The Impact of Direct Provision Accommodation for Asylum Seekers on Organisation and Delivery of Local Health and Social Care Services: A Case Study

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Abbreviations used in the Report

(in alphabetical order)

Frontline staff

AMO	Area Medical Officer
CWO	Community Welfare Officer
HP	Health Promotion Facilitator/Tutor
GP	General Practitioner
MAC	Manager Accommodation Centre A
MAT1	Maternity Manager 1
MAT2	Maternity Manager 2
PHN1	Public Health Nurse 1
PHN2	Public Health Nurse 2
PHNM	Public Health Nurse Manager
RSG	Refugee Support Group
SW1	Social Worker (community)
SW2	Social Worker Maternity Department

Policy makers and service planners

HSE	Health Service Executive
LO	Liaison Officer
PCD	Development Officer Primary Care Department
RIA1	Reception and Integration Agency staff 1
RIA2	Reception and Integration Agency staff 2

Service users

AS (1-10)	Asylum Seeker (1-10)
LSU (1-7)	Local Service User (1-7)

Section 1: Introduction

Migration is a global phenomenon

In 2005, there were 190 million international migrants in the world, that is, one out of every 34 persons in the world was an international migrant. This total represented a 2.5-fold increase from 76 million in 1960. By comparison, the world population had a 2.1-fold increase from 3 billion in 1960 to 6.5 billion in 2005. As a result, international migrants represented 2.5 per cent of the world population in 1960 and 3 per cent in 2005.(1) Migration may be a result of forcible displacement because of complex social, political or environmental events. Worldwide, at the end of 2007, a total of 67 million people had been forcibly displaced, mostly as a result of armed conflict or natural disasters. Many of these people seek asylum in other countries.(2)

The right to seek asylum is stated in the Universal Declaration of Human Rights, which states that 'everyone has the right to seek and to enjoy asylum in other countries from persecution'.(3) An asylum seeker obtains asylum if he/she meets the United Nation's definition of a refugee: someone who '*owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of their nationality, and is unable to or, owing to such fear, is unwilling to avail him/herself of the protection of that country*'.(4)

In 2007 the total number of refugees under the UNHCR mandate was 11.4 million. Mostly refugees fled to neighbouring countries, resulting in up to 90% of refugees being hosted within the region of their origin. Europe hosted 14% of the world's refugees with around 330.000 new asylum claims during 2007. These global migration patterns have relevance for Ireland in that they are contributing to recent and unprecedented patterns of *inward* migration (see Figures 1 and 2). (5)

Figure 1: Number of applications per year for refugee status in Ireland 1992-2007 (6)

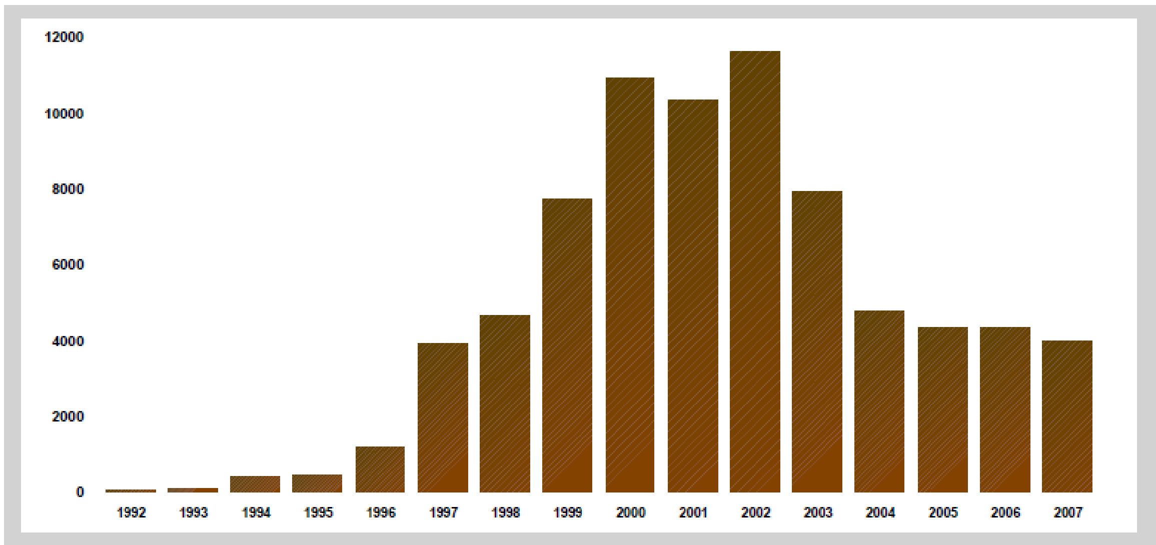
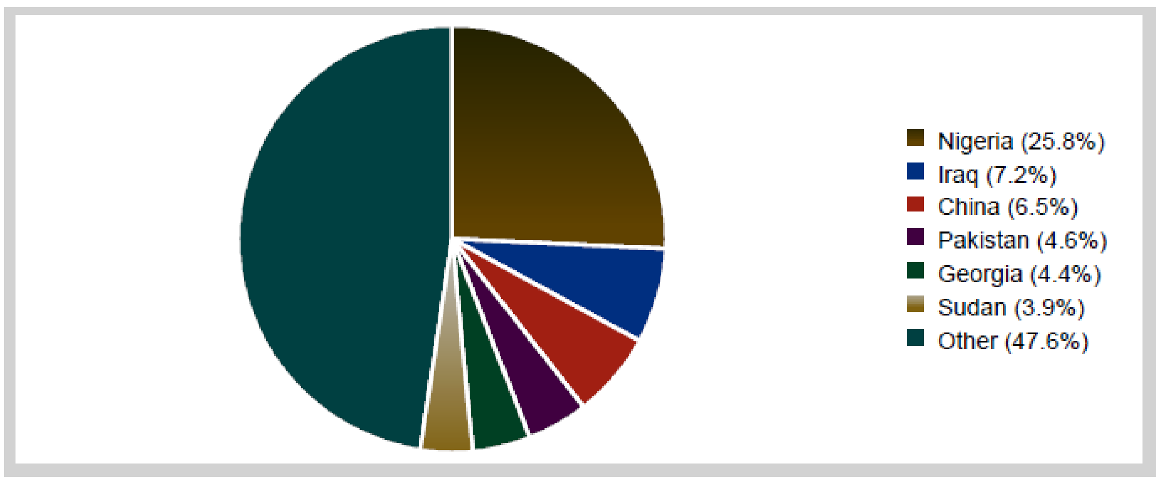


Figure 2: Top six stated countries of origin 2007 in Ireland (6)



Equal access to healthcare for asylum seekers

Equal access to healthcare is an acknowledged human right: according to the UN Universal Declaration of Human Rights, 'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care.'(3) The WHO states universal access to healthcare as its goal (WHO Alma Ata Convention 1978, (7)). Do asylum seekers have equal access to healthcare in their host countries?

There is an EU Directive laying down the minimum standards for the reception of asylum seekers, often referred to as Reception Condition Directive, which was published in 2003.(8) The Reception Condition Directive aims to ensure that asylum seekers will have a dignified standard of living for the duration of their asylum claim (Preamble 7). In regard to health care the Reception Condition Directive states:

> 'Member states shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illness.....Member states shall provide necessary medical or other assistance to applicants who have special needs.'

The ICF (Information and Cooperation Forum), a network comprising human rights organisations in seven European countries, states that the Reception Condition Directive is vitally important, as it calls for qualitative improvements in the standards upheld by the member states. However the situation in reception systems in Europe remains varied, including in the field of health care.(9)

An extensive comparative overview of the implementation of the Reception Condition Directive assesses health care in a positive light. However, it draws attention to differences in the provision of medical screening, emergency care and essential treatment of illness, and organisation of access to health care.(10, 11) Similarly, other research indicates that, in spite of this attempt at harmonisation, health policies towards asylum seekers still differ significantly between the EU countries. This may result in the fact that health needs of asylum seekers are not always adequately met.(12) In this context, Hargreaves et al. refer to 'Europe's health-care lottery' for asylum seekers.(13)

Out of the 27 European Union countries, Ireland and Denmark are the only two that have chosen not to opt into the EU Reception Directive.(11, 14). At a national level, Irish health policy recognises that Ireland is, increasingly, a multicultural society and identifies asylum seekers and refugees as a marginalised community with specific care needs.(15, 16) The 2008 National

Intercultural Health Strategy is a more recent important development which shows commitment from within the Irish Health Service Executive to provide high quality care for ethnic minority cultural groups.(17)

Overall, we contend that while there have been some important initiatives that aim to ensure that asylum seekers' universal right to healthcare is protected, in practice there are problems with access to healthcare. This is problematic because asylum seekers have complex health and social care needs which are influenced by a myriad of factors including the experiences that led to their need for asylum (e.g. persecution and violence), the experience of being an asylum seeker in an unfamiliar country (e.g. language barriers, lack of knowledge of available services and supports, hostile responses from host communities) and the challenges inherent in that process of seeking asylum in their host country (e.g. long delays in the application process).(18, 19)

This research is concerned with the challenges inherent in the process of seeking asylum in their host country with a focus on the use of direct provision for asylum seekers.

Direct provision for asylum seekers

Direct provision is the term used to describe a specific accommodation policy for asylum seekers whereby they are accommodated in full-board accommodation centres run in an institutional style rather than private or self catering accommodation. Direct provision centres are spread across the country as a result of a related 'dispersal policy'. This involves moving asylum seekers to accommodation centres in different regions in order to share the resource burden equally amongst a wide range of local authorities.(20)

In Ireland, typically, accommodation centres are old hotels or hostels and they operate as a result of a commercial arrangement between the state and the accommodation centre owner. Residents receive €19.10 per adult per week, and €9.60 per child and child benefit.(21) They often live in shared, crowded rooms with very basic facilities and amenities.

National reports have emphasised that direct provision is a violation of basic human rights and research indicates that living in direct provision is linked with poverty, poor physical health, negative mental health and with specific problems for women's health in relation to pregnancy and child health.(e.g 22, 23)

Arguably, there is also an impact of dispersal and direct provision on health service providers because the volume and nature of their work would be affected by the arrival of asylum seekers

in their local setting. Of course this, in turn, could impact on the asylum seekers' access to, and experiences of, healthcare consultations. However, research on the impact of dispersal and direct provision on the work of health service providers is scarce. The available research is described below.

Impact of dispersal and direct provision on health service providers

A UK study examined the impact of dispersal on health care services and implications for service providers and their work. This study showed that health care providers were concerned about decision-making where to disperse asylum seekers: placement decisions seem to be based purely on accommodation availability rather than the capacity of local health care services. Healthcare providers in this study perceived that there was inadequate co-ordination by the National Asylum Support Service (NASS) and that this was the main barrier to effective and efficient delivery of healthcare for asylum seekers. Some specific issues mentioned were lack of notification about incoming dispersed asylum seekers, departure from agreed language clusters, inconsistent standards of NASS accommodation providers, high mobility of asylum seekers within the dispersal system and problematic bureaucracy intended to support asylum seekers. Most health care providers said that their principal problems arose from the number, diversity and irregular flow of asylum seekers.(24)

To date, the only research in Ireland examining the experiences of statutory service personnel at the frontline in responding to basic needs of asylum seekers and refugees focuses on the Community Welfare Service. (25) This study highlighted the challenges for staff when working with asylum seekers. They had difficulties working with, and understanding, cultural differences. They had difficulties with language differences and communication. They desired intercultural training to advance their knowledge and skills. They described problems with inter-agency communication and collaboration which negatively affected their frontline role. Overall, the study reflected direct provision in a predominantly critical light.(25)

Summary

To summarise, there are several international and national declarations and policies that aim to ensure that asylum seekers have access to health care. However, there are problems with access to healthcare across and between European countries. This is problematic because it is known that asylum seekers' health and well-being is negatively affected by a range of factors including the experience of living in direct provision accommodation. However, very little is known about the impact of direct provision on the organisation and delivery of health services, specifically, the

experiences of statutory and non-statutory service providers, regional health planners and local communities.

There is a strong interest in this issue in the Galway region from the Health Service Executive, Western Area Primary Care Department and a local non-governmental organisation, the Galway Refugee Support Group. This is because of recent experiences with the establishment of direct provision accommodation centres in the region: the sudden and unanticipated opening of direct provision accommodation centres which created a series of significant challenges for all stakeholders (asylum seekers, statutory and non-statutory service providers, regional health planners and local communities). The present research is designed to systematically examine the experience of all stakeholders in detail in order to make recommendations for policy and service provision.

Research Aims and Objectives

The aim of this research is to explore, with all relevant stakeholders, the impact of direct provision accommodation for asylum seekers on the organisation and delivery of the local health and social care services. Specific objectives are to:

1) Document experiences of different stakeholders
2) Identify specific needs of different stakeholders
3) Examine the extent to which these needs were met or not
4) Identify recommendations for future practice.

Section 2: Methodology

Research design

This is a qualitative study using a retrospective, case study design.(26) A case is a bounded system explored over time. In this study, the case is a direct provision accommodation centre located in a rural area in the west of Ireland. We name it Accommodation Centre A. The nearest village is located 4 km away from it. There is no access to public transport available from the accommodation centre.

The case study was initially designed to explore the accommodation centre in relation to its opening which happened with minimal notice for key stakeholders. During the course of the research, the accommodation centre was closed, also with minimal notice to stakeholders. The case study was thus extended to capture stakeholders' experiences around the closure of the centre as well.

Ethical approval for the study was obtained from the Research Ethics Committee of the National University of Ireland, Galway.

Sampling and recruitment

Purposeful sampling strategies (27) were used to identify 'information rich' participants. Information rich participants were stakeholder groups who were involved with the opening and closure of the accommodation centre or who were affected by that in some way. Three stakeholder groups were identified for this case study:

- Policy makers and service planners (national and regional)
- Frontline staff (statutory and non-statutory)
- Service users (local service users and asylum seekers).

Age and gender were also included as sampling parameters to ensure that a wide range of views were documented.

Potential participants were invited to take part in the research by letter or personal contact. Responses were monitored to create a database of interested participants from which sampling occurred. The majority of people who were approached did participate in the study. There were some people who did not take part; one frontline staff, a receptionist of a GP surgery, was not comfortable participating in a research project. Two local service users felt that they were unable

to contribute enough to the research question to merit participating. Three asylum seekers did not take part because they felt uneasy about signing a consent form and having their interview tape recorded. The final database comprised 40 interested participants, all of whom were interviewed (see Table 1).

Table 1: Overview of Research Participants

<table>
<tr><th colspan="2">Policy makers and service planners
(n=4)</th></tr>
<tr><th>Regional</th><th>National</th></tr>
<tr><td>Health Service Executive
• Development Officer (n=1)
• Senior Administrative Officer (Liaison Officer) (n=1)</td><td>Reception and Integration Agency (RIA)
• Staff (n=2)</td></tr>
<tr><th colspan="2">Frontline Staff
(n=19)</th></tr>
<tr><th>Statutory</th><th>Non-Statutory</th></tr>
<tr><td>Community
• General Practitioners (n=4)
• Area Medical Officer (n=1)
• Public Health Nurses (n=2)
• Director of Public Health Nursing (n=1)
• Assistant Director of Public Health Nursing (n=1)
• Health Promotion Facilitator/Tutor(n=1)
• Social Worker (n=1)
• Community Welfare Officer (n=1)

Hospital
• Managers, Maternity Department (n=2)
• Social Worker, Maternity Department (n=1)</td><td>NGO
• Refugee Support Group (n=1)
• Clann Resource Centre (n=1)

Direct Provision Accommodation centre

• Managers (n=2)</td></tr>
<tr><th colspan="2">Service users
(n=17)</th></tr>
<tr><th>Host Community</th><th>Migrant Community</th></tr>
<tr><td>Local (n=7)</td><td>Asylum seekers (n=10)</td></tr>
</table>

Policy and service planners

The **Health Service Executive (HSE)** is responsible for providing health and personal social services for everyone living in the Republic of Ireland. The HSE operates a two tier system whereby people with lower incomes and persons over 70 years of age are eligible for a General Medical Scheme (GMS) and are entitled to free medical care. All asylum seekers and some refugees have this entitlement. The HSE nominate liaison officers who are contact persons for the Immigration Officer. This position was held by the Senior Administrative Officer.

The **Reception and Integration Agency (RIA)** was established under the auspices of the Department of Justice, Equality and Law Reform in 2001. It replaced the Directorate for Asylum Support Services and the Refugee Agency. The RIA is responsible for coordinating the provision of services to both asylum seekers and refugees, coordinating the implementation of integration policy for all refugees and persons granted leave to remain in the state, and responding to crisis situations which result in large numbers of refugees arriving in Ireland within a short period of time.(28)

Frontline staff

Statutory

Irish **general practitioners** are independent practitioners essentially self–employed with contractual arrangements with statutory health authorities (Health Service Executive). Three general practitioners had their single-handed practices in the immediate area, located 4 km from the accommodation centre. One of these general practitioners was replaced by a new colleague during the sampling stage of the study. All four general practitioners were interviewed. Like the majority of practices in Ireland, these practices had a mix of private patients and patients under the General Medical Scheme (GMS).

Area Medical Officers are HSE staff. They provide paediatric developmental assessment, school medical service, child welfare protection, immunisation, infectious disease and surveillance and liaise with GP and other healthcare personnel in relation to asylum seekers. The Area Medical Officer in this study covered the village in which the direct provision accommodation centre was located.

Public Health Nurses are HSE staff responsible for nursing care in the community. There were two Public Health Nurses actively involved in the area. The regional Director of Public Health Nursing and the Assistant Director of Public Health Nursing were also interviewed.

Health Promotion Officers work to improve the health of the population by offering a range of services.(29) In this study, the Health Promotion Facilitator/Tutor provided a Health and Well-being course to residents of the accommodation centre. Funding for this had been provided by the HSE West Health Promotion Unit.

Community Welfare Officers are HSE staff with responsibilities to assess the need for social welfare and administer welfare payments accordingly. **Social Workers** are HSE staff with responsibilities to support family welfare and social needs. One community welfare officer and one community based social worker were interviewed, as well as one hospital based social worker who was affiliated to the Maternity Department.

Finally, frontline staff from the hospital setting were involved: two **Maternity Department Managers** from the regional hospital were interviewed.

Non-Statutory

In Ireland there are a range of non-governmental organisations (NGO) working with migrant communities.(30) The **Galway Refugee Support Group** is an NGO and, apart from two paid staff at the time of the research, acts in a voluntary capacity. It attempts to meet a range of needs of asylum seekers in Galway city, such as offering initial support and welcome, information on local services and facilities (e.g. GPs, hospitals, schools), information on the legal procedures, personal support and assistance, etc.

The **Clann Resource Centre** was established in December 2002 under the Department of Social, Community and Family Affairs and is part of the Family and Community Resource Centre Programme. Clann is one of almost 100 Family Resource Centres set up by the government under the National Development Plan (NDP) 2000-2006 and the Community and Family Resource Centre Programme. The main aim is to provide supports and services through community development principles.(31)

Finally, two **direct provision accommodation centre managers** from the accommodation centre under study were interviewed. One was based locally and the other in Dublin.

Service Users

In terms of the host community, there were around 45 inhabitants in the townland around the accommodation centre on which this case study is based. There were around 76 asylum seeker residents in the accommodation centre itself, mainly families, women and children. The nearest bigger village, 4 km away from the accommodation centre, had an estimated population of 1903 inhabitants.[1]

Seven local service users participated, among them two members of a local residents' committee and regular patients of the local GPs. Ten asylum seekers participated, all of whom were interviewed after the accommodation centre was closed down, and they had been dispersed to other accommodation centres in the country.

Data Collection and Analysis

Case studies use extensive and multiple sources of information in data collection to provide a detailed in-depth picture of the case. In this study, in-depth interviews,(32) relevant documentation such as related articles in the local newspapers, and reflective retrospective observations by researcher HPieper, who was also a GP involved in the case, were drawn on for analysis.

In the fieldwork with participants, in-depth interviews were carried out. Participants were asked to complete a consent form at the time of data collection. Interviews were recorded with participants' permission with a portable device and, later, fully transcribed. In keeping with the iterative nature of qualitative research, data analysis occurred immediately as the data collection began and was continued throughout the process of investigation. The understanding gained during early data analysis shaped subsequent phases of data collection decisions, e.g. it lead to 'snow ball' samples.(27) A thematic analysis following Silverman(33) and Morse(34) was conducted using NVivo software.(35) Fieldwork using in-depth interviews continued until theoretical saturation occurred, that is, that no new themes were emerging in the analysis. As stated in the previous section, a total of 40 interviews were carried out.

Four key themes were identified during the analysis process and these are presented in the results section.

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[1] We have sourced information in this section from official documents. We have not referenced them because we are protecting the anonymity of the case study.

Section 3: Results

The results are presented under four main themes:

1. Notification about direct provision accommodation centre
2. Planning and preparing appropriate health and social care
3. Skills for providing for health and social care needs of asylum seekers
4. Development of interdisciplinary support systems between health care professionals.

Box 1 below shows an overview of these main themes and the sub-themes relevant to each one. This box also shows the way in which the themes are interrelated. The first one has a 'knock on' effect on the second in that there was a lack of notification about the opening of the accommodation centre which meant that there was insufficient time to plan and prepare appropriate health and social care services. There was also no time to address the skills gap among health professionals to meet the needs of the asylum seekers. A key outcome, on the ground, was the development of an interdisciplinary support system between health professionals.

Box 1: Overview of Themes

1. Notification about the direct provision accommodation centre

- lack of notification
- stress and anxiety
- anger

2. Planning and preparing appropriate health and social care

- insufficient time for planning and preparation
- immediate impact on workload
- limited resources to respond appropriately

3. Skills for providing for health and social care needs of asylum seekers

- Lack of experience working with asylum seekers and skills gap among health professionals
- 'Mismatch' between mainstream services and specialist health needs

4. Development of interdisciplinary support systems between health care professionals

- Informal divisions of labour in professional networks
- New roles and responsibility
- Impact of new ways of working on asylum seekers

Data from some participant groups feature in each theme (e.g. statutory frontline community staff) while data from other participants feature in some themes only (e.g. policy makers and service planners). Box 2 below provides an overview of participant data per theme.

Box 2: Participant data per theme

Theme	Participant Group
Notification about the direct provision accommodation centre	Statutory frontline (community and hospital) staff Non-statutory frontline staff Local service users Asylum seekers Policy makers and service planners
Planning and preparing appropriate health and social care	Statutory frontline (community and hospital) staff Non-statutory frontline staff
Skills for providing for health and social care needs of asylum seekers	Statutory frontline (community) staff Asylum seekers
Development of interdisciplinary support systems between health care professionals	Service planners Statutory frontline (community) staff Asylum seekers

1. Notification about direct provision accommodation centre

It was known at the outset of this study that there was poor notification about the opening of the direct provision accommodation centre, and so it is not surprising that it features as a main theme in the analysis. This theme offers a systematic account and analysis of the effects of the poor notification.

A major finding is that the lack of notification caused significant anxiety and stress among most stakeholder groups, particularly frontline health and social care professionals from statutory and non-statutory organisations.

Frontline staff

Statutory services: community and hospital staff

Some health and welfare service professionals got very short notice. Others got no notice at all and heard the news locally, either on the day that the asylum seekers arrived or after they had arrived. This was the case across all statutory services.

> *"I personally remember being off on the Friday and getting the phone calls to say this was happening and did I know, em... there was no prior consultation there was no there was no preparatory time really, em... and that was very flooring" (GP1).*

> *"I just got a phone call from Dublin and all those birth times, children were coming through the fax so it was kind of a big shock for me. I just didn't know what was happening and my assistant director, when I rang her she wasn't aware of anything, you know so it was kind of gruesome really you know" (PHN1).*

> *"But I did feel there was very little notice for the team because we heard about the centre opening at the same time as other professionals and the community. It meant having to suddenly respond to the complex needs of the various nationalities, the language barrier caused difficulties as well as a lack of resources. These families were feeling very alone as they had no extended family support system". (SW1).*

> *"I heard it locally in the village, that the hotel was going to be used, it's only as they started to arrive, I mean I think they got a week's notice, they got very short notice I think of coming down, you know, so we got no notice from Dublin that they were coming" (Mat1).*

Non-statutory services

Similarly the Galway Refugee Support Group got no prior notification but got a phone call asking if they would help support the asylum seekers on the same day they arrived.

> *"He (RIA) said "they're on the bus, as I speak". So he rang me the day that the people were arriving, to see would we be able to offer some support, and that was the first I heard of it" (RSG).*

The lack of notification about the opening of the direct provision accommodation centre was also a cause of stress and anxiety for the local community at two levels: as local residents in the community, and also as service users of the local health and social care services.

Service users

Local service users

Community members reported similar experiences to frontline staff, and the lack of notification about the opening of the accommodation centre made them feel that they had been "left out of the loop" of the decision making processes.

> *"Never once did anyone ever approach our community to say, "let's have a meeting, we want to give information" you know, never once did the government, or the Management Company that had taken over the dispersal centre, nobody ever approached us, wanting to meet with us, and inform us" (LSU2).*

Different aspects of the community's response

There were different aspects to the community's response. In keeping with newspaper reports at the time, there was quite a lot of negativity. Some community members had the feeling of having been deceived.

> *"All our hopes were built up that there was going to be another bit of life back in the centre of our little village, and we were misled by the owner, and by all the people, that it was going to be a centre for tourists, for foreign students, for a nursing home, different things like that" (LSU1).*

For one participant there was negativity toward asylum seekers themselves, for instance concerns over issues such disease and a potential increase in crime rates.

> *"I am also worried about the coloured [sic] people from Sudan, Nigeria, Mozambique and these places that from a disease point of view. That they shouldn't, from what we hear AIDS is prevalent there and some of them must be coming in with disease and they are not being scrutinised at the point of entry"(LSU3).*

> *"Now they [asylum seekers] are responsible for a bit of crime as well" (LSU3).*

Interestingly, it is clear that, over time, these fears were not borne out:

"I think a lot of people were afraid when they [asylum seekers] came and then I didn't hear of anything. they probably thought that there was going to be vandalism and all that which there wasn't" (LSU4).

"So a lot of the older, local people, were afraid at first, they thought maybe, you know, this could be a bad, maybe these people could be bad, they didn't know" (LSU2).

Others discussed their concerns in relation to practical issues that had implications for the asylum seekers and the wider community. For instance, some emphasised the fact that the location of the accommodation centre was unsuitable because it was in a rural location with poor transport links. There were concerns that this would cause isolation among the asylum seekers.

"I think they [asylum seekers] were very unhappy with, I suppose, being so isolated, so rural, and no facilities. They felt that if they were in Galway City, at least they could go to language classes, go to learn English, they could, they had to rely on bus journeys to bring them in, and there was only one bus journey a day. then their concerns were highlighted and maybe in fairness we spread that in the local media, and they started to run two, the centre, there was, the company that was running the centre started putting on two daily runs to Galway City, and coming out in the evening. But we felt that, you know, having eighty-six people in on top of a population of fifty, in a rural area, and we felt it was unfair on them, and definitely unfair on us as well"(LSU 1).

Another practical concern was that of overload on the sewerage system given that there had been problems in that area previously.

"We also had concerns over pollution, because there had been pollution in previous years, with raw sewerage and faeces going into the lake, and we took samples at the time, that was back in the nineties, with the previous owners, and then the previous owner had applied for an extension... and we then appealed to An Bord Pleannála[2] we won it there, and we had the same concerns with it then, as we had with the centre being opened, and the refugee centre...because we felt, such a rural area, adjacent to a lake is classified in the Galway County Development Plan as a scenic, high visual amenity area, and we felt that having that intensity of trade in a small area would be a major

[2] An Bord Pleanála (English: *The Planning Board*) is a nominally independent statutory administrative tribunal that decides on appeals from planning decisions made by local authorities in the Republic of Ireland.

concern to us. It was a concern back in ninety-seven, when we posted, when we won our appeal with, An Bord Pleanála and it was a concern again now, so (LSU1).

Asylum seekers

The sudden opening was not considered problematic for the interviewed asylum seekers. Interestingly, asylum seekers expected some antagonism from local service users about their arrival, but they were surprised that they did not experience negativity.

We were surprised we thought that people in the village they didn't like us, that we should all leave, that they should close the hotel, but we never seen or come across any villager, at the end they were nice to us. The few we met were really nice. They were even bringing things to the hotel for us" (AS5).

Policy and service planners

Interviews with staff from the RIA and the HSE reveal some insight into the lack of notification about the opening of the accommodation centre. Both acknowledged difficulties as a result of it and explained and emphasised the unusual circumstances.

First, an amendment to the Irish constitution in 2004 meant that from January 2005 it was no longer possible for persons born in Ireland to obtain automatic Irish citizenship (see box 3). The Department of Justice, Equality and Law Reform accepted applications to remain in the state under the previous legislation up to March 2005.(36) As a result, in addition to the regular inward flow of asylum seekers for that time (4,323 in 2005), an additional 17,917 people arrived.(37)

Box 3: Information on Amendment to the Irish Constitution, 2004, as stated in the National Intercultural Health Strategy 2007-2012 (37)

"**Legislation for Irish-born Children"**

Following the Citizenship Referendum in 2004, changes in citizenship provisions were enacted in the Irish Nationality and Citizenship Act 2004, which was commenced on 1 January 2005. From that date, it was no longer possible for persons born in Ireland to obtain automatic Irish citizenship. New procedures were announced regarding the consideration of claims for permission to remain in the state from the non-national parents of Irish-born children. Via the special scheme then operated by the Department of Justice, Equality and Law Reform, non-national parents of Irish-born children born in the state before 1 January 2005 could apply for permission to remain in Ireland on the basis of such parentage. As of 31 January 2006, of the 17,917 applications submitted under this scheme, 16,693 were approved and 1,119 given refusal decisions. The breakdown of the status of approved applications comprised 10,032 asylum

seekers, 2,455 "workers" and 972 students. The remaining 3,243 comprised people from a range of categories, including people residing illegally, people of whom the Department of Justice, Equality and Law Reform DJELR was previously unaware, and so on."

This meant that the RIA had to provide around 8,000 additional people with accommodation (personal communication, RIA), which put huge pressure on the agency. The RIA explained that a search for suitable locations had to take place and that selection decisions about suitable accommodation centres had to be made quickly. Consultations with the community are generally not done, because in previous cases public debate and opposition has led to scenarios in which accommodation centers could not be opened. In particular the urgency of the situation was seen as over-riding any need for consultation with the community.

> *"Against that background then the referendum in 2004 changed that constitutional position and in order to allow a little bit of leeway for people who might have some doubt about whether they had the child born before the change of the referendum or after it or whatever, the government effectively allowed a little bit of breathing space for people and they put this deadline of the end of March in 2005 on it. So that is what gave rise to the eighteen thousand people coming back to the country to make their claim for Irish born status for their child, and as (RIA2) said then, we accommodated some eight thousand of those, and that was in addition to the normal stream of asylum seekers coming in. So you can see from that, that if we had as many as we would have had over a three month period in 2005, from January to March 2005, in addition to having the regular intake of seventy or eighty a week of asylum seekers coming in, we had this huge storage of an eight thousand coming in on top of it, and that necessitated going to the market to get some additional accommodation" (RIA1).*

> *"When people are coming at you, you know to be housed and accommodated, you don't have the luxury of saying, 'well, you hold on there for a while till we go and consult with some local community about where we're going to put you', you know, you have to get, if people arrive in today you have to have a bed for them tonight, you know you can't expect them to wait a week or a fortnight or three weeks, you know, and that is, those are the kind of constraints under which we were operating as an agency, and (Accommodation Centre A) is that, came in at that very, very busy time" (RIA1).*

> *"...to be opened very, very quickly because the alternative was that we would have people with nowhere to go and they would end up sleeping in parks or on benches in*

parks and stuff like that you know, and we obviously, our responsibilities under the Geneva convention etc. and all the European legislation, we had to make sure that we accommodated all of the people that were coming into us you know" (RIA1).

"If you go to the community initially, there's all sort of opposition being vocalised and voiced about it and the politicians get involved in it and everybody wants something done but not in their back yard, you know it's that kind of scenario, so that leads us to the position where we have to just go and get stuff, and you know try to get it up and running pretty much before anybody kind of knows anything about it you know, because the state invested monies in six major centres around the country that we thought were going to happen and go off the ground, they never did and a lot of money effectively went down the drain as a result of it, and that's not a luxury we can afford, right" (RIA1).

In addition, consultation with the HSE did not take place as it was feared discussion would be passed on to the local community and hinder the opening of the accommodation centre:

"In ordinary circumstances that would be applied today because the numbers are relatively stable. If we were in a position where we, for whatever reason we decided we were going to open another centre in the Western region, that would allow us a little bit more time and you know, the current circumstances would allow us a little more time obviously to liaise with the HSE in the West and educate the providers and so on, but that was not the predicament we were in, in early 2005" (RIA1).

"We were caught in a dilemma when the, particularly when the old Health Board structures were there, that if we advised the Health Board Management confidentially about a centre being opened, the Health Board Management felt obliged to advise their board members which they had no choice in doing, they advised their board members that such and such a thing was happening, once the board members got wind of the word that such, that a case was opening, the whole plan came apart at the seams you know, because there was a certain political turmoil at local level created about the whole thing" (RIA1).

Second, at the time the HSE liaison officer with a remit for asylum seekers was on sick leave. Therefore, there was no point of contact for the RIA at the local HSE. This meant that there was a significant 'gap' in communication that inhibited planning and preparation for this new development.

2. Planning and preparing appropriate health and social care

The lack of time for planning and preparing appropriate health and social care had an impact on all frontline staff. There was a range of specific problems and challenges. These are shown in Box 4 below. It is clear that some were shared by staff (e.g. lack of access to medical records, overcrowding in health and social care facilities) and others were specific to certain staff (e.g. increased need for foster care for social work services).

Box 4: Summary of perceptions of frontline staff

Statutory (community)	
GPs	• Most asylum seekers young mothers, many children, some pregnant within days of delivery • No medical cards available • No medical notes available • No clarity about previous tests - possibly repeated unnecessarily • Waiting room overcrowded
PHN	• No medical notes available • No clarity about previous procedures, e.g. vaccines • Waiting room overcrowded
CWO	• Waiting room overcrowded • LSUs' ill-feeing towards AS • LSU stopped attending
SWO	• Foster places for children during hospitalisation of AS required, drain on resources
Statutory (hospital)	
Maternity	• No medical notes with antenatal history • One AS in labour 48 hours after arrival • Overcrowding with visitors, non-adherence to visiting times
Non-statutory	
Refugee Support Group	• Out of their geographical region and official remit • limited resources to respond

A descriptive account of the issues for each staff group is provided below.

Frontline staff

Community statutory services

From the community based frontline staff point of view, the lack of notification meant that there was insufficient time to plan and prepare appropriate health and social care services. This caused stress at a professional level. They also experienced an immediate impact on workload and had limited resources to deal with this.

This was felt most by the general practitioners. Most asylum seekers were young mothers with small children. Some were pregnant within days of delivery with immediate health needs. In light of the urgency the general practitioners initially provided their service free of charge, as the vast majority of the asylum seekers had only recently arrived in Ireland, and did not have a medical card yet.

Before obtaining a medical card it was necessary to clarify who of the three local general practitioners would agree to accept the asylum seekers as patients. This decision making process was time consuming and required several meetings of the general practitioners. Some of the general practitioners felt uneasy accepting more patients, as they already had very busy practices. Having to make such long-term decisions under pressure caused anger and anxiety among GPs.

> *"So there was a lot of frenzied activity and a lot of concern and it was very stressful" (GP1).*

.

> *"I suppose I had a busy practice em… I wasn't in any way ready to take on even, you know, 100 new medical card patients" (GP1).*

> *"There was a lot of anxiety among the GPs, they were from workload, now thinking of (Accommodation Centre A), so many people being out there, without any public transport, would that mean loads of house calls" (GP3).*

General practice waiting rooms were overcrowded due to patients arriving in great numbers and being unable to leave because of lack of transport from and to the accommodation centre. The concerns of the GPs about this were also recognised and acknowledged by the Development Officer of the Primary Care Department in the HSE.

"The immediate pressure of the residents arriving at the surgery in great numbers, and it causes, I suppose, because surgeries have physical limitations, and the size of surgeries weren't large enough, or waiting rooms weren't large enough to cope with the number of people that were going to be waiting at any one time" (PCD).

In the course of the meetings and negotiations between the general practitioners, it emerged that one GP was in a position to accept all asylum seekers as patients. This will be described in more detail in section 4, pages 38-40 of this chapter.

Following this decision, medical cards were provided very quickly, which was positive given that it normally takes a couple of weeks for applications to be processed.

Anxieties and concerns were not restricted to the general practitioners alone but permeated throughout the frontline statutory and non-statutory services. It was generally felt that the lack of notification had impacted on workload, whereby prior notice would have meant that preparations could have been made in advance. For instance, there was a particular problem arising from the fact that no records were available for the asylum seekers about prior medical history, treatments or procedures. Very few of the asylum seekers themselves had been given notes to bring with them. Advance notice of their arrival may have given some time for notes to be located. In the absence of notes, there was duplication of tests and procedures and consequent resource implications:

"if the Department of Justice had notified us in advance that (Accommodation Centre A) was going to be set up and maybe then we might have been able to have provisions ready for them" (CW).

"I suppose the first impact would be the liaison office here, when information is received from Dublin, into the liaison office, about the number of children coming to (Accommodation Centre A), and the number of ante-natal clients, and we didn't actually have proper records or information on these clients when they were coming" (PHNM).

Finally, the issue of overcrowding of waiting rooms, and the negative public experiences and perceptions around that, were evident again:

"But in that case now they're waiting 2½ hours and a lot of my clients would be elderly from medical cards and such as things like that so they felt that, they felt that it was

being taken over by asylum seekers which wasn't the asylum seekers' fault but it looked like that, priority was being given to them which it wasn't" (CW).

"...because the waiting area of 2½ hours was too long for a lot of people that instead of coming in and say 'I have a problem' they were kind of pushing the problem away and now it's got bigger you know we're kind of, we'd say it might have been a problem with the ESB bill and they'd leave it for another 3, 4 months" (CW).

While some of the other statutory services weren't affected in terms of space, other issues arose. For instance, maternity service and social work staff described a particular problem around childcare. Childcare was a major issue for the asylum seekers because they did not always have someone to care for their children while they were at appointments or in-hospital stays.

"She (asylum seeker mother) may have two toddlers or another small child with her and obviously the child can't stay in the hospital and again having moved from an area where there was support to an area where maybe she doesn't know anybody else, we've often ended up having to organise foster places through community care services. And again it's very traumatic for the child, it's traumatic for the mum, it's a massive use of our resources as well" (SW2).

Hospital

The maternity services experienced significant difficulties because of the poor notification and lack of medical records for care management. The most dramatic example relates to an asylum seeker who went into labour just 48 hours after arrival at the accommodation centre. She was brought to the hospital with no ante-natal history available and staff had a lot of difficulties.

"She would have had no chart, no ante-natal care here, so no past history, so we'd have to research all that information out of her, and who wants to be giving that when you're in the throes of labour, it's hard to get it out, any of her previous history, if she'd a PPH[3] or section, had a history, any medical history, or previous abnormality, or you know, just blood disorders, we didn't know any" (MAT2).

Another difficulty experienced by the maternity services was in terms of adherence to hospital visiting times. While acknowledging that this was partly due to cultural issues, and partly due to

[3] Postpartum haemorrhage (PPH) is excessive bleeding following the birth of a baby.

the circumstance in which the women were living, it nevertheless caused some difficulties for staff.

> *"They would stay long in to the evening, and the staff found that difficult, because they didn't come as one person, they probably came with a lot of children. And it wasn't because they were non-nationals, it was just, the staff found it difficult to manage, from ladies down there, visiting other ladies, they were from (Accommodation Centre B), and they were from a one-room environment, and, they didn't want to go back to that on a winter's evening, it was easier to be downstairs, so it was just trying to explain all that to staff, that it's not as easy as telling them to go home, and that was the reason they used to hang around here, you know, so its hard on them really" (Mat1).*

Non-statutory services

The Refugee Support Group also had very short notice of the opening of *(Accommodation Centre A)* and while the geographical area was out of their remit and they were under-resourced they felt that their support was needed.

> *"At a human level, you felt that these were people who were being planted in the middle of the countryside, and that you couldn't in conscience leave them without any resources or support or contact. So our Management Committee decided that we should visit, and try and organise some meetings with the residents out there, and just talk to other people in Galway City."* (RSG)

3. Skills for providing for health and social care needs of the asylum seekers

Frontline staff: community and hospital

Most statutory frontline staff emphasised that they did not have experience of working with asylum seekers. They found it difficult to suddenly respond to a new group of service users because they felt they lacked skills to provide health and social care.

> *"Well it was very difficult, it was very difficult to suddenly be faced with the situation where you were going to have a whole population group with probably very different needs to what you were used to, em you didn't, you didn't have any direct experience in that area and there was no, there was no kind of preparatory work" (GP1).*

> *"I wouldn't have had a lot of experience in that area. My role was made more difficult and was usually complex due to the different cultures and experiences of the asylum seeking families. Due to the movement of families and my short term involvement, it was difficult to link families into services for support".*
> *(SW1).*

> *"Well I'm not a psychiatric nurse, and most of the clients have had either post-traumatic stress, or depression, or anxiety, or suicidal tendencies, they're post-trauma, post-rape, post-torture, and I mean, like I dealt with it, but I was only giving a band aid service as well, because I'm not qualified like that, you know*" (PHN3).

For some frontline staff, there was a particular 'gap' in experience and skills in relation to mental health needs of asylum seekers. One social worker made a direct link between mental health issues and direct provision accommodation.

> *"The direct provision system has created massive difficulties in terms of people's coping ability…and working with a lot of refugees and asylum seekers, and people are so displaced anyway, but that arbitrary movement of people certainly raises stress levels, raises anxiety, cuts people off from where they're actually beginning to make, you know, a system where they're integrating, and it really causes them lots of difficulties, you know" (SW2).*

This lack of experience and gap in experience and skills in relation to mental health is indicative of a more general 'mismatch' between the services designed for 'mainstream' service users and asylum seeker service users living in the direct provision centre under study. Put simply, the work

that they were planning to do with the asylum seekers based on work in 'mainstream' services was just not what the asylum seekers needed, or indeed wanted.

> *"I asked her (public health nurse) to go out and try and start up a breast feeding support group, and to help the nurses on the ground. But she found, her experience was, that the mothers had so many [personal] problems, that she had to deal with, in conjunction with the Area Nurses, that she really, that the focus of health promotion really wasn't (inaudible) at the time, it was all the other issues that they had, you know, relating to their own personal lives" (PHNM).*

The health promotion worker found that the methods and sessions she was used to working on with other groups did not work with this group, and she felt out of her depth in dealing with issues in which she didn't feel qualified.

> *"And every time I would come in to kind of do a piece of work, it might be looking at culture or it might have been just looking at diet, I really got the sense that I was out of my depth, "what am I actually doing here"? Am I encouraging them to be empowered, which is often one of the key areas of the work that I do, is to empower people to take responsibility for their own lives, but this can be very difficult when you're dealing with a grouping that have very little control over their circumstances, which was about as impossible as whatever." (HP)*

However, over time and with increased discussion with the women they came to understand each other and the issues that were of most concern.

Box 5 below provides a summary of the emerging issues and the frontline staff for whom these issues arose:

Box 5: Emerging issues of frontline staff

Emerging issues	**Frontline staff**
Lack of experience working with asylum seekers	GP, PHN, HP, SW, CW
'Mismatch' between mainstream services and asylum seekers' "specialist" needs	PHN, HP, CW, SW

Service users - asylum seekers

The asylum seekers themselves found it difficult at first to adjust to a different health system and it took a while for them to understand how it works, particularly in terms of medical treatment.

> *"(Translator)...she felt that GPs often wouldn't give her any treatment at all. However, she noted that in the hospital hardly ever treatment was given. She found that in Algeria this was very different that doctors and pharmacists in Algeria would always give medication. She wondered if possibly her own expectations would have been too high in this country. Maybe there is a difference between Algeria and Ireland in that respect" (AS7).*

The lack of information that the asylum seekers were given in terms of supports and services in turn led to extra pressure on some services when newly arrived asylum seekers would turn up at the inappropriate service looking for information.

> *"They were coming in asking me questions about different organisations and things like that which I didn't know about myself because I hadn't dealt with asylum seekers full time before. I had to find that information for them and they were coming back a second week, a third week to get this information with other questions, whereas a lot of that could have been dealt with by phone so I spoke to the manager and said if there's questions like that feed the phone so they're not holding up the clinic on other people and if they had to come in to me for money or emergencies come in" (CW).*

4. Development of interdisciplinary support systems between healthcare professionals

The first three themes describe key reactions to the situation that developed in the local area. This fourth and final theme describes the main responses by statutory and non-statutory staff.

Meetings to plan responses and service delivery

There was shared concern among frontline staff that solutions must be sought and a number of formal meetings were organised to attempt to address some of the main concerns. For instance, the Reception and Integration Agency (RIA) organised a formal meeting three weeks after the opening of the accommodation centre, which all relevant frontline staff were invited to attend. Most attended.

> *"I attended a meeting at (location) and most of the professionals that were dealing with (Accommodation Centre A) or their direct bosses were there, and everyone expressed difficulty, resource difficulty, time pressure, and they didn't perceive they were able to cope with all of the additional work that would be involved in (Accommodation Centre A), especially because the number, the large number of women who were pregnant, and because of the number of young children, and the immediate work implications of all of that" (PCD).*

However, despite this *formal* meeting, frontline staff from statutory services felt that there was no formal response, that is no concrete actions or supports for their day-to-day work. Many health service providers felt that they did not receive the support they needed in order to be able to cope effectively with the problems and workload arising from the opening of the accommodation centre. What transpired was that many health and social service professionals had to proactively and *informally* seek support from each other to help them with their new work. Table 2 provides information on the formal and informal meetings that occurred across participant groups and it is clear that there were far more informal meetings than formal ones.

Table 2: Summary of reported meetings

Summary of reported meetings		
	Formal	**Informal**
Frontline staff		3 local GPs (1st week after opening) Dedicated GP with • PHN (1st week after opening) • Manager accommodation centre (2nd week after opening) • Fellow in Asylum Seeker and Refugee Healthcare local university (3rd week after opening) PHN with • PHNM (1st week after opening) • Manager accommodation centre (1st week after opening) • Health Promotion tutor (4th week after opening)
Policy and service planners	RIA, HSE, all frontline staff (3 weeks after opening)	HSE/PCD with • GPs (2nd week after opening)
Service users (local)		Local residents' committee (1st week after opening)

As a result of these informal meetings, two interrelated responses were documented:

- Divisions of labour in professional networks
- Negotiation of new roles and responsibilities.

These are explored below with two illustrative examples in relation to the informal responses of (i) the general practices involved and (ii) public health nursing and health promotion staff.

General Practitioners

Informal division of labour

In the initial phase of the opening of the accommodation centre, and before the formal HSE meeting, the three local general practitioners in the village held a meeting to discuss how they would cope with the increased workload and potential problems:

> *"And shortly afterwards, I think the Wednesday of the next week or so, we had a meeting with these three GPs, and mainly there were a couple of issues, there was a lot of anxiety among the GPs, they were from workload, now thinking of (Accommodation Centre A), so people being out there, without any public transport, would that mean loads of house calls?" (GP3).*

The outcome of this meeting was that one general practitioner agreed to take on responsibility for the entire group of asylum seekers.

> *"And as it turned out in this project there was a GP in the locality who was willing to take the whole project and run with it you know" (GP1).*

This was because he had a smaller practice size than the other GPs in the area and, therefore, was able to provide a solution to the potential workload issues. He also had an interest in the area.

> *"It was very interesting to have people from abroad, and I have worked abroad, I have worked in developing countries before, so I have traveled an awful lot, so I really like that international flair, so I thought I can learn something from it, first thing, I don't have to go out to do developing work, I can do it in (local village) also, the challenge, so from that point of view it was nice, I was happy enough with that" (GP3).*

While some support was offered from the Primary Care Department to this general practitioner, he felt that, in practical terms, he had to seek support for his role rather than the support being automatically provided.

> *"I actually made, when I took the asylum seekers on, I found out that there was a GP in NUIG who was involved in asylum seeker health care, so we met for lunch... If that hadn't happened, now I wouldn't have had any support...but there was no, I thought there was lack of support from the HSE probably and the Reception and Integration Agency" (GP3).*

The fact that one GP took on responsibility for the residents of Accommodation Centre A meant that its opening had very little impact on the other GPs in the area.

> *"And as it turned out it impacted very, very little on the practice" (GP1).*

However, this decision did impact on the dedicated practice in many ways. The challenges were mostly related to an overcrowded waiting room, transport issues and negative attitudes among the community. These do reflect some of the material already presented in relation to the concerns and fears people had about the arrival of asylum seekers in the town (see Box 6 below).

Box 6: Summary of issues affecting the dedicated GP practice

Overcrowded waiting room

"...the bus came, and a whole bus load (inaudible) small waiting room, and all that, from the ten people who fit in the waiting room, but if a bus comes there with six mothers and three/four children, and then that room is full, the problem there was actually, and the bus came, filled the waiting room, and after having been seen by ourselves, or by myself, it wouldn't disappear, and go out of the surgery, but come back in the waiting room, and wait until two or three hours later, the bus would pick them up again" (GP3).

Reactions to overcrowding by local service users

"For other patients coming in they came in and they saw you know a waiting room full of coloured [sic] people which was a challenge to their psyche, in a lot of cases" (GP4).

"Well there'd be a few of them in the waiting room. Now maybe they had appointments ahead of me but my time came for 11 o'clock and like why they wouldn't be, I could have been somebody going to work, and they weren't going to work so I don't know whether that would be, that would be a selfish way of looking at it, but mm, I think there was three of them in it and I think two of them got called before me but I was going to rear up if the third one was called" (LSU3).

This meant that the dedicated GP had to take on new roles and responsibilities to manage the situation.

New roles and responsibilities

The dedicated GP tried to educate the asylum seeking service users about appropriate use of primary and secondary health care services in Ireland. He visited the accommodation centre and provided staff at the reception desk with information leaflets.

"I tried to organise that chaos which was there in the beginning, while as well instructing the asylum seekers, how to deal with emergency services, how to, when they, to educate them basically when not to travel, that you can't be seen on the same day possibly, that you need an appointment, you need to make an appointment, and you should make an appointment for yourself, and not expect to be seen with the whole family. So I, the next day, organised that leaflet went out to (Accommodation Centre A) tried to explain how to, in a friendly way, how to work that" (GP3).

He also addressed potential negative attitudes among the community by displaying information leaflets about the current Anti Racism Strategy and multicultural welcome posters in the waiting room of the surgery. He had obtained this material after networking with the local Refugee Support Group.

"So I made contact with (Refugee Support Group). I didn't even know that that exists, so, and I got information leaflets... I tried to educate the people about the asylum seekers, and Anti-Racism Strategies, put them out in the waiting room, and tried, in a way, to make the presence more welcome, basically to bring people together" (GP3).

Impact of new ways of working on asylum seekers

However, the existence of a dedicated general practitioner for the asylum seeking service users had a positive impact on their own experience and perception of the health services, both in terms of the speed of originally accessing a GP and of the service provided to them. The asylum seekers who were interviewed did not feel that there were any problems relating to overcrowded waiting rooms, nor did they feel like they had experienced any negative attitudes from other patients.

> *"When we came that same day they were very accommodating, because it was the evening time, the manager was there, the social worker was going to come the following day. And the following days the social worker came, she came and she attended to us and she assigned Dr. Pieper as our GP" (AS5).*

"When we came we didn't know any GP, we didn't know how to get a GP so it was arranged by the social worker and we were sent a letter telling us how we have a GP" (AS3).

"Mm, well I think GP wise we didn't have any problems, if my children are really sick, I didn't have any problem with the GP" (AS4).

"Well I think GP wise we didn't have any problems" (AS4)

"No, no. it was fine. It was very positive" (AS3).

Although, overall, being very positive about his engagement, the dedicated GP was also critical about the arrangement of being the *only* local GP caring for asylum seekers. His main concerns were in relation to the set up of a 'segregated' service and the economic impact that would have on the earnings for that particular general practice.

"I know people, some people talked about the black surgery, and where the coloured [sic] people would go to. I think some patients chose as well to go to a different doctor at the time because of that" (GP3).

"Yes that has an economic impact on the surgery if private patients don't come any more. but more importantly I think it just inhibits the inter-cultural growth and understanding if there is one specialised practice. I think if everybody has a share and then it's easier for the communities to grow together and to learn from one another" (GP3).

Public Health Nursing and Health Promotion

Informal divisions of labour

Another good example of this informal division of labour relates to the public health nursing and health promotion activities. As mentioned above, the health promotion worker found a mismatch between the mainstream services or activities in health promotion and the specialist needs and issues for asylum seekers. The health promotion worker brought the issue to the attention of her manager but, as the quote below indicates, was lacking a clear precedent or pathway to follow:

> *"So I approached my Department where I work from, and I put this to my section leader, the person who would be over me, and she also found this to be a new area of need and wasn't quite sure how to proceed. This was an area that has very little documented. There is no-one that I know who has talked about working on the ground before, in this kind of way." (HP)*

The public health nurse involved had a similar experience in relation to the mismatch between mainstream services and the needs of the asylum seekers and she describes the way in which she approached the mismatch by talking with the asylum seekers themselves:

> *"I got very little orientation into (Accommodation Centre A), I kind of self-directed myself to meet up with all the clients... literally in the beginning I just went knocking on all the doors, introducing myself, and asking the clients what their health issues and concerns were" (PHN2).*

Then, a chance encounter between the health promotion worker and the public health nurse led to a shared sense of the problem and an increased confidence that they could work out a solution together. They worked towards building up a program of work addressing the needs of the group. This involved additional work and new roles and responsibilities for each worker in the sense that they had to modify their approach and negotiate a new and appropriate programme of public health nursing and health promotion. For instance, they identified the relevance of group work rather than one-to-one work with the asylum seekers and modified their work accordingly.

> *"But the minute that I met up (the PHN2), we said "ok, lets look at what is actually needed, and create a support around that". So for instance, she had the expertise and knowledge of healthcare, and she had the expertise to provide the things that they needed most. In other words, "do I change the diet with my child", you know, practical*

elements, which was far more empowering than talking about things that were not in their control. They needed more security in what they knew and experienced, like what is suggested in the Maslow triangle, before they could utilize empowerment and move into the self actualization, if you want to put it that way." (HP)

And I had the expertise of the group work, so for instance I could manage the group, and instead of her (PHN) doing one-to-one sessions only, which she had been doing her best to do before, and they weren't attending, or very few of them were attending, they could also start to become a group, and this was very powerful."(HP)

Through interaction and discussion between the hostel workers, the public health nurse and health promotion worker, some inroads were made into identifying what the pertinent needs of the group were and plans were made and programs put in place to address those issues. Over time and with increased discussion with the residents they came to understand each other and the issues that were of most concern. One of the frontline managers of the accommodation centre described this:

"I think that at the beginning it was, we told health care [public health nurse] what we needed, what problems we have here and then she prepared a program. And then she started to train the residents week after week. It was funny because at the beginning she was so surprised because she showed me her program and it was completely different, well because they need more basic things to learn. Like even open the window or how to dress the baby here in this, because it was like you know sometimes the baby was in a shirt and I don't know maybe some blanket on it and whether it was almost like this, outside, you know you have to cover more. So they really, really needed basics, how to treat the baby, that the room must be clean and tidy. And the food should be in the fridge" (MAC).

5. Closure of Accommodation Centre A

After the urgency of the situation had calmed down, Accommodation Centre A was closed only a year later, in May 2006, and asylum seekers were dispersed to other direct provision accommodation centers in Ireland. The reason for the closure was the decreased demand on accommodation after a lot of applicants had been given permission to remain in Ireland on the basis of parentage under the legislation of the Irish born child.

> *"A lot of those people, a lot of the people within direct provision subsequently achieved leave to remain, and in actual fact I think we lost about three and a half thousand people out of our direct provision beds in a very short space of time once they were processed. And that resulted in it being closed quite quickly because the numbers went down" (RIA1).*

It appeared that this was hardly noticed by the interviewed members of the local community. Across the health services the closure was regretted, mainly because continuity of care was, again, interrupted. This was particularly the case for the general practitioner and the public health nurse.

There was worry and stress at the outset over the potential impact that the arrival of the asylum seekers to Accommodation Centre A could have had in terms of access to their own service provision, as well as the impact on workload and on other patients. However, most interviewees agreed that over time, as the residents had settled in and had become more knowledgeable about how the health and welfare system worked, there had been a feeling of everything settling down. The broad view was that over time the residents had become settled, services were working out well and the impact on the general community and local service users was minimal.

When Accommodation Centre A was closed, again there was lack of notification. Health and social services were only informally notified about the closure when word spread from asylum seekers or management of the Accommodation Centre A to frontline staff. In the case of the community welfare officer this had a highly beneficial effect on her work. Thanks to having got informal advance notice and knowledge about where the residents would be dispersed to, she was able to prepare files of residents and direct them towards the appropriate offices on the receiving end.

> *'I had been prepared these people were going to be transferring out of (Accommodation Centre A) and a lot of them, a lot of the residents themselves had come into me and they were telling me that they were going and they could tell me well I have a letter here to say I'm going to (Accommodation Centre B) or I have a letter here to say that I'm going to up*

to (Accommodation Centre C) in Dublin so they knew where they were going but again we were the last to be informed by the services.' (CWO)

Section 4: Discussion and Recommendations

Introduction

Asylum seekers have complex health and social care needs, some of which are due to their experiences of seeking asylum in their host country. For instance, there is important international and national research about the negative impact of living in direct provision accommodation on the health and well-being of asylum seekers. However, very little research has been done on the impact of direct provision on the organisation and delivery of health services. This, arguably, impacts on asylum seekers' health and well-being as well as the experiences of statutory and non-statutory service providers, regional health planners and local communities. It is necessary to know more about organisational level impact because organisational context influences decisions about resource allocation within the health service, and also shapes professional behaviour. These factors, in turn, create a healthcare experience that is responsive, or not, to the needs of asylum seekers.

The present research focused on the organisational level impact of direct provision accommodation on the healthcare services. It was designed to examine the experience of all stakeholders involved in order to make recommendations for policy and service provision.

Study design strengths and limitations

We used a qualitative approach, specifically a retrospective case study design. We focused on the case of a sudden and unanticipated opening of a direct provision accommodation centre (referred to as Accommodation Centre A) in a rural area in the West of Ireland which was known to have created a series of significant challenges for all stakeholders: asylum seekers, statutory and non-statutory service providers, regional health planners and local communities. We obtained a sample of 40 participants which is large for a qualitative study. We highlight that there was very good representation across participant groups. We were particularly pleased to have participation from the asylum seekers who were residents in Accommodation Centre A because they had moved from the area at the time of the research. It was important and valuable to make appropriate efforts to include their voices in the case study.

We used semi-structured interviews to gather data from representatives of all stakeholder groups. Although these are retrospective in nature and based on people's recollections of past events, we note the concordance of accounts from different participant groups, and also the resonance of the accounts with available documentation from that time (e.g. media reports). Through these interviews, we obtained in-depth descriptions of participants' experiences and their reflections on these. The research team involved in data collection and analysis was comprised of a general practitioner researcher and two social scientists. This multidisciplinarity is known to enhance qualitative analysis and is highlighted here as a positive feature of the research process.(38)

Another interesting feature of the study methodology was that one of the researchers (HPieper) was a GP involved in the case study. This offered a unique opportunity for him to provide retrospective observational data, and also to comment on the 'credibility' of the emerging findings. We are also aware, however, that his immersion in the case might have influenced data collection, perhaps limiting what certain stakeholders would say about their experiences. Therefore, a portion of interviews (10%) were conducted by another member of the research team (PClerkin). Also, the analysis has been shared with participants to allow them the opportunity to comment on the accuracy of our descriptions of their experiences and the credibility of our interpretations.

Summary and discussion of key findings

Our research objectives were to ***(1) document experiences*** of different stakeholders and ***(2) identify their needs*** in the context of the opening of a direct provision accommodation centre. In the Results section, we have described the experiences of different stakeholders and through this we provided details of their needs.

In this section, we summarise key messages from these results about experiences and needs. We offer a synthesis of these in order to discuss our other two objectives: ***(3) whether their needs are met or not*** before moving to a final section that ***(4) makes recommendations for future practice***.

Experiences and Needs

The experiences and needs of stakeholders have been described under four themes:

1. Notification about direct provision accommodation centre
2. Planning and preparing appropriate health and social care

3. Skills for providing for health and social care needs of asylum seekers
4. Development of interdisciplinary support systems between health care professionals.

A major finding is that the lack of notification about the opening of Accommodation Centre A was really very problematic for frontline service providers. This finding is not surprising, resonates with media accounts of the situation at the time, and also underlines our interest in conducting this case study in the first place. What is important about this finding is that it provides in-depth understanding about the nature of problems experienced at the time by different stakeholder groups.

To summarise, it created ***practical problems*** for frontline providers (statutory and non-statutory) in terms of overcrowding of waiting rooms, and placed a strain on already over-stretched resources.

It created ***clinical challenges and problems*** because health records were unavailable, the scope for continuity of care was nil, there was duplication of clinical tests and, therefore, unnecessary use of healthcare resources. There were also examples of clinical safety issues in terms of inadequate history about asylum seeker services with some stark examples of problems in relation to maternity care for pregnant women.

Frontline staff in statutory services, particularly in the community setting, reported that they did not feel they had the necessary ***skills*** to work to a high quality level with asylum seekers and their specialised healthcare needs. The accounts from health promotion and public health nursing staff provide an excellent insight into the ways in which mainstream programmes and services may not always be relevant to the needs of asylum seekers who require specialised and targeted care in the community. It is problematic that frontline providers who *are* skilled and expert in their roles were in a situation in which they felt unskilled and unconfident about their work.

Another issue for frontline service providers was the ***psycho-social impact*** of the situation. They were stressed about the pressurised situation in which they found themselves and were angered by the strain they experienced.

The sudden opening of Accommodation Centre A was problematic for local service users as they felt surprised and 'out of the loop' with regard to plans for their local community. The practical problems at the front line of service delivery (e.g. overcrowded waiting rooms) caused unease: local service users sometimes objected to long queues in their general practice surgeries or at

community welfare clinics. This is not a positive context for integration of new communities into our society. However, that said, it was striking that the experience of asylum seekers in the study area was broadly positive. They did not report experiences of negativity or hostility and commented that, in fact, local community members were nice to them.

Overall, from these experiences, it is clear that there was a need for better notification about the opening of Accommodation Centre A and a need for a co-ordinated plan of action to support the delivery of appropriate and responsive healthcare to the asylum seekers. Notice of the accommodation centre and its opening would, for example, have provided frontline staff with time to examine the available resources, access appropriate medical records, and assess the potential utility of mainstream services for the new service users versus the need for more specialised services. This activity would have set the groundwork for a co-ordinated plan of action across statutory and non-statutory organisations. There could also have been activities at a community level to notify and involve the local community in planning. From this we can say that, in this case study, the needs of the frontline service providers and local service users were not met.

There were some formal meetings to plan a response to the opening of Accommodation Centre A, but this was after the opening of the centre and so the meetings were taking place in an established 'stressful situation'. Furthermore, the number of formal meetings was minimal and their impact seems only minor.

We have learned that a number of effective informal meetings took place before and after the formal ones at which service providers from statutory and non-statutory organisations worked very hard to devise plans to ensure an effective response for the newly arrived asylum seekers. There are examples of general practitioners meeting and negotiating a division of labour for the care of asylum seekers. Primary care colleagues met and created informal alliances to manage the situation. NGOs liaised with each other to organise support for the asylum seekers. As a result of these negotiations and divisions of labour, some frontline staff took on new roles and responsibilities to manage the situation. They worked hard to ensure that there was not a gap in service provision, often going 'beyond the call of duty' to do so. The result was a number of interdisciplinary networks that operated effectively on the ground. It is interesting and encouraging to consider that the asylum seekers report positive experiences of general practice care and health promotion activities, for instance.

However, despite some positives, it is clear that what emerged was an *ad hoc response*. Furthermore, this ad hoc response was contingent on interpersonal and inter-professional alliances and networks and good will within those. The example of one general practitioner taking on the whole community of asylum seekers is a stark illustration of this point. It was positive in the sense that the asylum seekers had access to general practice care (and we know that they were very satisfied with that care) but it was problematic because, with almost a 'twist of fate,' their experience of general practice could have been radically different. What if one general practitioner was not willing or able to take on this role? What if the general practitioners refused to take any of the asylum seekers on as GMS patients? This is a real and documented scenario for asylum seekers in other places across the region and country.(39) Is it appropriate that the healthcare of asylum seekers is contingent on a 'twist of fate'? Undoubtedly, it is not a case that 'one size fits all': each local setting and context is different and poised for better or worse to respond effectively to the opening of direct provision accommodation centres. For this reason, it makes sense that there is a local response to the opening of a direct provision accommodation centre and negotiations at a local level about the most appropriate way to organise health and social care delivery. The key point, however, is that this must be a co-ordinated set of negotiations, not ad hoc.

To conclude, we acknowledge that national and regional policy makers and service planners were working in a demanding situation. The national policy makers from the Reception and Integration Agency emphasised that they had to respond to increasing numbers of asylum seekers and their pragmatic needs for accommodation. In addition, at a regional level, it was very unfortunate that the HSE co-ordinator for asylum seekers was on leave due to ill-health. This left a 'gap' at planning level which, arguably, contributed to the resulting experiences. However, while these 'unusual' elements of the case must be noted it is also true that they are not 'unique' to Accommodation Centre A. Only a year after its opening the accommodation centre was closed down quite suddenly and with minimal notice. Since then, a second accommodation centre was opened in the region, again with minimal notice or time for advance planning. Also, the local post as HSE co-ordinator for asylum seekers (liaison officer) has been discontinued as part of the restructuring of the Health Service Executive. This means that we cannot be complacent about the experiences in this case study because they are not specific to the case.

It is important to generate workable recommendations for future practice to maximise the scope for effective health and social care for newly arrived asylum seekers in accommodation centres around the country. The Health Service Executive's National Intercultural Health Strategy (2008)

provides a stronger policy context and requirement than before for appropriate formal and effective responses in this situation.

We propose the following recommendations for best practice:

- ✓ There should be an available co-ordinator for asylum seeker healthcare (liaison officer) in all regions of the Health Service Executive.
- ✓ There should be a minimum of one month's notice from the Reception and Integration Agency to statutory and non-statutory health and social care organisations about the opening and closing of direct provision accommodation centres.

These overarching recommendations set the context for the remaining ones in that the regional co-ordinators would have responsibility to put the remaining recommendations into action, and would require notice from the RIA to do so.

- Formal meetings should be organised by the HSE co-ordinator to take place within organisations/professions and across organisations and professions to negotiate divisions of labour that are effective and responsive to the needs of asylum seekers.
- Arrangements to transfer health and medical records of incoming asylum seekers to relevant health and social care professionals is imperative.
- Local communities should be informed of plans for new accommodation centres and plans to respond to the resultant impact on health and social care services. Information about the latter may address concerns that local service users have about the sharing of resources across communities.
- Health and social care professionals working with asylum seekers should have access to training through the Health Service Executive for working in cross-cultural consultations.

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