonly expect people with mental difficulties to be active in seeking treatment. Providers contend this is unrealistic for refugees and asylum seekers who may have insufficient knowledge or skills to access mainstream services, feel ashamed to go to services, or lack trust in services and staff. Providers identified the main barriers for migrant women face in terms of access to services; transport, language and childcare. In particular, the need to provide outreach social support and counselling services to Direct Provision centres was deemed essential.

"Balseskin is first service as Reception Centre. It is top notch, in-house GP, nurses, counselling and crèche... All services located in Dublin, then the transfer happens in number of days and they arrive to centres where they have no services. They assume they are arriving at another Balseskin, it is a big culture shock. When there are no services they often get angry with the manager because think they should have services like Balseskin." KI 4

Service providers highlighted that the challenges of adjustment continue for a long time in migrant women’s lives: managing a different environment, a new culture, their traditions and memories left behind with their present social and psychological needs. Service providers also pointed out that in their experience generally, refugees do present resilience, individual resources and abilities to deal with inconceivable difficulties provided they receive adequate support and appropriate services.
There is no doubt that migrant women in this study encountered a multitude of traumatic and stressful experiences in their lives prior to migration, during the migration journey, and particularly in their post-migration lives. These experiences and situations place them in a position of risk, where their well-being and mental health is threatened by the adversities they encounter. Yet, despite their life difficulties and social suffering, the participants showed remarkable resilience and tried to exert agency in many aspects of their lives.

Migrant women’s resilience and perseverance were lucidly evident in accounts of their lived experiences. Their daily lives entail a constant negotiation concerning identity, recognition and social inclusion. The participants of this study were asked what kept them going in adverse circumstances. The key strategies they identified to cope with current stressors and past traumatic experiences were:

I. **Hope – looking to promise of future**

II. **Religion – belief system helps make meaning**

III. **Family - support and maintaining connections to culture of origin**

IV. **Exercising agency – integrating into Irish society**

**HOPE – LOOKING TO PROMISE OF THE FUTURE**

While every migrant’s experience is unique, this study reveals that the women shared many common hopes for the future. The main reason they had left their homeland was to have a secure life, good livelihood and a better education for their children. In reality, it was a long journey for them and they experienced compound stressors. However, they were grateful for improvements they experienced in their lives and they kept looking to the promise of the future.

All of the participants said they feel physically safe and unthreatened in Ireland, particularly those who had left war zones or unsafe countries.

Yes I think that’s what keeps it going. Like if you look around and nothing is working and there’s one thing for you to be grateful for is the fact that I am safe and I can sleep with my eyes closed if I choose to sleep. So, that is the one thing that you keep going. P.10

---what we are saying that you are happy about, you know, like if you look at everything that is going on and you say, “Okay maybe my papers is not here.” Or, “I’m not eating the right food.” But there’s one thing that you still to prefer that you are safe, and your children are safe. P. 24

All asylum seekers expressed hopes of getting refugee status, to have their own home and for their children to be educated. For the refugees in this study they hope to be reunified with all their children and to learn English. For all participants a better future for their children was their main goal.

I have to do this for my children, and I have to make them feel good. Also the children give you much hope. Like, “Mom don’t be like this, everyone will be fine, we will fix it, you don’t need to worry, God is with us.” I think that’s a really good thing. P.37

---what I do when I’m depressed here now, I just have to work. I work. Before I come down (low mood) now I’m ok because my kids are my priority. They are, so I don’t want them to see it in me that I’m kind of down. It will affect them. I know that myself, so I have two boys and they’re very smart boys. So just I try to make myself, I control my emotion. I don’t allow my emotion to control me. So I make sure that my kids are looking up to me. I don’t have anybody here, so you have to. I do it for my kids’ sake. P.19

Many participants saw their children settled in Irish schools, adapted their parenting styles and in many ways became more autonomous. This was a major shift in their post-migration lives and they considered these achievements as markers of success in their journeys. They made meaning of what was happening and despite the stressors; they voiced a sense of gratitude and hope for the future.

**RELIGION**

For migrant women in this study, faith and religion had a positive influence on coping and helped them to accept their difficulties along with providing a sense of hope that life would improve. The refugees in particular discussed placing trust in God and utilising the Quran as a guide and resource for coping, as well as a motivator toward perseverance. They relied on their faith when they needed emotional support.

Many reported that praying to God provided relief from feelings of stress and discontent. Religion helped them by causing an increase in feeling freedom from harm, control of their sense of selves, preserving their sense of self-esteem, maintaining healthy relationships and minimising stress (Steigjen et al., 2016).

Sometimes when you feel like really you are losing your mind, you pray, please God help. P. 28

Please God help me, mind my mind because sometimes you feel really bad and if you lose your mind, who will then fight for your children, for your family, for your rights? So, you will till in the end, and then something like a small light, maybe just a friend, maybe just a prayer. Maybe something small to keep a little bit stronger and then for some days you go with that power that you. P. 35

Additionally, religion provided a stable, shared belief system and provided affiliation and social support from the religious community. In particular African asylum seekers reported that attending church or mosque assisted them in forming contacts and helped them to locate others who shared their beliefs and made them feel part of a community.

**FAMILY – SUPPORT AND MAINTAINING CONNECTIONS TO CULTURE OF ORIGIN**

The participants voiced immense emptiness for the loss of their families whom they had left behind. Maintaining connection with family and friends was an important coping strategy for these migrant women. It was from their families that they found support and comfort and they took advantage of technology (i.e. internet) to assuage their loneliness and remain connected to their families who were “back home”. The women in this study reported having few Irish friends. They mainly established connections with their ethno-cultural communities.

-----sometimes you’re just stuck in here (DP) and you have to kind of be friends with others, you just have your good manners, so you won’t be problematic-- But, meanwhile in your country, you have your family, that’s the pure thing I can say, the real support. P. 24

Like back home we have that structure where there will be aunts and uncles or like family or community will help with the child. If the mother is not too well, they will talk to the mother in a way that, it’s not like they will offer professional counselling, but in a way they will talk, it will be like they are trying to wake you up, they say like, “You are sleeping, what is going on? It’s okay, it’s part of life, if something happens to you, you can go through it, you can pass it”. P. 38

So I think for the kids to know that they have rights and being treated with respect because back home everything is by force, kids don’t really have a voice to talk back. --and if they do something wrong, straight away you are spanning them. So, we have a better communication now, so my kids say ‘I have my Irish mum and my Nigerian mum and I like my Irish mum better than my Nigerian mum’..... So, I try to see the gifts and I know that there are challenges but there are gifts in it. P. 8

So, for you to cope, appreciate that and say, “I’m now having what I didn’t have”. Because basically what we did, especially those that come from Africa, we go to work for school fees, for clothes, for shelter, for food. So, when we get here, all those we have, even though it’s in the Direct Provision, but we have all those things. So, what I’m saying is that, I’ll tell them to appreciate those and be thankful for that. Once you do that, anything else doesn’t matter at the end of the day. P. 12
EXERCISING AGENCY – INTEGRATING INTO IRISH SOCIETY

All participants emphasised that they wanted to be involved in and contribute to Irish society. They are grateful for the opportunities they have received in Ireland and they want to make a meaningful contribution to the local community. This they believed would somehow compensate for the burden of asylum seeking and improve their sense of self-worth and agency. For many participants the opportunity to pursue education and training was important to realising their dreams and achieving their potential. Learning new skills and upgrading existing skills was seen as vital even while waiting for their international protection applications to be processed.

Some participants exercised agency by seeking ways to relieve boredom and stress through physical exercise and running. The engagement in physical exercise was conducive to relaxation and wellbeing as one woman (P. 22) said, Running is my therapy. For others it was availing of their own resources; sometimes I just stroll about, take a walk, go shopping even when I don’t have money, I just go to shops, look at things. Maybe sometimes I go by the seashore there, just sit down, look at nature. Those with poor English were anxious to improve their language skills. Some were very unhappy about the limited access they had to English classes – 2 hours per week. While the refugees were very appreciative of the opportunity to attend classes every day.

The migrant women in this study had availed of support from voluntary and non-governmental organisations offering services, activities and advocacy. These included specialist organisations such as migrant organisations, those offering support and community centres. Many had attended women’s groups, mental health awareness and parenting classes.

In the Migrant Centre there was a parenting course that I did and being an African mom there is high expectation for your kids. So, there was the part where they taught us like different levels of development for a child. So, it kind of just make you relax as a parent --- So I think being here kind of made me a better parent to my kids. Because we talk more, there’s more communication with the kids. It’s not as forceful. Like my eldest son was telling me that being in Ireland made him realise he had two moms. Like the African woman, and the Irish now. So, and then he said, “I prefer the Irish more better than the African” Many felt they had to understand their rights and be persistent to get the healthcare and support they needed, with the help of social networks and voluntary organisations to overcome specific barriers and support their individual resilience.
This qualitative exploratory study set out to explore the mental health experiences of a sample of migrant women in Ireland and their access to services. The findings reveal that migrant women experienced significant stressors that have serious implications for their mental health and psychological well-being. The study shows that while the women were affected by traumatic experiences in their country of origin or during the flight, at the time of the interview, current stressors, especially for the asylum seekers played a more significant role in determining their mental health. The migrant women's personal distress was experienced on a daily basis and was inseparable from social, political, and institutional processes and determinants i.e. social suffering. Findings show that the women's lives were characterised by stressors related to: (1) practical challenges faced daily as asylum seekers and refugees, (2) powerlessness and lack of agency and (3) grief and loss.

Similar to previous studies on the mental health of migrant women in Ireland, the women interviewed reported anxiety, sadness, grief and symptoms of depression. Despite experiencing these symptoms, most women had not the opportunity to discuss their symptoms with a health care professional as they experienced complex barriers to healthcare access. The study identified the key barriers to accessing mental health services include: cultural beliefs about mental health involving notions of stigma and shame, language barriers and lack of information about services.

Even when migrant women are able to access healthcare, getting specialty care such as mental health services or counselling may be challenging. Considering that migrant women are likely to seek healthcare from primary care services, healthcare providers should be equipped, and resources made available to attend to their mental health needs. Within the healthcare setting, assessing the mental health needs of migrant women requires culturally appropriate tools. There is a need for healthcare providers to have basic knowledge about the challenges that migrants and particularly asylum seekers, face in the current socio-political context. Lack of awareness or understanding of the realities of migrant women might pose a barrier to effective screening and interventions that would address their mental health needs. This is especially important for primary care providers responsible for services to asylum seekers in Direct Provision. It is also vital that healthcare providers employ culturally appropriate screening tools that account for potential variations in the conceptualisation of mental health symptoms among different migrant groups. For instance, compared to the dominant Western notion of duality of physical and emotional symptoms, some migrants may somatise emotional distress and report physical symptoms. In addition cultural constructions of mental health narrowly defined by pre-migration trauma may overshadow migrant women's day-to-day experiences of stress and the social determinants of mental health, thereby abdicating social responsibility for health on refugee women and families.

Despite the challenges they experienced, the migrant women nevertheless resisted the impact of their often hostile context and demonstrated resilience by exerting agency in many aspects of their lives. Lindqvist (2018) suggests that the perspective of migrant women as agents rather than victims has not made its way into the literature. She contends that western illness discourses and diagnoses such as posttraumatic stress disorder frame migrant women's social suffering. Questioning the notion of migrant women as oppressed and victimized, Hondagneu-Sotelo (2013) instead argues for a wider perspective on female migrants. She highlights the competence required for migrant women to cross the multiple borders; not only nation borders but ‘structural, discursive, intersectional and agentic borders’. Hence, mental health policy and practices need to shift the gaze away from discourses which conflate migrant women’s identity as dependent, toward practices that support women’s agency.

In general, for migrant women in this study the resilience factors that enabled them cope with traumatic experiences and current stressors included; (1) hope – looking to promise of the future, (2) religion – belief system, (3) family support and connections to culture of origin and (4) exercising agency and integrating into Irish society. These factors as captured in Figure 8 below interacted with one another and comprised the interplay between individuals, families and their social context. The enablers positively influenced resilience: they helped migrant women to strengthen their sense of power and agency, to provide a sense of involvement, and to sustain their spirit within the family and the new society.

The stories of the migrant women reveal that resilience is not an all-or-nothing state, as creating a dichotomy whereby refugees and asylum seekers ‘are seen as either “vulnerable” or “resilient” is overly simplistic (Bonanno, 2012). The results show that the same migrant women can be in a way both (vulnerable and resilient) depending on the available resources, support systems and transitions faced over time – i.e. getting ‘ their papers’, having access to work, receiving appropriate services, social support from significant others, and experiencing agency in their lives. Furthermore, past experiences appear to interact with managing current difficulties and future hopes. For example, long waiting periods in DP appears to diminish migrant women’s hope because of their adverse past experiences. Altogether, this interplay between individual, social, and contextual factors supports the ecological model (Miller et al., 2016) for understanding resilience as outlined in Figure 8.

Figure 8. Stress factors and resilience factors for mental health in migrant women

Migrant women had the desire to move on and to live a stable and meaningful life, contributing to Irish society. Their emphasis on education for their children and hope for the future is consistent with other studies on the experiences of migrant women (Sriwardhana et al., 2014). Migrant women’s focus on staying in Ireland appears to be a conscious and functional choice. Nevertheless, it might make these women, particularly asylum seekers, vulnerable if they have to face the possibility of going back to their country of origin.

We also have to be aware that protective factors may not equally benefit all migrant women across various levels of risk sometimes, reducing the exposure is more important than building resilience (Sriwardhana et al., 2014). A fundamental determinant of migrant women’s hardship in this study and the associated psychological distress is the international protection process and Direct Provision system in Ireland. The findings of this current study add to the existing evidence of the urgent need for reform to the Direct Provision system. Doing so, will decrease fear in migrant communities, reduce their exposure to risk, enable them rebuild their lives and integrate into Irish society.
Despite the traumatic and stressful events that may precipitate and accompany a migrant women’s pursuit of refuge, mental health problems are not an inevitable consequence of their experience. Instead, a migrant’s well-being is shaped by a complex interplay between stress and resilience factors. The most important social factors are potentially modifiable and therefore of particular interest to groups who seek to improve migrant women’s well-being, including health professionals, public health, voluntary sector and policy makers.

The participants in this study identified a number of changes, which could be made to improve the mental health of migrant women. These included structural changes, access and support from mental health services, and enhancing collaboration and promoting integration. They also made suggestions to AKDwA regarding its services to support the mental health of migrant women.

6. RECOMMENDATIONS

STRUCTURAL CHANGES

- Replace Direct Provision with a more humane and supportive system. This report provides further evidence of the significant relationship between living in Direct Provision and the deterioration of mental health among migrant women. Currently the loss of autonomy and dignity experienced by migrant women in Direct Provision centres is detrimental to the mental health of an already vulnerable group.

- The asylum processing system needs to be more transparent and faster. This is particularly important given the evidence of psychological distress caused by the prolonged waiting for international protection decisions, as highlighted by the participants in this study.

- Introduce vulnerability assessments for all applicants for international protection including assessment of mental health. Use this vulnerability assessment to deliver targeted mental health support to applicants on dispersal.

- Extend the support scheme for Programme Refugees for up to 3 years. Research shows that significant mental health issues occur for refugees post resettlement over this period (Cooper et al., 2019). Consideration should be given to embedding the delivery of this support scheme within local services, as outsourcing to various NGOs limits consistency and building up of good practice over time and across projects.

ACCESS AND SUPPORT FROM MENTAL HEALTH SERVICES

- Provide outreach services in Direct Provision that build trust and ensure regular contact and consistency of support for international protection applicants. These services should follow the model of support services available in Balseskin Reception Centre and include:

- Designated primary care social worker to support the psychosocial needs of asylum seekers living in Direct Provision. These professionals can establish trust with asylum seekers and provide social and psychological support to individuals and families. They can develop links between them and local service providers e.g. family resource centres, community and advocacy groups.

- Designated psychological and psychotherapy/counselling service should be made available at local level to provide support for migrant women. This service should provide outreach to DP on a drop-in and sessional basis. It should also sign post to specialist mental health services.

- General practitioner service and primary care services should be adequately trained and resourced to meet the complex needs of this vulnerable population in line with the recommendations of the Faculty of Public Health Medicine (2016). Assessment and interventions should consider not only pre-migratory trauma, but also current stressors migrant women experience, to support their overall well-being.

- Translation services should be readily available in primary care and to all health providers that care for asylum seekers and refugees including psychology and psychotherapy/counselling services.

- Establish regional consultant-led multidisciplinary teams specialising in mental health services for refugees and asylum seekers in line with the recommendation of the College of Psychiatrists of Ireland (2017). Assessment and interventions should consider not only pre-migratory trauma, but also current stressors migrant women experience, to support their overall well-being.

- Train all frontline and health care professionals in gender and cultural sensitivity including understandings of mental health.

- Specialist services such as SPIRASI, which provides support to victims of torture, should be funded to extend further its regional services. Provide specialist support services to migrant women who are victims of domestic abuse on a regional basis. Currently specialist services tend to be Dublin-centred.

COLLABORATION AND CO-ORDINATION OF SERVICES

- Improve intersectoral collaboration and coordination by establishing forums where statutory services, NGOs and migrant women’s groups could share knowledge, skills and coordinate service delivery. The mixed economy of service provision in Ireland with an increasing outsourcing of essential services to NGOs, voluntary and charitable organisations has resulted in a general fragmentation of the health and social care system.

- Develop mutual training to exchange expertise between different services, which can lead to a greater shared understanding and better ways of working together. Many organisations providing mental health services to migrant women work independently of each other. This is particularly problematic for migrant women since they often present with multiple needs, and require integrated collaboration between services to benefit from the whole system.

- Develop a directory of mental health services, organisations, and community supports and make available to all providers. Good collaboration and coordination is essential to optimise the use of restricted resources and to ensure migrant women are not neglected because no service takes responsibility.

- Disseminate culturally appropriate mental health information to migrant women in association with ethnic groups, church leaders and to health care practitioners in local areas.

INTEGRATION AND SUPPORT

- The feeling of powerlessness is a major issue in the lives of migrant women therefore it is essential to afford them some power and personal agency, by supporting and activating their education, work opportunities, volunteering in the local community in order to build resilience.

- Integration should begin at the point of asylum application and continue into Direct Provision and beyond. Time spent in the Direct Provision system should allow people to be meaningfully occupied and opportunities for engaging in education should be facilitated.
Use a systemic approach to support social integration through employment. The right to work should be extended to asylum seekers while applications for appeals are being considered. The right to apply for a driving licence should also be allowed.

Specific psycho – education programmes for migrant women creating awareness of mental health and building resilience and self-confidence are required.

Affordable, accessible childcare should be provided for migrant women as it significantly impacts their mental health awareness.

Art and group work activities

Relaxation exercises

RECOMMENDATIONS FOR AKIDWA

The migrant women made a number of suggestions to enhance the work of AKIDWA in the area of supporting mental health and well-being. Many had already participated in groups facilitated by AKIDWA and they endorsed the programme on FGM, mental health awareness groups and parenting groups.

Their key recommendation was the provision of outreach counselling service in Direct Provision centres. They also proposed group work and psycho-education to provide social and emotional wellbeing support for migrant women in the following areas:

- Mental health awareness
- Mindfulness, meditation
- Relaxation exercises
- Parenting classes
- Art and group work activities

They felt it was important to include activities within group sessions particularly for those with limited English and they also valued the receipt of a certificate of attendance.

Finally it was suggested that AKIDWA could have a role in educating church leaders about mental health issues for migrant women.

I think if AKIDWA took and have sessions, invite the leaders of the churches who are men because I know among us, a lot of women are going through a lot, but the church will not tell them to go and look for help and will tell them it’s a shame for you to leave the abusive marriage.

Final Word goes to Debbie

I think the biggest difference, the beginning of my transformation was with my GP and then the counselling and then the education part, I think what education will do to you and actually meeting people outside the walls of Direct Provision makes you grow and then you find yourself.
LET'S TALK Mental Health Experiences of Migrant Women


Mental Health Europe (2016) The need for mental health and psychosocial support for migrants and refugees in Europe. Brussels: Mental Health Europe.

Mental Health Reform (2013) Ethnic Minorities and Mental Health; A position paper, Dublin: Mental Health Reform.


