

Tackling Poverty: Tackling health inequalities



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Sara Burke



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Combat Poverty Agency
Bridgewater Centre
Conyngham Road
Islandbridge
Dublin 8

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Purpose of Paper

The purpose of this paper is to explore the impact of poverty and health inequalities among communities of interest participating in the Combat Poverty Building Healthy Communities (BHC) programme 2005 to 2007.

Groups participating in the BHC programme over the three years (2005 to 2007) included disadvantaged urban and rural communities and other excluded groups, defined here as 'communities of interest' or sectoral groups. These communities of interest are lone parents, the Deaf community, Travellers and other ethnic minorities including refugees and asylum seekers and women users of mental health services. These groups are geographically located across the country but are united by their particular experience of health inequalities (some operate at national level, others at a local or regional level). The issues experienced by disadvantaged urban and rural communities are dealt with in another paper.

This paper will outline the experiences of poverty and health inequalities as experienced by the particular communities of interest participating in the BHC programme, the common issues experienced by these groups, and the policy context in which their issues are taking place. It draws on material and publications

produced by the participating BHC projects, issues raised at BHC networking events and research carried out by the projects and by the Combat Poverty Agency.

Introduction

In Ireland, poorer people experience poorer health and die younger than those who are better off. Although research on health inequalities is at an early stage of development in Ireland, it is well established here, as elsewhere, that there is a social gradient in health. The poorest people live the shortest lives with the worst health. Correspondingly, the more one moves up the social and economic ladder, the longer one's life and the better one's health experience¹.

There is also a growing body of evidence that certain groups experience particularly acute health inequalities. These include people living in disadvantaged urban and rural communities and other marginalised groups such as Travellers, refugees and asylum seekers, Deaf people, people with disabilities, users of mental health services and lone parents². Other

1 Farrell, C, McAvoy, H, Wilde, J and Combat Poverty. *Tackling Health Inequalities. An All-Ireland Approach to Social Determinants*. Institute of Public Health and Combat Poverty Agency. 2008

2 Combat Poverty. *Health Policy Statement*. Dublin. Combat Poverty Agency. 2007

communities of interest such as prisoners, undocumented migrant workers, the homeless, drug users, lesbian, gay and bisexual community, may also experience acute health inequalities but they are not the focus of this paper as they were not specifically represented among the groups participating in the Building Healthy Communities Programme 2005-2007.

The Building Healthy Communities Programme 2005 – 2007

The Combat Poverty Agency is a statutory advisory body responsible for developing and promoting evidence-based measures and proposals to combat poverty in Ireland.

Under its *Strategic Plan 2005-2007*, Combat Poverty developed work to support disadvantaged communities (both geographical and sectoral) to tackle poverty and health inequalities under a programme called Building Healthy Communities.

The Building Healthy Communities programme had the following aims:

- To promote the principles and practice of community development in improving health and well-being outcomes for disadvantaged communities
- To build the capacity of community health projects to draw out practice and policy lessons from their work
- To inform and support policy initiatives relating to the links between poverty and health
- To explore mechanisms for effective, meaningful and sustainable community participation in decision making regarding health.

There are four interlinked elements to the Building Healthy Communities programme:

- Networking and sharing experience
- Supporting inclusion
- Research and documentation
- Practice and policy lessons.

The Building Healthy Communities programme is based on the assumption that a community development approach to health has an important role to play in involving people who experience poverty and social exclusion in contributing to anti-poverty and public health policies and practice.

Combat Poverty defines community development as “a process whereby those who are marginalised and excluded are enabled to gain in self confidence, to join with others and to participate in actions to change their situation and tackle the problems that face their community”³.

In 2005, under the second phase of the programme, ten initiatives were funded. All the projects worked to tackle health inequalities in strategic and innovative ways, using community development principles and practice. All of the projects actively involve the target groups with whom they are working and some of them are run by the target groups themselves. For example, the Irish Deaf Society, the Ethnic Minority Health Forum and the Women Together Network are solely run by Deaf people, ethnic minorities and women users of mental health services.

The Building Healthy Communities programme was developed in collaboration with the Health Service Executive and the Department of Health and Children, who also provided financial support to the

³ *The Role of Community Development in Tackling Poverty*, Combat Poverty Agency, 2000

programme. The programme was also complemented by a wider programme of activities on health undertaken by Combat Poverty.

The groups selected to participate in the 2005 to 2007 BHC programme were:

1. One Parent Exchange and Network (OPEN)
2. Irish Deaf Society (IDS)
3. Women Together Network (Schizophrenia Ireland)
4. Galway Travellers Support Group
5. National Health Forum for Ethnic Minorities, Cáirde
6. Galway Refugee Support Group
7. Fatima Health Initiative
8. Fettercairn Community Health Project
9. West Offaly Integrated Development Partnership
10. Community Action Network (In collaboration with Cáirde, Northside Community Health Project Cork (NICHE and Fatima Health Initiative).

For the purpose of this paper, the first six projects listed here are considered communities of interest. They are the focus of this paper. The area-based projects are the topic of another paper by Combat Poverty entitled: *Tackling Health Inequalities Locally*, published in 2009.

Format of the paper

Each group is considered in relation to their work undertaken with the Building Healthy Communities programme, their experience of health inequalities and access to and utilisation of health services. These sections vary in size due to the different focus of each project and the variety of available evidence in each particular area.

One of the most valuable aspects of the Building Healthy Communities programme is that, despite the diversity of the projects involved, there was substantive common experiences between the groups. This led to a solidarity between the groups and enhanced their understanding of inequality and discrimination. For example, the exclusion from mainstream society and health services experienced by the Deaf community was also a common experience by ethnic minorities. Also the mental health issues experienced by the Women Together Network was also shared by Travellers, other ethnic minorities and lone parents. These issues are dealt with in a section on the common experiences of the projects. The paper concludes with a brief overview of the policy context and a list of the resources produced by the projects.



Health inequalities

Health inequalities as experienced by BHC communities of interest, including experiences of access and utilisation of health services

Lone parents

The One-Parent Exchange Network (OPEN) is a national network of 80 local lone parent self-help groups. OPEN represents the diversity of interests of lone parents, particularly those living in/or at risk of living in poverty, and promotes their inclusion and progression within wider society. It does this by: assisting its member groups to strengthen their capacity to provide information, services and supports for lone parents, especially those who are isolated; and through campaigning for policy change that recognises family diversity, supports access to appropriate public services, promotes economic independence and improves the quality of life for lone parents and their children. The involvement of lone parents is central to the work of the organisation, locally and nationally.

During consultations undertaken by OPEN in 2004, lone parents were found to

suffer high levels of isolation, poverty and exclusion. Stigmatisation was a key issue. These factors had implications for the mental health of lone parents. Anecdotal evidence showed depression among lone parents and an over-reliance on prescription drugs as a response.

Through the Building Healthy Communities Programme, OPEN secured funding for a three-year mental health project to address issues of isolation and stigmatisation among lone parents. Focus groups were set up in four urban and rural communities to research issues, explore initiatives underway and to provide recommendations for action. They published a report of the findings of the project in 2007⁴.

Poverty and health inequalities among one-parent families

Census 2006 shows that there were 189,213 one-parent families, representing nearly one in five or 18% of all families in Ireland. Of these, 86% of one-parent families are lone mothers, while 14% are lone fathers. Over half of one-parent families have one child, 26% have two children, and 10% have three children.

⁴ OPEN. *Lone parents' experience of isolation and stigmatisation*. Building Healthy Communities Programme Research Report. Dublin. OPEN. 2007.

The census also found that there were 169,761 lone-parent households, (12% of all households in Ireland) and that 19,452 one-parent families, (over 10% of all lone parents), live in multi-family households. For example, they live with their own parents. The EU Survey of Income and Living Conditions figures for 2006 show that one-parent families continue to suffer a disproportionate level of poverty. A lone parent household with one child was 'at risk of poverty' in 2006 when total income was less than €269.31 per week. Adjusting this figure for inflation (Consumer Price Index at June 2008) means a figure of €296.55. Four in every ten (39.6%) one-parent families were 'at risk of poverty' in 2006. This is equivalent to 67,225 one-parent households. This is over double the figure for the population as a whole, where 17% of the population was 'at risk of poverty'⁵.

Almost a third (32.5%) of one-parent families were living in consistent poverty, representing 55,172 lone parent households. The consistent poverty rate for one-parent families is more than four and a half times the average rate, which is 6.9%.⁶

Just over half of lone parents rely on social welfare payments and 98% of those relying on social welfare payments are women. The Department of Social and Family Affairs estimates that approximately 60% of those in receipt of one-parent payment are in employment, much of it low paid work. Lack of affordable, accessible, quality childcare is a big obstacle to employment of lone parents.

Lone parents also have low levels of educational attainment. Approximately nine

per cent of lone parents under 35 have only primary school education, while 36 per cent have intermediate education. This means, in effect, that 46% have education to a minimal schooling level.

Almost a fifth (18.8%) of one-parent families experienced debt arising from ordinary living expenses. A similar proportion (18.1%) went without heating at some stage in 2007. One in ten lone parent households were not able to afford new (not second hand) clothes (10.2%) or went without a substantial meal at least one day in the past two weeks (9.9%).

In 2005, there were 16,795 one-parent families on the waiting list for social housing. One-parent families made up 38% of all households on the list, while 23% of Rent Supplement recipients are on the One-Parent Family Payment^{7,8}.

There is an absence of specific studies on the health status of lone parents but given the exceptionally high levels of poverty among lone parents and the strong relationship between poverty and ill health, it is reasonable to assume that lone parents experience poor health and die younger than people in higher earning, two parent families.

As it is widely acknowledged that disadvantaged women experience higher rates of depression and admission to psychiatric hospitals, the impact of poverty on mental health is also acknowledged. OPEN, therefore, decided to develop specific responses to the mental health issues as experienced by lone parents as part of the work funded under the Building Healthy Communities Programme. Lone parents were centrally involved in developing and carrying out the research.

5 OPEN. Facts and Figures. www.oneparent.ie

6 Consistent poverty – This is also known as the *combined income-deprivation measure* of poverty. It combines relative income poverty with relative deprivation. People whose income falls below the relative income poverty line and who also experience relative deprivation are regarded as living in consistent poverty.

7 www.oneparent.ie/facts/21

8 OPEN. *Out of the Traps, Ending poverty traps and making poverty pay for people in poverty*. Dublin. OPEN. Dublin. 2005.

The research found that 90% of those who participated had experienced depression, 76% felt that their parenting was affected by their anxiety, stress and depression and 62% felt their stress was impacting on their children. The main factors contributing to stress were money and financial issues, the challenges of parenting alone, relationships with ex-partners, emotional issues, housing and accommodation issues and time management. Eighty five per cent experienced sleep deprivation because of stress. Social isolation was a big issue for participants, particularly for those in rural areas who also experienced geographical isolation.

The research found stigma as one of the strongest factors associated with poor mental health. The lone parents identified stigma as a result of poverty, social exclusion and negative attitudes to lone parents at individual and institutional level. They believed that reliance on welfare payments reinforced this stigma. Participants were acutely aware of the stereotypes of lone parents having babies to secure housing and extra social welfare benefits.

Poverty, poor housing and accommodation options, and the stresses of parenting alone were raised by research participants as contributing to high levels of anxiety.

Lone parents identified that the disapproving attitude of some public service providers towards them has negative impacts on their self esteem and confidence. Difficulty in accessing information on what services are there for lone parents and an absence of knowledge about rights and entitlements contributed to their stress levels.

Lone parents identified involvement in lone parents' groups, hobbies and community involvement and children's participation, as positively enhancing their mental health.

Accessing and utilising health services for lone parents

While health services were not the specific remit of the OPEN BHC project, the research found that "access to appropriate and high quality health services (including secondary services such as transport and childcare) are vital to the health and well-being of lone parents. The inaccessibility of appropriate services for rural lone parents exacerbates other factors impacting negatively on lone parents' health"⁹.

Their work also highlights the decrease in funding for mental health services in the past decade, the need to involve lone parents in the planning, design and delivery of health services and for mental health services to deal with the family unit as a whole, not just the mother or child.

Involving lone parents in the development and implementation of health strategies, including mental health services, is central to improving the health status of lone parents. To achieve this level of involvement of lone parents, local lone parent infrastructures need to be supported to facilitate this participation.

This work also highlights how important it is that mental health is considered in the context of the social, economic, environmental and cultural circumstances which impact on the health of lone parents¹⁰.

9 OPEN. *Lone parents' experience of isolation and stigmatisation*. Building Healthy Communities Programme Research Report. Dublin. OPEN. 2007.

10 OPEN. *Lone parents' experience of isolation and stigmatisation*. Building Healthy Communities Programme Research Report. Dublin. OPEN. 2007.



The Deaf Community

The Irish Deaf Society (IDS) is a national representative organisation of the Deaf in Ireland. The IDS promotes the rights of Deaf people and their access to all aspects of life, primarily by upholding the status of Irish Sign Language (ISL), which is the language of communication and culture for the Deaf community.

In 2005, as part of the Building Healthy Communities programme, the IDS carried out a nationwide survey of Deaf peoples' experience of accessing and utilising the health services. They carried out research with health service providers. Both aspects of the research found that the health sector lacks ISL with which to communicate health information and services to Deaf people. This impairs access and heightens health risks for Deaf people. They produced a range of resource materials for Deaf people on health information in ISL and for service providers on engaging and communicating with Deaf people.

Poverty and health inequalities among the Deaf community

It is not known exactly how many Deaf people there are in Ireland. In 1996, it was estimated that there were over 5,000

Irish Deaf sign language users¹¹. The Deaf community estimate that for every Deaf sign language user there are approximately nine other hearing people who use sign language. These include the children, relatives and friends of people who are Deaf. Therefore, it is estimated that there are over 45,000 members of the Deaf community. These include people who have all levels of hearing loss and none. These figures are likely to be an underestimation of how many people are Deaf or hard of hearing. Many people lose their hearing with age and given the aging population, the number is increasing.

Deaf people experience higher rates of poverty and social exclusion than the population as a whole¹². There are significantly high levels of illiteracy among the Deaf community. Eighty per cent of Deaf adults have literacy problems compared to 25% for the population as a whole¹³.

11 Matthews, P. *The Irish Deaf Community: Volume 1: Survey report, history of education, language and culture*, Dublin. Institiuid Teangeolaíochta Éireann. 1996

12 Conama, JB, Grehan, C. *Is there poverty in the Deaf community?* Dublin. Irish Deaf Society. 2001

13 Irish Deaf Society. *Some Sound Advice. Improving access and utilisation of health services for the Deaf in Ireland*. Dublin. Irish Deaf Society. 2007

The absence of ISL interpreters in day-to-day life experiences for Deaf people means they are excluded from the mainstream in most aspects of life. The absence of ISL interpreting means that Deaf people are excluded from the majority of educational opportunities, which can have lifelong consequences for the Deaf person, resulting in difficulty in accessing employment or securing anything other than low paid work. The absence of ISL interpretation also results in barriers to participating in everyday life, with Deaf people experiencing difficulties in accessing public transport and public services, or participating in leisure activities.

Communication and language barriers are also the main health obstacles facing Deaf people. Deaf people are not seeking special treatment. They require adjustments to communications to ensure equal access to and utilisation of health services.

Access and utilisation of health services for Deaf people

Access and utilisation of health services by Deaf people is the central focus of the IDS BHC funded work. Their survey of users and providers of health services found: "that the Deaf have poor experiences of the healthcare system with many Deaf people feeling excluded and marginalised. It found it impossible for the Deaf to access health services on an equal basis. The inequality experienced by Deaf people puts their health and well-being at risk"¹⁴.

The research found that the majority of people surveyed were reluctant to attend health services out of fear of communication barriers. Health service providers expect Deaf people to lip read and to speak. However, the majority of Deaf people would prefer to use ISL. Lip reading is often guesswork and written

¹⁴ Irish Deaf Society. *Some Sound Advice. Improving access and utilisation of health services for the Deaf in Ireland*. Dublin. Irish Deaf Society. 2007

communication is not reliable due to the high levels of literacy difficulties among the Deaf.

Obtaining information on health and access to health services is also a huge barrier as it is often given in oral or written forms. Deaf people cannot ring up a helpline looking for information and may not be able to read letters or other forms of written information sources.

The IDS survey, carried out in 21 counties gathered testimonies of Deaf people's experiences of the health services. Their findings include: the inaccessible nature of health information; doctors and nurses who do not know how to deal with Deaf people, which can result in humiliating experiences for the Deaf person, often resorting to communicating through their children; and the absence of any procedures for dealing with emergency medical issues with a Deaf person. Waiting rooms in hospital, GP surgeries and health centres can be very difficult with no method of communicating with the Deaf person. There is an absence of ISL interpreters in health settings. Discrimination can be experienced by Deaf people by, for example, being denied fertility treatment, or being told not to drive because they are Deaf or having no access to counselling after a traumatic health experience such as a miscarriage.

The IDS have gathered details of extreme cases where people have died due to lack of information. For example, people who have had cancer treatment were unaware they had to go for check ups, were denied ISL interpreters and died prematurely from cancer.

Research in the UK backs up these findings, with 49% of profoundly or severely Deaf people being left unclear about their condition because of communication problems with their GP or nurse. Thirty per

cent avoid going to see their GP because of communication problems. Thirty three per cent of profoundly Deaf people were unsure about medical instructions or had taken too much or too little medication because of communication problems¹⁵.

In June 2008, a survey of 38 Irish hospitals found that just one acute hospital and three maternity hospitals had access to ISL interpreters, but none of the other 34 hospitals had¹⁶.

ISL interpreters cost money and Deaf people who seek an interpreter have found that health services are often reluctant to pay for the service. Under equality legislation, public services are directly responsible for providing interpreting services to Deaf people.

The IDS published guidelines for health service workers on how best to communicate with Deaf people, called *Some Sound Advice*¹⁷. They have also produced DVDs for Deaf people on specific health issues such as health literacy, men's health and maternity services. The IDS wants to work with the HSE to provide more accessible health services for the Deaf community.

15 Royal National Institute for the Deaf. *The Simple Cure*, a national report into deaf and hard of hearing people's experiences of the NHS. London. Royal National Institute for the Deaf. 2004

16 Hands ON survey of Irish hospitals. <http://www.rte.ie/tv/handson/thisweek09032008.html>

17 Irish Deaf Society. *Some Sound Advice. Improving access and utilisation of health services for the Deaf in Ireland*. Dublin. Irish Deaf Society. 2007



Women users of mental health services

The Women Together Network (WTN) was established during 2005 on the basis of funding from the Building Healthy Communities programme with support from Schizophrenia Ireland (SI), WTN's parent organisation. The genesis of its foundation was that the SI found that many women did not attend local support groups, as they found it difficult to talk about their issues in front of men and there was a need for a specific women's network.

WTN provides a network for women who have experienced mental health difficulties. Through their participation in the network, the women identify factors which contribute to their experiences of poverty, isolation and segregation from the mainstream of society.

The WTN promotes interaction between women with mental health difficulties through attendance at workshops and meetings¹⁸. For many of the women the network meetings were their first opportunity to participate in group work and share experiences of mental health services and the poverty and exclusion associated with their mental health conditions. The WTN have documented their experiences of health inequalities.

18 Women Together Network. *Evaluation Report*. Women Together Network and Schizophrenia Ireland. 2005

Poverty and health inequalities among women users of mental health services

While everyone has mental health needs in Ireland, one in four have mental health problems and one in ten people report that they suffer from a mental illness. In the national survey of lifestyle attitudes and behaviour (SLAN) 19.5% of women surveyed reported they had been told by their doctor that they had difficulties with anxiety and depression, compared to 13.4% of men¹⁹.

There is a two-way relationship between poverty, social exclusion and poor mental health. In Ireland the highest rates of admission to psychiatric hospitals are those from the unskilled occupational class, while common mental disorders are twice as frequent among the lowest income groups as compared to the highest²⁰.

Women involved in the Women Together Network have each experienced mental health difficulties. For most of them their mental health difficulties impact on their ability to obtain work and to stay in employment. Long stays in psychiatric hospitals can prevent people from accessing work and result

19 NESF. *Mental Health and Social Inclusion*. Dublin. NESF. 2007

20 NESF. *Mental Health and Social Inclusion*. Dublin. NESF. 2007

in unemployment. None of the women involved in the network are in full time employment. All of the women involved are on long-term disability payments, on Community Employment schemes or on training courses. Their low income and dependency on social welfare payments impact on all aspects of their lives – their housing, their health, their ability to maintain relationships and to participate in social activity. They all experience poverty and/or social exclusion as a result of their mental health issues.

Research carried out for the mental health strategy: *A Vision for Change* found that 70% of people with mental illness were dependent on welfare payments or had no income²¹.

Women who have participated in the WTN found their input empowering, allowing them to demand respect and have their voices heard. The women planned and organised all the workshops and meetings themselves. Again this was a new and positive learning experience for the women. They found their participation in the workshops “overwhelmingly positive...” This is an important outcome as it highlights that the target group which is the women themselves benefited from the funding²². The workshops gave the women an opportunity to validate their lived experiences. At one of the network meetings, the women identified the losses they had experienced in their lives. These included their human rights, attractiveness, sexuality, drive, people skills, security, happiness, human dignity, belief, self respect, social life, quality of life, home life, family life, career, job prospects, money, opportunity and freedom.

21 Department of Health and Children. *A Vision for Change*. Dublin. Department of Health and Children. 2006.

22 Women Together Network. *Evaluation Report*. Women Together Network/Schizophrenia Ireland. 2005

Specific issues experienced by the women include the stigma associated with the diagnosis of a mental illness and the absence of support for women with mental illness, particularly those living in rural areas. They also identified barriers to obtaining employment such as: how to explain gaps on their CVs due to their mental health; whether to explain to potential employers about their mental health; and the absence of information on employment rights and legislation. All of the women who participated in the network expressed a desire to continue with their education and seek employment but lacked the practical means to do so.

The women also had difficulty with family members who found it difficult to accept their mental illness. They also had difficulty with raising children while unwell. In particular, they worried about the economic stresses of raising their children on low income and the stigma associated with having a mother with a mental illness.

Two workshops were held on budgeting and the ‘wellness recovery action plan’ during 2007. Members of the network have spoken publicly about their experiences of mental health services and the stigma associated with their conditions at national conferences run by Combat Poverty, Amnesty International and the Mental Health Action Group during 2007. They also produced a leaflet on the WTN and distributed it during 2008.

One of the results of the workshops was the production of a book of poetry and prose called *Speak for Yourself* where women write about their experiences of mental illness and exclusion²³. In July 2008, the WTN held a national networking meeting attended by over 60 people.

23 Women Together Network. *Speak for Yourself*. Prose and poetry from the Women Together Network Writers Groups 2006-7. Edited by Susan Knight. Aungier Press. 2008

Access and utilisation of health services for women users of mental health services

All the women in the network have experiences of the health services, in particular mental health services. Many of the issues that come up at the WTN meetings are related to their use of the health services and their medication.

On hospitals and health care professionals, women were critical of the lack of the gender segregation in hospitals, resulting in some women having to share toilet and shower facilities with men. Other complaints about the health system included having their clothes removed from them; health care professionals speaking to them in a way that they do not understand; and difficulties with having a male doctor leading to, for example, a reluctance to discuss the impact of medication on sex drive, their menstrual cycle and fertility problems.

In relation to medication, the women expressed concern about not being consulted on the type of medication prescribed to them, their lack of choice in types of treatment, the dearth of information and their sense of helplessness around medication.

Women in the network are usually on medication for their condition. Their medication often has side effects which includes weight gain. The weight gain contributes to poor self esteem and low self worth.

Previous research carried out by SI shows that one of the main difficulties with users of mental health services is the absence of pathways out of the system and back in to the real world²⁴.

The WTN hopes to establish itself on an independent basis in 2008/9, to involve more women in the network and to work with the HSE to advocate for the rights of women users of mental health services and to improve the women's experience of mental health services.

²⁴ Schizophrenia Ireland. Submission to the National Economic and Social Forum on Mental Health and Social Inclusion. 2006.



Travellers

The Galway Travellers Movement, through the BHC funding, carried out a community-led Health Impact Assessment (HIA) of an official halting site in Galway to determine the links between their living environment and conditions and their health. The project was carried out by the resident Travellers in partnership with state agencies, such as local authorities, the Health Service Executive and local Traveller representative groups.

The Health Impact Assessment model incorporates participative community development methods in evidence gathering, and developing community responses to issues raised during the HIA process.

The project aims to develop an understanding among Travellers and health professionals of the links between accommodation standards, poverty and health. It also aims to enable the Traveller community to initiate a community development response to addressing issues raised.

Poverty and health inequalities among Travellers

Irish Travellers are a small indigenous ethnic minority group representing 0.5% of the population. In the 2006 census, there were 22,435 Travellers. Travellers are younger than the population as a whole with two out of every five Travellers aged

less than 15 years in 2006, compared with one in five for the whole population. Older Travellers (those aged 65 years and over) accounted for just 2.6% of the total Traveller population compared with 11% for the general population. Travellers have a higher birth rate and a shorter life expectancy than the general population.²⁵

Travellers have continually identified poverty and accommodation as being key factors in causing poor health. It has been stated in the *National Health Strategy for Travellers*: "It is clear that an immediate improvement to the living environment of Travellers is a pre-requisite to the general improvement in health status"²⁶.

Traditionally Travellers' economic activity was as self employed traders in scrap-metal, seasonal agricultural work, horses and market trading. Now, only a minority of Travellers have remained economically active within the Traveller economy. Travellers continue to find it very difficult to access employment in the mainstream labour market leaving many Travellers long-term unemployed and living on

25 http://www.cso.ie/newsevents/pr_censu2006vol5.htm

26 Department of Health and Children. *Traveller Health: A National Strategy 2002-2005*. Dublin, 2002. http://www.dohc.ie/publications/traveller_health_a_national_strategy_2002_2005.html

social welfare. In the past 15 years, many Traveller men and women took up Community Employment (CE) schemes but the reduction of the CE schemes in the last few years has resulted in fewer Travellers working within their community on such schemes. Their low income and poverty is compounded by poor quality accommodation and discrimination.

The *First Progress Report of the Implementation of the Task Force on the Travelling Community* (2001) concluded "One in every four Traveller families is currently living without access to water, toilets and refuse collection. The accommodation provision has not kept pace with increasing demand over the past five years"²⁷. In 2004, there were 788 Traveller families living on the side of the road with no hot water, electricity or sanitation and another 323 families sharing very basic facilities, while 352 families were living in emergency or temporary facilities²⁸. There is no evidence that accommodation for Travellers has improved significantly since 2001 or 2004.

Travellers experience racism and discrimination, which contributes directly and indirectly to their levels of poverty and social exclusion. This also impacts negatively on their health, causing low self esteem, anxiety, stress and a feeling of inferiority for many.

While no national survey of Travellers health has been carried out since 1987, it is known that Travellers live shorter lives and experience poorer health than their settled counterparts. The 1987 survey found that Traveller men live ten years

fewer than settled men and Traveller women live twelve years fewer than settled women. It also found the rate of still births was twice the rate of the rest of population, while the infant mortality rate was three times the national average²⁹. The persistence and range of chronic and long term illnesses amongst Travellers is directly related to living conditions and exclusion from service provision³⁰.

Not only does poverty contribute to poorer health among Travellers. This relationship also works in the opposite direction with poor health being a contributory factor to continued poverty. Even if Travellers have a medical card, many less obvious costs of illness are not covered by welfare payments and a medical card, for example, travel to and from doctors' appointments. Travellers often do not live on bus routes or near public transport and may have to use taxis. High costs associated with keeping their home warm and damp-free despite poor living conditions are another factor. Poor health can also keep children out of school for long periods of time.

Access and utilisation of health services for Travellers

Travellers also experience discrimination and barriers in accessing and utilising health services. Travellers often find it hard to get on a GP's list. Literacy problems can cause difficulty in keeping medical appointments or obtaining accurate information on illnesses or treatment.

The Galway Traveller Movement's Health Impact Assessment (HIA) is measuring the associations between conditions on a halting site and the health of residents there. Twenty Traveller families have been living on this

27 Department of Justice, Equality and Law Reform. *Progress Report of the Traveller Monitoring Committee*. Dublin. 2001.

28 Galway Travellers Support Group. *Composite Submission to the National Intercultural Health Strategy from Travellers and Traveller Organisations Nationally*. 2007.

29 Barry J, Daly L. *Travellers Health Status Study – Census of Travelling People 1987*. Health Research Board. Dublin. 1988.

30 Department of Health and Children. *National Travellers Health Strategy, 2002-2005*. Dublin. Department of Health and Children. 2002.

poor quality, official site for five years. The site is next to a landfill. It does not have electricity, flush toilets, washing facilities or fire safety equipment. This is the first time the health impacts of a halting site have been monitored and measured.

The project found that Travellers go to the Emergency Department of the local hospital more often, suffering from cuts, falls on the site, diarrhoea, infections and respiratory problems. The stress of the grim conditions on the official site causes mental health problems. The lack of basic facilities on the site has negative physical and mental impacts. For example, there is nowhere to wash or dry clothes so the children will refuse to go to school in dirty clothes. Also the generator is turned off at night, so keeping fresh food on the site is impossible. The bad odours from the nearby dump and the porta-loos stop children going outside to play.

While there are guidelines for standards on new halting sites, there are no standards in place for existing sites. The findings from this project will be used to set guidelines for standards on halting sites. This project is also engaging the health services in getting them to recognise their role in ensuring better accommodation conditions for all Travellers. The active involvement of Travellers in the HIA has allowed them to influence decision-making on a new site that is being developed for the residents there.



Other ethnic minorities

Other ethnic minorities including refugees and asylum seekers

Two of the groups funded in the second phase of the BHC programme are groups made up of ethnic minorities, working to build the capacity of ethnic minorities to influence the planning and delivery of public policy and health services, which impact on their health status and needs.

As part of the Building Healthy Communities programme, Cáirde set up a National Ethnic Minority Health Forum made up of 27 ethnic minority-led community groups, each of whom seeks to improve opportunities for better health and well-being for ethnic minorities. Through the forum and the training they received, participants have built their capacity to address issues affecting their communities and to influence change. Each of the leaders has participated in training and together they take action on health issues. Each group acts as a liaison with the health services and provides simple information on rights and entitlements and how to access services for ethnic minorities.³¹

31 Cáirde. Community Development and Health Programme, *An Intervention for Social Change. A Case study of the Capacity Building Phase of the Programme*. Dublin. Cáirde. 2006.

The Galway Refugee Support Group is a community development organisation that works with over 2,000 asylum-seekers and refugees to ensure the provision of appropriate services, supports and opportunities to participate in all aspects of Irish society. Health is a key issue for this community. Specifically, the MARTA (Migrants Asylum Seekers and Refugees Training for Action) devised training for community health representatives and built peer support networks within different asylum-seeker/refugee communities in and around the Galway area.

Poverty and health inequalities among ethnic minorities including refugees and asylum seekers

There has been a radical change in the ethnic make up of Ireland in the last decade with a significant increase in people from ethnic minorities living and working in Ireland. The population of Ireland increased by 8% between 2002 and 2006, (from 3.9 million people to 4.2 million) and migration played a dominant factor in the increase. The number of migrants in Ireland nearly doubled between 2002, and 2006, going from 222,000 non-Irish nationals to 420,000.

The 2006 census asked people about their ethnicity and 95% classify themselves as white, 44,000 people consider themselves black or African. 16,000 Chinese and 36,000

are from other Asian backgrounds. Irish Travellers (of whom there are over 20,000) are also an ethnic group but are considered separately in this paper.

Many people from ethnic minorities who have come to live in Ireland in the past decade came here for work. While some of these are well paid with jobs in the IT sector or as medical doctors, many are engaged in low paid work in the service sector. A small proportion of migrants come here as undocumented workers, refugees and asylum seekers. It is very hard to quantify the number of undocumented migrant workers. In February 2007, there were over 7,000 refugees living in Ireland with 5,711 asylum seekers awaiting a decision on their status. Of these 5,210 were living in Direct Provision. Under the 'direct provision' scheme, asylum seekers are accommodated in shared hostel-type centres, on a full-board arrangement with a small allowance. Living in direct provision hostels can aggravate an already stressful and anxious situation for asylum seekers.

Ethnic minorities are more likely to experience poverty and health inequalities than the non-ethnic population. Recent analysis of EU SILC data shows that non-Irish nationals are twice as likely to be in consistent poverty as Irish nationals³². Low paid and undocumented migrant workers, refugees and asylum seekers are most likely to experience poverty and social exclusion. This, combined with discrimination and racism, can result in multiple discrimination and hinder integration into society. Each of these factors – poverty, social exclusion, discrimination and racism – impact on health, both physical and mental.

A health needs assessment carried out by Cáirde in the North Inner City found that

32 Combat Poverty Agency. *Health Policy Statement*. Dublin. Combat Poverty Agency. 2007

migration status impacts directly on one's ability to access employment and education. It also directly impacted on accommodation, with many people living in sub-standard private rented accommodation where tenure was insecure. Regular changes in accommodation meant that children had to move from school to school which was not good for them. Experiences of racism and discrimination also impact on their ability to participate in mainstream society, leading to further exclusion.³³

Many of the people that the Galway Refugee Support Group works with live in Direct Provision accommodation and have to survive on €19.10 per week. There has been no increase in this allowance since 2001 despite major increases in inflation and the cost of living. Those in Direct Provision have little choice over their day-to-day lives, as meals are provided for them and they are not allowed to work or to be in education. They are socially isolated and ghettoised. Research conducted with asylum seekers living in Direct Provision has found very high levels of stress, poor nutrition and poor health among residents. Overcrowding and communal accommodation contribute to poorer health with up to four adults sharing a bedroom in some instances. Mothers sharing rooms in Direct Provision accommodation have stopped breast feeding their child due to overcrowding of rooms³⁴. The lack of play facilities for children, witnessing their parents' distress, never seeing them cook or work (because they are not allowed to) must all influence the children's well-being. Other costs of poor health contribute

33 Cáirde. *Assessing the health and related needs of minority ethnic groups in Dublin's North Inner City. A Case Study of a Community Development Approach to Health Needs Assessment*. Dublin. Cáirde. 2006.

34 Galway Refugee Support Group Submission to the Health Services Executive Intercultural Health Strategy Group. *A framework for the health care and support needs of people from diverse ethnic backgrounds and cultures*. Galway. 2007. GRSG.

to poverty, such as transport costs to hospital or doctors' surgeries³⁵.

Up to May 2004, all families with children (including asylum seekers) received child benefit payment. Since then, Child Benefit has been withdrawn from asylum seekers, leading to increased inequalities between asylum seeking children and other children, exacerbating existing inequalities experienced by asylum seeking children and their families.

Access and utilisation of health services for ethnic minorities including refugees and asylum seekers

People from ethnic minorities can experience difficulties accessing and using health services. Language, communication and cultural barriers are major obstacles to use of the Irish health service by ethnic minorities.

The Ethnic Minority Health Forum carried out research with their communities and found that the health services are rarely accessible to them, particularly for people who do not speak English or who do not have residency papers. Specifically, they identified the lack of accessible and culturally appropriate information on health services, health issues and health service entitlements.

Ethnic minorities can find it very difficult to understand Irish health services, to navigate their way around them and to know what they have to pay for. For those in employment, the cost of going to see a GP can be prohibitive and there is an absence of out of hours services³⁶.

35 Cáirde. *Assessing the health and related needs of minority ethnic groups in Dublin's North Inner City. A Case Study of a Community Development Approach to Health Needs Assessment*. Dublin. Cáirde. 2006.

36 Galway Refugee Support Group Submission to the Health Services Executive Intercultural Health Strategy Group. *A framework for the health care and support needs of people from diverse ethnic backgrounds and cultures*. Galway. 2007. GRSG.

For asylum seekers, it is not clear which services they are entitled to and which they are not entitled to.

The absence of translation services results in people who do not speak English using relatives or friends to translate. This can cause embarrassment when sensitive, confidential information is being discussed between doctor and patient.

Irish health service providers do not always understand the cultures of those for whom they are providing services. Specific services do not exist. For example circumcision (which needs to be carried out within eight days of birth) has long waiting lists in hospitals. Ethnic minorities report experiencing direct and indirect discrimination, such as finding it hard to get on a GP's list. There can also be communication barriers between health professionals and patients. The absence of specific mental health services and the fragmentation between services were also highlighted. Ethnic minorities find it hard to find out about their entitlement to the medical card and which services and drugs are covered by it³⁷.

The specific effects of Direct Provision were also highlighted. For instance, it dehumanises people and has a negative impact on their mental health and self-esteem, and it directly leads to poverty and discrimination³⁸.

Migration status also has significant impacts on health and entitlement to health services. For example, migrant workers from recently entered EU countries are not

37 National Ethnic Minority Health Forum. Consultation for the National Intercultural Strategy in Health. Report from a national conference held on 23 January 2007, in Tullamore. Galway Refugee Support Group participated in this consultation.

38 Ibid, National Ethnic Minority Health Forum, 2007.

entitled to any welfare benefits under the Habitual Residency condition³⁹.

Those involved in the Galway Refugee Support group have documented the difficulties that they have had in getting a GP, and the problems they have with doctors who are unfamiliar with their culture and diseases from other countries. An Asylum Fellow project, which provides a GP service for asylum seekers and ethnic minorities in the region who were having difficulty getting on a GP list was established in NUI, Galway to specifically address this issue. The Galway group, in collaboration with the Occupational Therapy Department in National University of Ireland (NUI), Galway, carried out research on the mental health needs of refugees and asylum seekers and found that accommodation facilities, in particular direct provision, increases anxiety, depression and Post Traumatic Stress Disorder (PTSD). It also found that asylum seekers not being allowed to work and refugees who are long term unemployed increased the risk of PTSD. This can be exacerbated by social isolation and family separation⁴⁰.

The CEO of the Mental Health Commission has said: “the disparities in mental health care and services for racial and ethnic minorities recounts that racial and ethnic minorities... are more likely to receive poor quality and inappropriate mental health care”⁴¹. There is an absence of regional and local psychological and counselling support

services to meet the specific needs of refugees and asylum seekers. For example, survivors of torture have to travel to Dublin for counselling.

Research carried out in Galway found that asylum seekers attended their GP more often than the Irish patients. They were five times more likely to be diagnosed with a psychiatric illness than Irish citizens and were more likely to be prescribed a prescription for antibiotics and psychiatric medication than their Irish counterparts⁴².

These projects have identified their own communities’ health needs and they have built the capacity of ethnic minority groups to assist policy planners and service providers in the development of effective public policy and health services. The challenge now is to act upon these findings and for public services and government departments to involve ethnic minorities so that policies and services reflect the diversity of people living and working in Ireland today.

39 Ibid, National Ethnic Minority Health Forum, 2007.

40 Galway Refugee Support Group (GRSG). Submission from GRSG to NESF Mental health and Social Inclusion project team.

41 Brid Clarke, CEO of Mental Health Commission speaking at conference on ‘Addressing the Mental Health Needs of Minority Ethnic groups and Asylum Seekers in Ireland. National Conference HSE West January 2006. Quoted in Galway Refugee Support Group Submission to the Health Services Executive Intercultural Health Strategy Group. Galway. 2007. GRSG.

42 Dr Julie McMahon, Prof AW Murphy, Dr Peter Cantillon, Ms Gloria Avalos, Dr Anne MacFarlane A survey of asylum seekers’ general practice service utilisation and morbidity patterns. Irish Medical Journal. 2007



Common experiences

Common experiences of poverty and health inequalities with communities of interest involved in the Building Healthy Communities Programme

There are some overwhelming common experiences for the five groups represented by six organisations working with communities of interest in the second phase of the Building Healthy Communities Programme. The five groups represented are lone parents, Deaf people, women users of mental health services, Travellers, and ethnic minorities, including refugees and asylum seekers.

Poverty, inadequate income and health inequalities

Common to each of these groups is the experience of high levels of poverty and social exclusion, and, directly linked to this, their poorer health status and shorter lives.

While there is still a dearth of data on the health experience of these specific groups, their remarkably high levels of poverty and the health information that does exist,

proves that these groups experience the acute end of health inequalities because of their low income and high levels of exclusion from society. Specific measures are needed to reduce poverty and health inequalities experienced by these particular groups.

Denial of basic human rights

Each of the projects involved in the Building Healthy Communities Programme are denied some of the most basic human rights on a day-to-day basis, whether this is access to sanitation, to accommodation, to the right to work or education, or access to public services, including health services. There is a need to ensure that these groups are aware of their human rights and are supported to progress the realisation of their rights.

Housing

Also common to each of these groups is the poor housing and accommodation in which many live. Some Travellers and asylum seekers live in particularly appalling conditions, where they are denied access to heating, water, cooking facilities or private space. Lone parents, Deaf people and women users of mental health service are disproportionately dependent on social housing or on poor quality private rented accommodation. Improving the living conditions of these groups is central to improving their health status.

Education

With the exception of some ethnic minorities who come to Ireland with high educational attainment, there are high levels of educational disadvantage among these groups. Low levels of literacy, poor educational achievement and early school leaving are common experiences of each of these groups. Opportunities need to be put in place so that they have the chance to return to education, while measures need to be urgently introduced to improve the chances of children growing up in these communities, as education is an essential component to any route out of poverty and inequality for these groups. Provision should also be culturally appropriate.

Mental health

One of the most striking components of the communities involved in the Building Healthy Communities Programme is how their experience of poverty, exclusion and inequality has direct links with the poor state of their mental health. For each of the groups, this is one of the most important and critical health issues. Addressing the causes of their anxiety, stress and mental illness is central to improving their health. Also critical is access to good quality, accessible mental health services, in which patients have a say in their treatment plans and options.

Community development approaches

Each of these projects utilises a community development approach to addressing their health issues. Central to the projects is the involvement of people who are experiencing the inequalities, be they Deaf people, lone parents, Travellers, women users of mental health services, members of ethnic minorities, or refugees and asylum seekers. Up to now, there have been limited opportunities to participate in the development of policy. Only if these groups are adequately resourced to participate in such processes and to build their own capacity will services and policies be

designed to meet the needs of these most excluded groups in the future.

The BHC projects are not the only groups experiencing such acute inequalities. Others such as disadvantaged urban and rural communities, the homeless, drug users, prisoners, lesbian, gay and bisexual people, people with disabilities and long term illness and their carers, also need to be engaged and resourced in a similar way so that their needs can be met.

Access and utilisation of health services

People who are poor and excluded are likely to experience poorer health. Therefore, they have a greater need for access to good quality, universal health and social services. Many of the people in the communities who participated in the BHC programme have no idea of what services they are entitled to or how to access them.

Many are denied access to information on their health and health services or the treatment they require because of poor literacy or because they do not speak English or the unavailability of translators. Because, for the main part, translation services are not provided, these language and communication barriers mean that much of our health services are inaccessible to them. Even for those who can access such information, cultural barriers and the lack of training and information of health care professionals means that communication barriers remain between healthcare professionals and these very excluded groups.

The disjointed nature of the Irish public health service means that it is very difficult for people to find their way around the services. Even for people with medical cards, some services have to be paid for and these become inaccessible due to the charges associated with them, for example counselling. For others, transport to health appointments or medicines not covered

by the medical card are an additional burden to already tight budgets. For some - undocumented migrant workers and asylum seekers, for example - services are not available to them unless people pay up front. Some services, while they exist, have such long waiting lists that people borrow money so as to access private care quicker, for example an outpatient appointment or a psychological assessment. Others have to wait the long wait for what can be life saving diagnosis and treatment in the public health system.

Other public policies that cause poor health

The failure to implement the recommendations of previously published government policies and commitments means that government inaction is directly contributing to poor health. For example, the failure to act on many of the central accommodation recommendations of the 1995 Task Force on the Travelling Community directly results in poorer health being experienced by Travellers who live on the road side. The Equal Status Act 2000, 2004 and the Disability Act 2005, all placed obligations on the health services to do what is reasonable or practicable to accommodate the needs of health service users, such as Deaf people. However in the vast majority of instances where Deaf people use health services, no interpretation services are provided.

In relation to mental health services, the vast majority of recommendations in *A Vision for Change* remain unimplemented in full.

Other government policies actively contribute to poorer health. For example, the introduction of measures such as Direct Provision, which means that asylum seekers must live in Direct Provision accommodation where they cannot cook their own food and are denied the right to work or enter education contributes to poorer health status. Some asylum seekers involved in

the BHC projects have been left in direct provision for up to seven years before a decision is made on their status. Such long term institutionalisation can have lasting negative impacts on health and well-being.

Also poverty traps, which prevent lone parents returning to education or entering the labour market, and the inadequate provision of childcare means that it is virtually impossible for lone parents to get out of the cycle of poverty. Public policies need to take into account the impact that they have on the health of the population, in particular groups who are most marginalised and excluded.

Environment, transport, education, tax and social welfare policies, nutrition and employment policies are all central to contributing to better health and reducing health inequalities.

This programme confirmed that the projects are located in the social model of health and work to form a model informed by the social determinants of health.⁴³

⁴³ Farrell, C., McAvoy, H., Wilde J., and Combat Poverty Agency (2008) *Tackling Health Inequalities; A social determinants approach.*



Brief overview

Brief overview of policy context relevant to inequalities experienced by BHC groups

The overall poverty goal in the *National Action Plan for Social Inclusion 2007-2016* is to reduce the number of those experiencing consistent poverty to between 2% and 4% by 2012, with the aim of eliminating consistent poverty by 2016⁴⁴.

As the groups involved in the BHC programme are disproportionately at risk and living in consistent poverty, achieving this goal would have significant positive impacts on these most marginalised communities.

Other goals contained in the *National Action Plan for Social Inclusion 2007-2016* are also central to the achievement of better health for the most disadvantaged communities. These include reducing the number of pupils with serious literacy difficulties in primary schools serving disadvantaged communities. The target here is to halve the proportion from 27-30% to less than 15% by 2016. The housing

target aims to deliver high quality housing for those who cannot afford to meet their own housing needs and to underpin the building of sustainable communities. This target requires achieving the housing commitments outlined in *Towards 2016*, by meeting the accommodation needs of 60,000 households between 2007 and 2009⁴⁵. "This will embrace meeting special housing needs (the homeless, Travellers, older people and people with disabilities)".

The *National Action Plan for Social Inclusion* also commits to 500 primary care teams by 2011 and developing a strategy aimed at achieving the integration of new comers in our society⁴⁶. As 90-95% of all health care needs can be met through the primary care system, enhancing such a system is central to improving health and providing accessible, quality health services⁴⁷. *Quality and Fairness, A Health System for You*, although eight years old, is the key health policy document⁴⁸. This has equity

44 Government of Ireland. *National Action Plan for Social inclusion, 2007-2016*. Dublin; Stationery Office. 2007.

45 Department of An Taoiseach. *Towards 2016 Ten-Year Framework Social Partnership Agreement 2006-2015*. Department of An Taoiseach. Dublin. 2006.

46 Government of Ireland. 2007. Ibid

47 Department of Health and Children. *Primary Care. A New Direction*. Dublin: Department of Health and Children. 2001.

48 Department of Health and Children. *Quality and Fairness, A Health System for You*. Dublin: Department of Health and Children. 2001.

and fairness as one of its central principles. It outlined a range of 121 actions required to develop and enhance the health system. Some of these relate directly and indirectly to the communities involved in the BHC programme and most of these remain unimplemented. For example, there has been little progress on Action 1, to introduce Health Impact Assessment as part of public policy developments, or on Action 18, to implement a programme of actions to achieve the national anti-poverty and health targets for the reduction of health inequalities, including a target for premature mortality; for life expectancy of the Travelling community; health targets for Travellers, asylum seekers and refugees; and for low birth weights.

Equality legalisation introduced under the Equal Status Act 2000 and 2004 and the Disability Act 2005, each require public services to do all that is reasonable and feasible to meet the needs of health service users. The rights of patients to equal treatment means making adjustments to the way health services are provided. Under the Equal Status Act “discrimination includes a refusal by a provider of a service to do all that is reasonable to accommodate the needs of a person with a disability by providing special treatment or facilities, if without such special treatment or facilities, it would be impossible or unduly difficult for the person to avail him or herself of the service”⁴⁹.

Under the Disability Act, “from December 2005, communication by a public body to a person with a hearing or visual impairment must as far as practicable be provided, following request, in an accessible format”⁵⁰. Clearly, as the majority of Deaf

people do not have access to an interpreter for their use of health services, the equality and disability acts are being ignored. *A Vision for Change* is the main policy document in relation to mental health policy⁵¹. The Annual Report 2007 from the Mental Health Commission is very critical of government’s failure to introduce key components in the mental health policy, stating “the absence of progress in implementing *A Vision for Change* is a missed opportunity”⁵².

In 2008, the HSE published a *National Intercultural Health Strategy 2007-2012*. This specifies the need to “ensure services are provided equally to all and respond appropriately to the specific health and social care needs of new and well established minority communities”⁵³. The strategy outlines a range of actions required to make health services more responsive to the needs of ethnic minority groups.

In 2008, the Department of Health and Children and the HSE, in partnership with the Health Service National Partnership Forum, published a *Service User Involvement Strategy*⁵⁴. This outlines the rationale for involving service users and the benefits of doing so at individual, community and national levels. Specifically it says “service users, especially those whose voices are seldom heard, have a right to be involved in the development of health and social services that they use

49 Consolidated text of the Equal Status Act 2000 and 2004. www.justice.ie/en/JELR/EqualStatusActsConsltdtd_00_04.pdf/Files/EqualStatusActsConsltdtd_00_04.pdf

50 Disability Act 2005. www.oireachtas.ie/documents/bills28/acts/2005/a1405.pdf

51 Department of Health and Children. *A Vision for Change*. Dublin: Stationery Office. 2006.

52 Mental Health Commission. Annual Report 2007 Mental Health Commission including the Annual Report of the Inspector of Mental Health Services. Dublin: Mental Health Commission. 2008.

53 Health Service Executive. *National Intercultural Health Strategy 2007-2012*. Dublin. HSE. 2008

54 Health Service Executive, Department of Health and Children. *National Strategy for Service User Involvement in the Irish Health Service 2008-2013*. Dublin. HSE. 2008

and this is a key element in the delivery of patient centred care.” It also states that “service users should be centrally involved in their own care”⁵⁵. Goal 5 specifies: “all involvement work will prioritise the participation of socially excluded groups and those whose voices are seldom heard”.

While there is no cohesive policy on ethnic minorities or immigration, a range of policies and laws directly impact on the quality of life and well-being of migrants and ethnic minorities in Ireland. These include Direct Provision, the dispersal policy (which led to the dispersal of asylum seekers around the country) and the Habitual Residency rule⁵⁶.

Likewise, there is a range of policies and rules which impact on lone parents, despite the absence of a policy overarching all work relevant to lone parents. Critical for lone parents are welfare to work policies, the level of income maintenance, childcare policies and opportunities for life long learning.

Conclusion

The communities involved in the BHC are some of the most excluded groups in Irish society, who experience a disproportionate burden of ill health and poverty. While there is a raft of policies, laws and rules which impact on the health needs and status of these people, many of the central policies which could positively influence their health, remain unimplemented years after their publication. Also other non-health public policies which have detrimental impacts on peoples’ health are developed and implemented without any cognisance of their health impact.

Only through the implementation of

existing policies and the fairer distribution of resources can the health of these communities be improved and health inequalities reduced.

55 page 11. Health Service Executive, Department of Health and Children. *National Strategy for Service User Involvement in the Irish Health Service 2008-2013*. Dublin. HSE. 2008

56 Habitual residence means you have a proven close link to Ireland.



Appendices

Appendix A – Publications, reports and submissions from Building Healthy Community Projects

OPEN

Out of the Traps. Ending poverty traps and making work pay for people in poverty. 2006

Addressing mental health issues amongst lone parents experiencing isolation. OPEN. 2007

Submission to the NESF Project Team on Mental Health and Social Inclusion. OPEN. 2007 www.oneparent.ie

CÁIRDE

Community Development and Health Programme. An Intervention for Social Change. A Case Study for Capacity Building Phase of the Programme. Grainne O'Toole. Cáirde. 2006

Assessing the Health and Related needs of Minority Ethnic groups in Dublin's North Inner City. A Case Study of a community development approach to health needs assessment. Cáirde. 2006

Submission to HSE on draft National Intercultural Strategy. Cáirde 2007

Submission to HSE on National Service User Involvement Strategy. Cáirde 2007

National Ethnic Minority Health Forum. Consultation for the National Intercultural Strategy in Health. Report from a national conference held on 23 January 2007, in Tullamore. Galway Refugee Support Group participated in this consultation. www.cairde.ie

WOMEN TOGETHER NETWORK

Women Together Network. Evaluation Report. Women Together Network and Schizophrenia Ireland. 2005

Schizophrenia Ireland. Submission to the National Economic and Social Forum on Mental Health and Social Inclusion. 2006

Women Together Network. *Speak for Yourself. Prose and poetry from the Women Together Network Writers Groups 2006-7.* Edited by Susan Knight. Aungier Press. 2008

IRISH DEAF SOCIETY

Some Sound Advice – Guidelines in improve access to and utilisation of health services for the Deaf in Ireland. 2007

IDS has produced DVDs on Introduction to Health Literacy, Men's Health and Basic Signs for Doctors and Health Service staff, Maternity services and a poster on how to communicate with Deaf people.

www.deaf.ie

GALWAY REFUGEE SUPPORT GROUP

The mental health promotion of asylum seekers and refugees in direct provision and private accommodation in Galway City. Galway City Development Board/HSE 2007.

Conference Report on Emerging Areas of Practice. Galway Refugee Support Group. 2006.

Galway Refugee Support Group Submission to the Health Service Executive Intercultural Health Strategy Group. *A framework for the health care and support needs of people from diverse ethnic backgrounds and cultures.* Galway. 2007. GRSG.

Galway Refugee Support Group (GRSG). *Submission from GRSG to NESF Mental Health and Social Inclusion project team.*

'Addressing the Mental Health Needs of Minority Ethnic groups and Asylum Seekers in Ireland. National Conference HSE West January 2006. Quoted in Galway Refugee Support Group Submission to the Health Services Executive Intercultural Health Strategy Group. Galway. 2007. GRSG. Email: refugee.galway@ireland.com

GALWAY TRAVELLERS SUPPORT GROUP

Galway Travellers Support Group. *Composite Submission to the National Intercultural Health Strategy from Travellers and Traveller Organisations Nationally.* 2007.

FETTERCAIRN HEALTH PROJECT

Taking the First Steps to a Healthier Fettercairn, Fettercairn Community Health Project Participatory Rapid Appraisal Report. 2007.

Ground Gained, A Participatory Action Research Report on Mental Health in Tallaght, supported by the Special Project On Long-Term Unemployment Tallaght, CDP. email: equalaccesscdp@gmail.com

CAN

Evaluation Report of CAN/NICHE Community Development and Health Training, CAN/NICHE, 2007 www.canaction.ie

A Guide to Influencing the Health Services. Community Action Network, Combat Poverty Agency, 2007

Community development is good for your health, CAN comment, CAN. 2006.

FATIMA GROUPS UNITED

Things Can be Different, The Transformation of Fatima Mansions. Fatima Groups United and CAN. 2007. www.fatimagroupsunited.com

Previous Building Health Communities Projects' publications

A Model for Community Participation in Primary Care. Lifford Castlefinn Primary Care Project. 2004. Health Services Executive.

Mulhuddart Primary Health Research Project. Sharon Cosgrove. 2004.

APPENDIX B

Combat Poverty publications

Farrell, C, McAvoy, H, Wilde, J and Combat Poverty. *Tackling Health Inequalities. An All-Ireland Approach to Social Determinants.* Institute of Public Health and Combat Poverty Agency. 2008

Tackling Poverty and Health Inequalities – Community Participation in Primary Care, Conference Report, Combat Poverty Agency, 2007

Health Policy Statement, Dublin, Combat Poverty Agency, Combat Poverty Agency, 2007

Poor Prescriptions: Poverty, Health and Access to Services. Layte, R, Nolan, A., and Nolan, B., Combat Poverty Agency, 2007

Silent People and Other Stories. Susan McKay for Combat Poverty Agency, 2007

A Guide to Influencing the Health Services. Community Action Network, Combat Poverty Agency, 2007

Community Development and Health. Siobhan Lynam, Combat Poverty Agency 2007

Evolution of Health Services And Health Policy In Ireland. Brian Harvey. Combat Poverty Agency 2007

Setting standards to achieve equity of access to quality of primary care services. Combat Poverty Agency 2006.

Community Development: Current Issues and Challenges. Anna Lee. Combat Poverty Agency 2006

Community Development and Public Policy: guidance on the application of community development approaches to different aspects of anti-poverty and social inclusion work. Combat Poverty Agency. 2006

The Role of Community Development in Tackling Poverty in Ireland. A Literature Review for the Combat Poverty Agency. Dr Brian Motherway. Combat Poverty Agency. 2006

Community Participation and Primary Care: learning from the Building Healthy Communities Programme. Combat Poverty Agency. 2005

Tackling Health Inequalities: a community development approach. Combat Poverty Agency. 2005

Health Services and the National Anti-Poverty Strategy. Combat Poverty Agency. 2005

Poverty is Bad for your Health. Ruth Barrington. Combat Poverty Agency. 2005

Community Development and Primary Care in Northern Ireland and England. Dr Philip Crowley. Combat Poverty Agency. 2003 www.combatpoverty.ie

Building Healthy Communities



Bridgewater Centre, Conyngham Road, Islandbridge, Dublin 8

Tel: 01 670 6746 Fax: 01 670 6760 Email: info@combatpoverty.ie Website: www.combatpoverty.ie