Our Voices,
Our Mental Health,
Our Rights:
Listen to Our Stories

A narrative inquiry with members of the Traveller, LGBT+, asylum seeking and refugee communities in Galway

About us

Galway Traveller Movement's work is rooted in an understanding of and respect for the distinct culture and ethnic identity of the Traveller community.

Vision

Full equality, social justice and human rights realised for members of the Traveller community, and meaningful participation of Travellers in social, economic, political and cultural life.

Mission

To challenge discrimination and racism experienced by the Traveller community in Galway city and county; to challenge the status quo and to empower members of the Traveller community to take action to realise Traveller rights.

AMACH! LGBT Galway aims to reflect equally the diversity within the lesbian, gay, bisexual and transgender community by encouraging positive participation from the community. We actively advocate for a solid and safe support structure for the LGBT+ community in Galway.

BRIDGE (Building a Receptive and Integrated Galway of Equals) is a project which seeks to promote the effective delivery of reception and integration supports (including advocacy and capacity building interventions) to asylum seekers and third country nationals living in Galway City and County.

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Contents

Glossary of Terms

Asylum seeker is the term used for a person seeking to be granted international protection as a refugee outside their country of origin and awaiting the determination of his/her status. People in this process are legally entitled to stay in the state until their application for protection is decided. They also have a right to a fair hearing of that application and to an appeal if necessary.

Bisexual is a term used to describe someone who is sexually, emotionally and romantically attracted to both men and women.

Coming out is a process that involves an LGBT+ person developing an awareness of and accepting their sexual orientation or gender identity, choosing to share the information with others and building a positive identity. It also involves dealing with the potential challenges that one might encounter as an LGBT+ person.

Direct Provision is a highly contested system of asylum seeker accommodation operated by the Reception and Integration Agency (RIA) of the Department of Justice and Equality which provides asylum seekers with accommodation free of charge. It was introduced in 1999 as an 'interim' system but is still in place. Asylum seekers in Direct Provision are usually entitled to state-funded medical care and children have full mainstreamed access to the primary and secondary education system. In 2017, the weekly allowance for adults was raised from €19.10 to €21.60 and for children from €15.60 to €21.60 per week.

Gay is a term traditionally used to describe a man who is sexually, emotionally and romantically attracted to other men. While the term 'lesbian' is typically used to describe women who are attracted to other women, many women with same-sex attractions self-identify as 'gay'.

Gender is a concept that describes how societies determine and manage the cultural meanings attached to men and women's roles, but also how individuals understand their identities in relation to these cultural meanings (gender identity). These understandings include, but are not limited to, being a man, woman, transgender, intersex, not identifying with any specific gender (nonbinary), gender queer, gender fluid, rejecting gender categories altogether (agender) and other gender positions. Gender may or may not depend upon biological traits and may or may not correspond to the sex assigned at birth.

Gender binary is the classification of gender into two distinct, opposite, and disconnected forms of masculine and feminine, whether by social system or cultural belief.

Heteronormative, or the 'heterosexual norm', refers to the assumption that heterosexuality is the only, primary or 'normal' sexual orientation, and can often cause other sexual orientations to be ignored and excluded. It is closely related to 'heterosexism', and its underlying assumption that heterosexuality is the superior sexual orientation. This assumption often results in an insensitivity, exclusion or discrimination towards other sexual orientations and gender identities, including LGBT+.

Lesbian is a term used to describe a woman who is sexually, emotionally and romantically attracted to other women.

LGBT+ is an acronym for 'lesbian, gay, bisexual, transgender and related communities'. The 'plus' is inclusive of other groups, such as asexual, intersex, queer, questioning, etc.

Refugee is the term used for someone who, due to a well-founded fear of persecution, war or violence, has been forced to flee their home country. The legal definition of the term refugee was set out in the 1951 UN Convention on the Status of Refugees.

Sexual identity is how one thinks of oneself in terms of to whom one is romantically or sexually attracted. Sexual identity may also refer to sexual orientation identity.

Sexual orientation refers to an enduring pattern of emotional, romantic or sexual attraction to men, women or both. It includes a wide range of attractions and terms, the most common being gay, lesbian, bisexual and heterosexual. People who do not experience attraction to any sex may define themselves as asexual.

Transgender is an umbrella term referring to people whose gender identity and/or gender expression differs from conventional expectations based on the gender they were assigned at birth. This can include people who self-identify as transsexual, transvestite, cross-dressers, drag performers, genderqueer, and gender variant. Transgender is commonly abbreviated to trans. Male-to-Female Transgender refers to a person assigned 'male' at birth but who identifies as female. Female-to-Male Transgender refers to a person assigned 'female' at birth but who identifies as male.

Transphobia is prejudicial or discriminatory attitudes and/or behaviour directed at people who are transgender, transsexual, or people whose gender identity or gender expression differs from the traditional binary categories of 'male' and 'female', whether intended or unintended.

The Traveller community is an ethnic minority indigenous to Ireland with its own traditions, language, practical skills, culture, arts and music, and strong values built around families, care and extended families. One of the biggest influences on Traveller culture is the nomadic lifestyle, a distinctive feature of Traveller culture that differentiated between Traveller and 'settled' lifestyles. The Traveller community accounts for approximately 0.5% of the Irish population. The 2016 Republic of Ireland census shows that, after Dublin city and suburbs, Galway city and suburbs has the largest number of Travellers with 1,598 persons.

Executive Summary

This report contextualises and documents a round table event about the mental health of Galway city's minority groups, held in the Maldron Hotel, Galway, on March 22nd 2019. A member of the LGBT+ community, a member of the Traveller community and a member of the refugee and asylum seeking community told their stories of engaging with the mental health services to an audience of mental health professionals and civil society members. The subsequent round table discussed the question, ***How can mental health services respond to minority needs and achieve cultural competence?*** The purpose was to situate members of each community as the experts in their own lives, and to engage in critical dialogue about mental health and wellbeing through a cultural, social and political lens. The event was organised by Galway Traveller Movement (GTM), Amach![1] (the LGBT+ organisation) and BRIDGE (Building a Receptive Integrated Diverse Galway of Equals) a project which works with asylum seekers and refugees. It was funded by Healthy Ireland, Galway City.

Part 1 of this report, composed of three chapters, sets the scene for the round table discussion. **Chapter 1** outlines the rationale for the project based on an ethic of social justice and human rights, drawing on qualitative questionnaire feedback completed by the three organisations. It discusses 'cultural competence' in relation to the politics of how 'mental health' is defined and addressed. It contests mainstream individualistic assumptions that obscure the social and political contexts of trauma, including racism, discrimination and heteronormativity, and which also obscure people's own knowledge and resistances. It argues for a community development approach to mental health that values insider voices and knowledge and challenges the status quo. This envisions an expanded collaborative context of co-produced knowledge, engagement and action between community members and mental health professionals.

Chapter 2 initiates an engagement with this insider knowledge of mental health and mental health services by documenting a

[1] *Amach is an Irish word which means 'out'.*

focus group discussion with/between six people from minority groups - one member of the asylum seeking/refugee community, three members of the Traveller community and two members of the LGBT+ community (five women and one man). The stories and insights of the participants are presented under the following themes: Mental Health and the Social World; The Mask; Social and Cultural Contexts; Responses/Non-responses of Mental Health Services (Waiting for Services, In the Psychiatric Unit, Not Listening, Therapeutic Relationships: Some Cultural Considerations); Women and Mental Health; Beyond the Professionals: Getting through Hard Times.

Three of the focus group participants told their stories at the round table event. **Chapter 3** introduces the collaborative narrative methodology of the preparatory conversations and the documentation if the stories. The narrative perspective positions the person as the expert in their own lives, and also assumes that our lives and identities are social, relational and multi-storied (White, 2007; White & Epston, 1990). This assumption

informs practices of 'double-listening' where one listens, not only to the trauma story, but also to stories of the person's responses and resistances (White, 2003, 2004).

Part 2 of the report documents the round table contributions. **Chapter 4** is authored by 'Sarah', a non-gender-conforming lesbian from a working class background. Sarah's story vividly describes how heteronormativity and class bias intersected to bring social anxiety into her life, amplified in many of her encounters with medical and mental health professionals. Yet, a powerful counter-narrative is her own sustained desire and search for a community of belonging respectful of difference. Holding to this desire enables her to interrupt the normative trajectory of medicalised responses. Her search for community becomes realised through her involvement with Amach as well as lesbian-friendly therapeutic support. Sarah's key message is about the need for a more holistic approach to mental health, and the need for mental health services to have an awareness of minority groups.
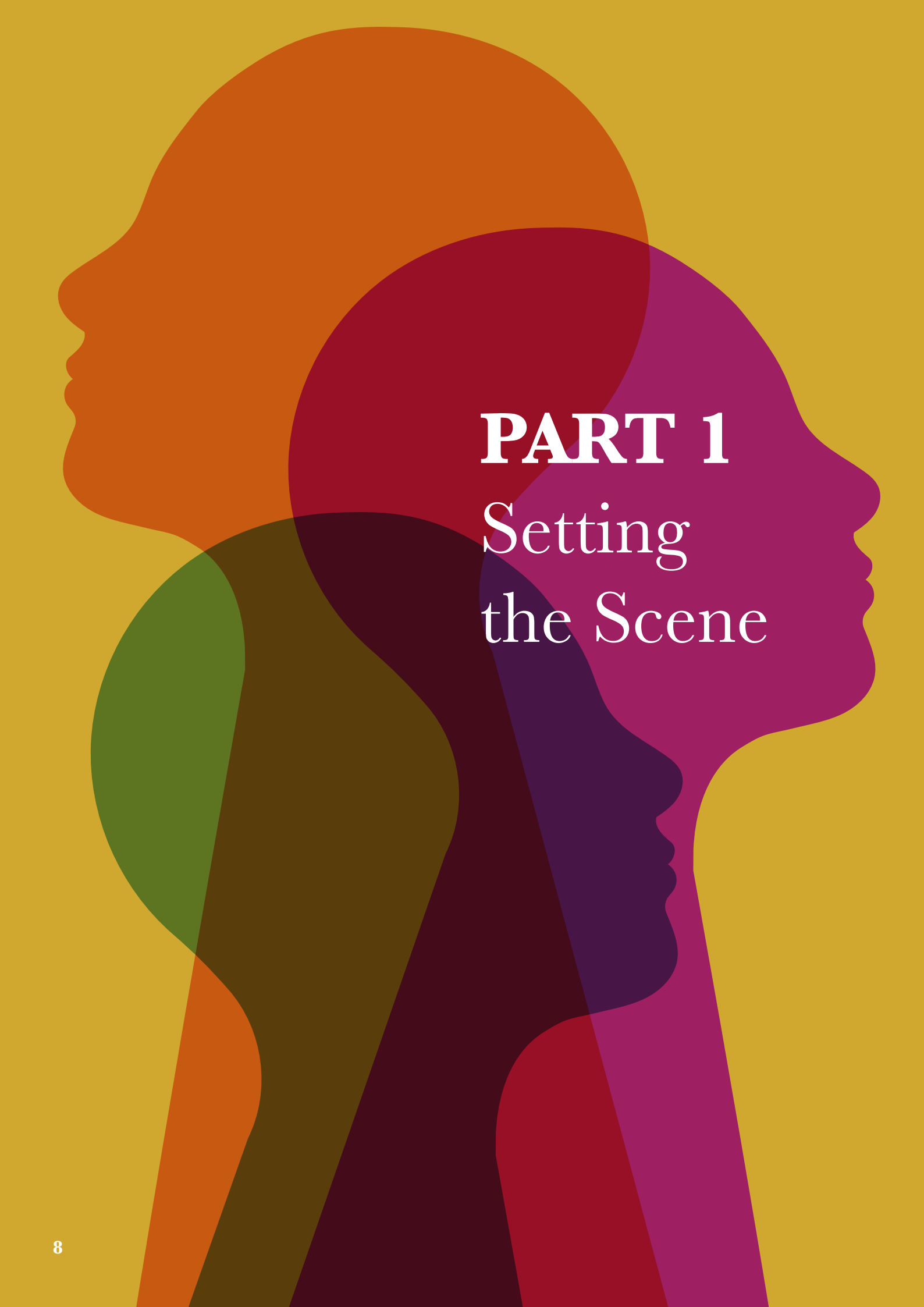
Chapter 5 is authored by 'Fatima', a lone parent, a survivor of Direct Provision, and a woman fighting against a history of awful poverty to create a future for her children. Fatima powerfully evokes the loneliness of life as an asylum-seeker who does not speak English. She tells of her reluctant relationship with anti-depressants, and how the important benefits of the family therapy she and her children received are undermined by the stresses of living in Direct Provision. Yet, she narrates how she stayed connected to her own knowledge and skills of survival through music, working and cooking – defying the rules - in order to keep hope alive. Sarah's story is also one of an appreciation of kindness. Her key message is about the importance for asylum seekers of being listened to.

Chapter 6 is authored by 'Margaret', a member of the Traveller community. She opens her story with a detailed account of how her beloved brother suddenly became mentally unwell, of her knowledge that something very grave was at stake, and the devastating effects on her and her family of initially not being listened to in the psychiatric unit of University College Hospital Galway. Her story expands into an account of the personal, social and cultural history of her knowledge and concerns, embodied through family bonds where she is the oldest of thirteen. Margaret's is a story of family grief and trauma.

It is also one of knowledge, skills and wisdom developed through family connections of love and care, forged in a context of anti-Traveller racism and discrimination. Margaret credits the support of family, living on her halting site, and friendships with both Travellers and settled people - developed through her involvement with Galway Traveller Movement - as being vital for sustaining her own mental health. These connections and her experiences all inform her insistence that mental health professionals must listen to and become friends with the Traveller community.

Chapter 7 presents the report of the round table discussion after listening to these stories in response to the question, ***How can mental health services respond to minority needs and achieve cultural competence?*** The recommendations of participants are combined with questionnaire recommendations from the three organisations and structured under the themes of: Social Analysis of Mental Health; Principles of Mental Health Practice; Training in Cultural Competence for Mental Health Professionals; A Community Development Approach to Mental Health; Quality Culturally Competent Mental Health Services for Minority Groups; Political Action and Public Education.

PART 1
Setting the Scene

Chapter 1
The Politics of Mental Health for Minority Groups

Introduction

In a room in the Maldron Hotel, Galway, on March 22nd 2019, 'Sarah' from the LGBT+ community, 'Fatima' from the refugee and asylum seeking community, and 'Margaret' from the Traveller community[2] told their stories of engaging with the mental health services. Each story, imbued within its own social, cultural and political context, wove around the tables of the quietly attentive gathering: mental health professionals, other members of the LGBT+, Traveller, and asylum seeking and refugee communities, and civil society groups. Hanging in the air was the question everyone would discuss at their tables afterwards: ***How can mental health services respond to the needs of minority groups and achieve cultural competence?***

The purpose of the round table discussions was to engage in critical dialogue about mental health and wellbeing through a cultural, social and political lens. Funded by the Healthy Ireland Initiative, the event was organised by three Galway community organisations: Galway Traveller Movement (GTM), an organisation of Travellers and settled people working in solidarity together; Amach!, the LGBT+ organisation; and BRIDGE (Building a Receptive Integrated Diverse Galway of Equals) a project which works with asylum seekers and refugees. It was funded by Healthy Ireland.

The work and activism of the three organisations is against a devastating background of anguish and despair for many community members. A recent study highlights that young LGBT+ people report rates of self-harm as two times higher, and attempted suicide as three times higher, compared to their non-LGBT+ peers (Higgins et al, 2016). In the Traveller community, the suicide rate for Traveller women is six times higher compared to settled women and the rate is seven times higher for Traveller men compared to settled men (Abdalla et al, 2010). While refugees, asylum seekers and migrants have been identified as suffering up to ten times the rate of post traumatic disorder (PTSD) compared to the indigenous population (Fazel et al, 2005), the College of Psychiatrists of Ireland (2017) points to the inappropriateness of the term 'post-traumatic stress disorder' for many refugees, asylum seekers and migrants because 'the process of migration into an alien and frequently hostile culture can mean that the trauma is still ongoing. It has not yet reached the "post" stage' (p. 1).

A cultural, social and political perspective is not the norm for considering questions of mental health and mental health service provision. It is more common to regard what are called 'mental health problems' as somehow located in the person's mind or brain, with an array of expert interventions designed to produce

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[2] *These are pseudonyms.*

individual change. Yet, the kinds of mental pain and distress, and the sense of despair and hopelessness experienced by many members of the Traveller community, the LGBT+ community and the asylum seeking and refugee communities, more often have their genesis in the social and political domain – in systemic discrimination, exclusion, racism and heteronormativity. The traumatisation of oppressed groups is an insidious aspect of everyday life as Burstow (2003) describes:

> *Oppressed groups are subject…to what Root (1992) called the insidious traumatization involved in living our everyday lives in a sexist, classist, racist, ableist and homophobic society: the daily awareness of the possibility of rape or assault, the daily struggles to stretch insufficient wages so that the family eats, encountering yet another building that is not wheelchair accessible, and seeing once again in people's eyes that they do not find you fully human. (p. 1308)*

If the individualistic model of mental health does not work for members of minority groups, then it does not work for mental health professionals either. Many find themselves exasperated and/or demoralised, perhaps experiencing fatigue and burnout, as their interventions often seem to show little sustained result.

The current qualitative project addresses issues of mental health for minority groups through an ethic of social justice which requires a shift in analysis, context and action. Our analysis regards the personal as social, cultural and political. Our purpose is to initiate a transformation in the perspective mental health services take in working with members of minority groups. Ours is a community development approach that challenges the status quo. We invite mental health professionals to join with community members and their organisations in adopting an ethic of social justice in order to open up an expanded context of the personal, social and political for engaging with people. All this requires a shift in how knowledge and expertise is recognised and positioned. In our project, the experts we listen to are the members of the groups themselves, and they share their knowledge through story-telling.

This chapter outlines the rationale for this project, drawing on questionnaire[3] feedback completed by GTM, Amach! and BRIDGE[4]. It addresses the notion of 'cultural competence', the policy context of mental health, and the importance of a community development approach. It also discusses questions of power and politics regarding how mental health is defined and addressed.

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[3] *See questionnaire, Appendix 1*

[4] *No claims are made about the generalisability of the questionnaire responses. This primarily qualitative feedback is from the particular perspectives of GTM, Amach! and the Bridge Project to set out their rationale for initiating the project.*

Why this project?

Such critical discussion is urgent. In the views of GTM, Amach! and BRIDGE, the HSE mental health services being offered to Galway's minority communities are, in general, not responding appropriately to their needs. In questionnaire feedback provided by the organisations, each drew on their particular experience to *'strongly disagree'* with the statements that *'the HSE mental health services in Galway provide an excellent service'* to respectively the LGBT+ community (Amach!), the Traveller community (GTM) and the asylum seeking and refugee communities in Direct Provision (BRIDGE and Amach)[5].

This overlapping consensus is reflected in the three organisations' accounts of negative aspects[6] of people's engagement with the HSE mental health services:

• a lack of clear information for services users; a lack of clarity on the levels and types of support given and, sometimes, who it is appropriate to access support from;

• long waiting times with little information or support in the interim period;

• people often waiting on long lists to be told that the service they have been referred to is not the right one for them and the "loop back to the start of the process again";

• the quality of the service received is very dependent on the personalities of individuals working there;

• the perception of overprescribing of anti-depressants and sleeping tablets; that children are being prescribed drugs too easily;

• the difficulty of getting residential care if needed;

• how those with addictions to drugs and alcohol are *"put down to the bottom of the pile"* - *"mental health services want them free of the addiction before working with them but their mental health is driving the addiction"*.

These negative experiences are intertwined with issues specific to community members. Amach! notes that long waiting lists are of particular concern for members of the transgender community waiting for psychologists, and the *"lack of capacity within the services for those we refer"*. Amach! also reports a heavy reliance on patient advocacy for appropriate referral as doctors sometimes do not have the correct information. BRIDGE highlights how many asylum seekers and refugees cannot know about or access services because of language barriers, as well as negative experiences with interpreters when accessing a service. GTM highlights how membership of the Traveller community can mean being pre-judged, not being listened to or taken seriously, and being denied a quality service. They also report *"a complete lack of understanding of Traveller culture"* and a lack of focus on the *"root causes"* behind the mental health issues, for example, *"limited understanding of the impact of oppression and discrimination on the mental health of the Traveller community"* and *"the trauma caused by discrimination and being hated by the majority population"*.

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[5] Q. 11 of the questionnaire invited respondents to rate statements that 'the HSE mental health services in Galway provide an excellent service' to (a) members of the asylum-community living in Direct Provision; (b) members of the Traveller community and (c) members of the LGBT+ community. According to the organisation's experience, these were rated on a scale of 0-10 where 0 was "strongly disagree" and 10 was "strongly agree". Each organisation rated the statement referring to services for their target community at 2 i.e. GTM for the Traveller community, the Bridge Project for asylum-seers in Direct Provision, and Amach! for members of the LGBT+ community. Additionally, Amach! rated the statement for asylum seekers at 1, reflecting their experience of working with members of the LGTBI community seeking asylum.

[6] Organisations were invited to describe both positive and negative aspects of the services. The account of positive aspects is reported below.

The three organisations variously describe the effects of these negative experiences on the people looking for support from the mental health services as *"devastating"*, *"frustrating"*, and *"being overwhelmed when looking for support and being referred from pillar to post"*. The result is a lack of confidence and a lack of engagement with the services – an *"inclination to give up"*. This means increased risk of isolation, a sense of *"hopelessness and suffering in silence"* resulting in further marginalisation, exclusion and ongoing mental health issues.

Hearing community members' stories of engaging with the health services, and witnessing the effects of these encounters on people's lives, was the motivation for GTM, Amach! and the BRIDGE to come together to initiate change.

The Need for Cultural Competence

GTM, Amach! and BRIDGE are not alone in their critical evaluation of the mental health services. The Mental Health Commission concludes in its 2017 Annual Report that there is much to be concerned about in the national mental health services (Mental Health Commission, 2017). This warning, notes an Oireachtas Report on the future of mental health, 'is not the first note of alarm from the State's statutory body for quality assessment of mental health services' and 'should be a sobering check for the reality of mental health services' (Houses of the Oireachtas, 2018, p. 15).

These notes of alarm are despite a now thirteen-year-old policy framework for the mental health services, *A Vision for Change* (Department of Health and Children, 2006). That policy framework includes a section on 'Responding to the Mental Health Needs of Minority Groups' which states:

> *[T]ravellers, gay and lesbian individuals[7], deaf individuals, and people from other countries and cultures, require specific knowledge and understanding on the part of those delivering mental health services, in terms of their culture and other characteristics. (p. 40)*

However, there has been little implementation of this recommendation in *A Vision for Change* on the need for culturally appropriate mental health services (Mental Health Reform, 2014).

[7] *A Vision for Change does not include any references to bisexual or transgender people.*

This raises the question of cultural competence in the mental health services. Mental Health Reform and Mental Health Commission (2016) guidelines on ethnic minorities use the term cultural competence to refer to:

> *the attitudes, behaviours, knowledge and skills that mental health professionals need to have in order to deliver culturally responsive mental health services, while recognising that such competency must incorporate addressing power imbalances and institutional discrimination. (p. 4)*

They highlight the need for a more developed framework for implementing cultural competence, 'that would specify the content of competency training and define the scope and meaning of the "culturally sensitive" mental health services referred to in *A Vision for Change*' (p. 4). Research produced by the Gay and Lesbian Equality Network and BelonGto Youth Service also recommends that cultural competence training specific to LGBT populations should be a standard component of all health professional training curricula (Maycock et al., 2009, p. 143). Notions of 'culture' which conjure ideas of fixed behaviours and beliefs must, of course, be avoided. Culture must be viewed rather as a complex, dynamic and heterogeneous web of meanings and values, including recognition of the intersections of gender, ethnicity, class, disability, age, sexuality and so on.

At a fundamental level, the issue of cultural competence opens up questions of cultural knowledge. In particular, it invites the question: who has the relevant cultural knowledge for informing practice? The obvious answer, of course, is the community members themselves. Indeed, A Vision for Change advocates a community development approach to mental health for engaging with minority groups – something we consider as integral to cultural competence:

> *Community development models of mental health are particularly useful in the provision of mental health services to culturally diverse groups. Services need to reach out actively to communities to find alternative paths to channel support to individuals and families… The community development approach can be a useful way to engage with people from minority groups and is a useful complement to what is offered by mental health services. (Department of Health and Children, 2006, p. 40)*

The point of the current initiative is not to diminish the work of the many kind and committed mental health professionals. Rather, it is an opportunity to open up possibilities for a more expansive context of collaboration, engagement and solidarity which harnesses the combined energies of community organisations and mental health professionals. At the heart of this is a cultural and political shift which positions community members as the experts in their own diverse experiences of mental health, and their own social and cultural contexts. This also requires an analytical shift in the paradigm of mental health to recognise that most of what become called 'mental health problems' for minority groups have their roots in structural inequalities.

Our story-telling and critical dialogue initiative is based on the insistence that a transformative social justice and rights-based approach must inform the mental health policy of minority groups. The International Covenant on Economic, Social and Cultural Rights guarantees the right to 'the highest attainable standard of physical and mental health'[8]. A rights-based approach accords with the recent strategic plan of the Mental Health Commission (2019), including the importance of ensuring compliance with national and international human rights principles. To recognise mental health as a human right also means recognising that the right to mental health of members of the Traveller, LGBT+ and asylum seeking and refugee communities is indivisible from their other economic, social and cultural rights. This is a transformative social justice perspective which also insists on recognising the social determinants of mental health (Kenyon, 2018; World Health Organisation, 2014). We regard telling these stories, too often silenced, as a form of political action, and participation in the practice of rights.

All of this opens up a fundamentally political question: what is mental health?

The Politics of Mental Health

A Vision for Change includes the important recognition that the notion of mental health is not a self-evident truth:

> *A 'model' for understanding mental health needs to be formulated, because the way mental health is viewed (i.e. the model used) determines society's approach to emotional distress and mental health problems. If there is no understanding of what factors influence mental health, we cannot hope to prevent mental health problems, to promote better mental health, or to deal effectively with mental health problems. (Department of Health and Children, 2006, p. 18)*

The policy advocates the biopsychosocial model which 'highlights the interconnection and interdependence of people's biological, psychological and social functioning' (p. 18). Importantly, *A Vision for Change* notes that 'The artificial separation of biological from psychological and social factors has been a formidable obstacle to a true understanding of mental health' (p. 18). This echoes the concerns highlighted above of Amach, BRIDGE and GTM about the over-reliance of mental health services on prescription drugs.

Yet, we should hesitate before uncritically assuming as an alternative the warm embrace of the psychological. Mainstream psychological approaches have evolved through notions of a 'normal' human being informed by the dominant Western, heteronormative, settled, middle-class, white culture[9].

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[8] *Article 12.1 (UN General Assembly, 1966).*

[9] *For perspectives critical of mainstream psychology's assumptions and which advocate politically engaged psychology of liberation perspectives, see for example Burstow (2003), Denborough (2008), Fox and Prilleltensky (1997), Moane (2002, 2009), Prilleltensky and Nelson (2002), Sonn and Montero (2009), White and Epston (1990).*

From this perspective, members of the LGBT+, Traveller and asylum seeking and refugee communities are already other. Moreover, mainstream psychological approaches view the problem as internal to the person, with interventions focusing on cognitive, behavioural or emotional change at the level of the individual. The person must accommodate and adapt to an unchanged social world, such as the stresses of Direct Provision, unserviced halting sites, normative assumptions that we are all 'straight', or that our identities slot into a gender binary. Individualistic discourses of mental health actively conceal the social and political contexts that produce trauma, pain and distress, and the struggles of surviving in a racist, heteronormative, transphobic, classist, sexist society. They also conceal the initiatives, resistances, and acts of care of individuals, their families and their communities. In the words of the former slave William Prescott, 'They will remember that we were sold but they won't remember that we were strong. They will remember that we were bought, but not that we were brave' (in Denborough, 2008, p.42).

The naming and defining of mental health and mental health problems then is an act of power. The received authority of mental health professionals to diagnose and intervene in another person's intimate territories of existence reflects enormous cultural power. What White calls 'the culture of the professional disciplines' is characterised by an exclusivist top-down notion of 'expert knowledge' (White, 1997, p. 20). This poses a particular challenge to a community development approach to mental health. The importance of such an approach lies in placing the knowledge of community members themselves at the centre, emphasising the connections of body, mind, relationships and society, including social transformation.

This wealth of analysis, knowledge and action is reflected in the work of Amach!, BRIDGE and GTM. Amach!, an organisation completely run by volunteers from the LGBT+ community, provides "a safe space for members of the LGBT+ community to meet, discuss, and explore issues impacting on them", particularly through its resource centre, Teach Solais. The organisation aims:

> *To support the LGBT+ community to have a voice, to participate in, and influence decision-making structures to challenge discrimination and bring about changes in the issues affecting the LGBT+ community.*

For example, to be able to offer free counselling based from the centre would be *"a valuable service that the community would avail of"*. BRIDGE similarly aims:

> *To promote integration and to support and empower new communities living in Galway City and County, by providing psychosocial support, information and advocacy and training and up-skilling.*

Indeed, the name itself speaks to a vision of social transformation: Building a Receptive Integrated Diverse Galway of Equals.

Galway Traveller Movement connects the psychological and the social by combining the provision of culturally appropriate counselling with political campaigning. Its vision is of:

> *Full equality, social justice and human rights realised for members of the Traveller Community, and meaningful participation of Travellers in social, economic, political and cultural life.*

Its vision is:

> *To challenge discrimination and racism experienced by the Traveller Community in Galway city and county; to challenge the status quo and to empower members of the Traveller community to take action to realise Traveller rights.*

However, a full appreciation of the vital contributions of community organisations to the mental health of minority groups appears to be lacking on the part of the mainstream HSE health services. While all three organisations are involved in referring community members to mental health services, only BRIDGE reports receiving referrals from mental health organisations. This appears to indicate an under-appreciation of the vital social and community dimensions of mental health. This lack of appreciation is pointedly illustrated by the threatened closure of Amach's resource centre, Teach Solais, because of an inability to secure core funding.

Yet, the picture is not all negative. Amach! highlights the importance of the local HSE Office of Suicide Prevention – albeit this is the only HSE service to have approached Amach!. The Suicide Prevention Officer is an active member of the Galway LGBT+ interagency group. Amach! also played an active role in the Connecting for Life Strategy. GTM also works closely with the local Office of Suicide Prevention and also contributed to developing the Connecting for Life Strategy. Additionally, GTM forms part of the Mental Health Subgroup of the Traveller Health Unit. At the level of front-line services, as BRIDGE highlights, the provision of free counselling to medical card holders is an important and positive aspect of the mental health services. The Bridge also notes the valuable work of the Community Mental Health worker, described as "very supportive" to individuals. The effects of such positive experiences on people receiving the service are "reassurance in services, trust in services". GTM too describes "some very positive feedback" from community members by taking a "broad understanding of the mental health services" to include counselling services, Grow, Pieta House, Console, Féileacáin - Still Birth and Neonatal Death Association of Ireland, etc. In these services, "People are welcoming and empathetic and attempt to understand the difficulties faced by the Traveller community". The effects of these experiences are that "Travellers feel included. Travellers are given hope. Travellers feel that they can return to the service. Travellers feel that their culture is respected. Travellers feel that their culture is understood".

We may view these positive experiences of collaboration and mutual respect as providing the seeds for a renewed collaborative vision of mental health care and practice in Galway City. This vision is also reflected in the three organisations' desire for deeper and more purposeful collaboration between the mental health services and community organisations based on "real listening". In this vision, mental health professionals are also agents of change. As Vikki Reynolds, a therapist, community worker and activist from Canada writes,

> *We have power. Many helping professionals try to mitigate or equalize power in their work with people. I invite us to embrace our power and be accountable to it. I believe we have an obligation to contest neutrality. We are not neutral about hate. We have the power to move things from private pain to public issue (Tamasese, 2001; Hanisch, 1970) and to resist the privatization of the pain of suicide. As change agents, I believe we need to 'belong' people who have been told by hate that they do not belong on this earth, and we need to participate in delivering justice to them and to all of us.*
> *(Reynolds, 2016, pp 183-184)*

To further set the scene for this listening and belonging, the next chapter documents some reflections and insights from a focus group discussion with members of the Traveller, LGBT+ and migrant communities.

Chapter 2
A Focus Group Discussion with Members of Minority Groups

On February 18th, 2019, six people with their own particular knowledge and experiences of the mental health services met in the offices of Galway Traveller Movement. They were taking part in a focus group discussion about mental health services as part of the project reported in this document. The participants were 'Margaret', 'Mary' and 'Ellen' from the Traveller community, 'Sarah' and 'Noel' from the LGBT+ community, and 'Fatima' from the asylum seeking and refugee community[10]. The author of this report facilitated the discussion[11]. The stories and reflections of the focus group members are reported below through the following analytical themes:

1. **Mental Health and the Social World**

2. **The Mask**

3. **Social and Cultural Contexts**

2. **Responses/Non-responses of Mental Health Services**

   • *Waiting for Services*

   • *In the Psychiatric Unit*

   • *Not Listening*

   • *Therapeutic Relationships: Some Cultural Considerations*

5. **Women and Mental Health**

6. **Beyond the Professionals: Getting through Hard Times**

Mental Health and the Social World

Mary: *Years ago if a person suffered with depression, they were put into a "mad home for mad people". My parents did it to me when I was fifteen, but they didn't have a choice. They did it because I would have ended up taking my own life if they didn't do it. Do you know what electric shocks is? It's like the electric chair. You're on a bed, straps to your head. Your arms are strapped and your legs are strapped. There's a needle put into your hand. I've had it done six times. They played with my head because they did serious damage. I still feel that drilling in my brain today. If I'm asleep it'll wake me up. My brain wouldn't have been fully developed. I was only fifteen years old. So I'm glad there's an understanding today of what mental health is and what depression is.*

Mary's story of electric shock treatment provides a stark reminder of the acute power relations at stake in the provision of mental health services. She draws attention here to her parents' lack of choice. Importantly, Mary places this lack of choice and her own horrendous experience in a historical context for the purpose of underlining and welcoming transformed understandings of mental health.

But what are these understandings?

For members of the focus group, mental health is profoundly connected to possibilities for engaging with the world, and particularly, the social world of human relationships:

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[10] *These are pseudonyms. All participants were directly invited to participate by the organisation with which they had contact for the purpose of contributing their knowledge about mental health and mental health services. Ethical issues with regard to confidentiality, anonymity and permission were discussed and clarified through group discussion prior to any recording. All contributions in this chapter and their representation have been agreed with the participants.*

[11] *Margaret O'Riada of Galway Traveller Movement and Suzanne McKane of the Bridge Project were also present for the discussion as 'outsider witnesses' who listened to and gave a structured response of acknowledgement to each participant after the main discussion (see White, 2004, 2007).*

Noel: Say if a person is fit physically or unfit physically. You can apply that to mental health. Everything slows down. You're not exercising your faculties.

Mary: You're keeping away from other people, locking yourself in a room where you want to see nobody. You just want to be left alone to die.

Siobhán: When you don't feel like locking yourself away. What is that feeling?

Ellen: That feeling is good. You can walk around and talk to people and get on with people and have a laugh and a joke. Your mental health is good then. You're able to function like a normal person.

The Mask

Noel introduces the notion of the mask which becomes a resonant metaphor for others in the group to describe ways of negotiating the social world:

Noel: Then there's the mask. We all know that one!

Mary: I've worn that mask so many times. My family never knew with me what was going on. Because you can become a very good actor. Covering things.

Siobhán: Fatima? Any sense of having to put up a mask?

Fatima: Yeah. I think all the time. To show everybody everything is okay. To show my kids, my daughters, my friends. But when everybody goes to bed you're just thinking.

Siobhán: And what is the effect of that thinking on you?

Fatima: I guess mostly stress. The stress is my problem. But I'm learning how to deal with it.

Sarah, Margaret and Noel describe how the mask can develop into taking drugs and alcohol:

Sarah: I used to write poetry to kind of deal with my thoughts as a teenager, and yeah, the mask would have been a common theme in those poems. It's an expression I would have used a lot more in my teenage years before I guess I went to the extent of drug taking and drinking that I did. I think that then became the mask. I was just partying all the time and not dealing with anything.

Margaret: I have a brother who is very unwell mentally. For him, it was a personal trauma that led to getting sick mentally. But he masked it with addiction. We knew thathe was unwell because he was taking stuff, but we couldn't see the real picture behind it. Some of my family members would say, "What's he doing? He's an addict. Why is he taking drugs?" They were annoyed with him. But I knew at the time, I said there's something wrong here, he's doing this to hide something else.

Siobhán: What are people's ways of getting through hard times?

Noel: Drinking.

Siobhán: Did that help you to get through?

Noel: It did at the time but I sobered up. Dutch courage when I attempted suicide.

Siobhán: Was drinking part of the mask?

Noel: Bigtime. Because I was the soul of the party and I worked in a pub as well.

Social and Cultural Contexts

All the above accounts describe active responses to particular situations in particular social, cultural, and economic contexts. Thus, for instance, Fatima's concern to "to show everyone everything is okay", and the stresses which attend her thinking at night, are linked to her position as a lone parent, a former asylum-seeker and a migrant woman struggling to create a life for her family in Ireland[12].

The social context of mothering is also a theme for Ellen and Mary, in their cases trying to mother their children whilst mourning the loss of another child. Indeed, for all three Traveller women, their discussion of mental health is deeply bound up with family bonds and the pain of bereavement, providing some poignant emotional insight into statistics of the high suicide rate and relatively low life expectancy among members of the Traveller community reported in the *All Ireland Traveller Health Study* (Abdalla et al., 2010).

Ellen: My mental health issues started when I lost my husband. He was only fifty-three years of age. Three years after that I lost a son at eighteen years of age. I'd often lock myself in a room and just cry and cry and cry and cry. Just looking at photos of him. Not even talking to my own children. My children were there and I wasn't even talking to them. And they were suffering as much as I was suffering. But I didn't see that that time.

Mary: I lost a child as well who got killed on me at two and a half. And that broke me. Broke me. I had kids to rear and they were only babies at the time. I would have been sedated with a lot of tablets.

I would have been on a lot of anti-depressants, sleeping tablets, all of that. Because my husband was an alcoholic at the time. And I was dealing with that as well. And then that happened to me. My child was killed of a Saturday morning and I've never got over that. I will never get over that. I will bring it to the grave with me.

And sometimes I want to be with him, but I know my other kids need me as well. When I suffered with depression or I took an overdose or whatever, I didn't want to hurt my kids. I wanted to hurt me. Because I was hurting. And my way of dealing with it was damaging myself. Because I wanted to be with my children here, but I wanted to be with my baby in heaven as well.

Margaret: My brother turned to addiction because of the loss of his brother when he was ten. His brother was eight. It wasn't until he was in his thirties we noticed him getting quiet in himself. And when we asked him if he was okay he'd say he was okay but he was going off doing a lot of drinking. Then we lost another brother ten years ago. And things got worse. He turned more to drink and drugs. And that's when he really went downhill. His addiction got worse. He was masking his severe depression. For him, that was his way of coping with the loss of family members.

The themes of mask and social and cultural contexts are interwoven in some experiences shared by focus group participants. Sarah and Noel describe their masks as linked to their sexuality, and as responses to the heteronormative culture of a small town and a rural context, and then, in Sarah's case, not fitting into the Dublin gay scene:

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[12] *Fatima tells her story in more detail in Chapter 5.*

Sarah: (The mask) had to do with my sexuality, most definitely. Ireland in the 90s, you couldn't really come out in a small town. So you had to wear a mask... (Then in Dublin) I was taking so much drugs. I didn't fit in on the gay scene. I didn't fit in outside the gay scene. So I was taking lots of drugs.

Noel describes his "bottling up" about being gay as being linked to his own cultural expectations of other people's responses:

Noel: That's why people bottle things up. Maybe not because you were told that, but because you know that you might be told that. Because I came from a rural area and it's a culture thing as well, what I thought their expectations would have been of me. I would have gone out as a macho man, would have played football, worked outside. I was very manual, things like that. It's your perceived notions. Because in hindsight for me, from a personal point of view, if I'd come out earlier the world wouldn't have changed. Everything would have been fine. In hindsight, it was complete nonsense but you don't know that at the time.

Responses/Non-Responses of Mental Health Professionals

The members of the focus group were nuanced in their discussion of the various forms of response (or non-response) of mental health professionals. The various professional roles and contexts mentioned were: GP, psychiatrist, psychotherapist, counsellor, mental health nurse, Accident and Emergency services, the Child and Adolescent Mental Health Services (CAMHS), Adult Counselling Service, and hospital psychiatric unit. Some responses were judged to be helpful and responsive to the person's needs at a particular time, and some were considered not so helpful – sometimes with serious negative consequences.

The Psychology of Waiting for Mental Health Services

Fatima describes the stresses associated with waiting for a mental health service. She describes how important it was for her that she received a speedy appointment for her daughters with the CAMHS, giving some credit for this also to her GP:

I'm very lucky with my GP. I've had three GPs in the last three years and the three were very nice. And then the CAHMS they were very nice and helpful. When you have this kind of problem, the people say, "Okay, I will call you soon". But as long as you wait, you get more stressed and more anxious. But I don't know what my GP did. I talked to her one day and the next day CAHMS called me. So everything was sorted in a few days. The things came fast so that was very helpful for me.

Margaret also addresses the consequences of waiting for a service, in this case, in the Accident and Emergency Department.

She empathically describes the social context of waiting in casualty from the perspective of a person who "suffers with depression". She then recounts the tragic consequences this waiting had for a personal relative:

Margaret: Now I have things to say about that hospital. Everybody knows this feeling who suffers with depression. You go into casualty. You're stuck in a waiting room with a hundred people. You've in your head that these people are looking at me, they're judging me. This is what goes on.

My relative was in casualty for hours and hadn't been seen, although they had promised my niece that there would be someone to see him. He had already attempted suicide twice. He had tried to drown himself but two boys pulled him out. Then he took an overdose and ended up in intensive care in the hospital.

So on this occasion, he left the hospital because he was there for hours and hadn't been seen. He went out the door. He went into the river and he got drowned. He was only twenty-eight years of age.

In the Psychiatric Unit

In the following exchange, Ellen and Margaret critically discuss medicalised psychiatric treatment responses. Ellen highlights the problems of becoming dependent on prescription medication. Margaret concurs, whilst also highlighting that sometimes medication is necessary and appropriate. Additional commentary is provided by Noel and Mary:

Ellen: I know a woman that went into the unit and she came out ten times worse than when she went in. They were filling her up with that much tablets that the doctor couldn't keep her going.

Noel: That happened to me the first time.

Ellen: The mother had to go up to the unit and tell them to give her no more tablets. She didn't even know if you were talking to her or not. She used to be as high as a kite. They shouldn't be filling people up with tablets like that. I knew another woman who was on heavy heavy depression tablets. Everytime I seen this woman, she was as high as a kite. She was addicted to them. That tablet was her life.

Margaret: I know medication can be abused and people can become dependent on it. But there is a time when people is very unwell. There is a time when people does have to have medication. When my brother got really really unwell, they had to find the right medication to get him back on track. I suppose there's different doctors and some might be better than others but they did get him back on track. He had to get one type of a tablet before he started to come around because he was very very sick.

The place you're saying (the psychiatric unit), he's been over there about a year and a half ago. He had to go back in because he had a relapse. There is a time over there where they have to lock the door because he was so unwell that if he got out -

Mary: As Margaret said there, being put away is a last resort.

Noel shares a positive engagement with a psychiatrist in the unit which he describes as tough love. Perhaps one of the striking things about this psychiatrist's particular matter-of-fact response is how it works to normalise being gay:

Noel: Tough love. It can not work and it can work.

Siobhán: What do you mean by tough love?

Noel: I'd have to give an example. When I was in hospital, I hadn't come out. That was part of what caused my depression. I probably came out drunk to maybe a few family members. But I would deny it then of course the day after. I was seeing a psychiatrist in the hospital. And every time I'd visit him, he'd ask, "Do you have something else to tell me?" And I'd say no. And he'd say, "Okay, I'll see you next time." And the next meeting, same way: "Do you have something to tell me?" And I'd say no. I knew what he was getting at. And then, it was probably the fourth session, again he said, "Do you have something to tell me". And finally I was strong enough to say it, "Yeah. I'm gay". He said, "Okay. See you in two weeks".

And I just thought it was the cruellest thing! I knew from day one what he wanted me to say. And then, when he kind of got me to say it, he said, "Goodbye. I'll see you next time". He ended the session. At that second, it was tough. I thought, "The bastard!" After finally for the first time ever saying it out loud, that's the reaction.

But it worked. I was on cloud nine walking down the hallway. I could say it sober for the first time. The weight was lifted. Big time. My sister was waiting for me when I came down to the ward. I said, "You won't believe what just happened!" And I told her I'd just told the doctor I was gay. And she went, "Yeah I know!" And that was it.

Noel, supported by Mary, also emphasises the important role of the mental health nurse:

Noel: The mental health nurse is very important. Because in the unit, you are assigned a nurse each day. And you might tell that nurse something you wouldn't tell the consultant or the psychiatrist. Because they're there for you, and they do take an interest.

Mary: And they come out to the house to you.

In the next section, Margaret recounts an experience of initially not being listened to as a family member by doctors in the psychiatric unit.

Effects of not being listened to

In the following exchange, Margaret and Sarah discuss particular incidents of mental health professionals not listening. In each case, the women link this not listening to apparently fixed ideas held by the medics about addiction and drug-using which they both contest. They emphasise the importance of the pre-addiction histories to which addiction is a response:

Margaret: One evening nearly four years ago, my brother got very unwell. We now know it's a thing called depressive psychosis. He just started hiding in the room and he stopped taking drugs for a few weeks. He even used to cover the television because he thought people were talking about him on the television. He was psychotic.

So we got him in the hospital. There's good and bad with the hospital. At that time, thebad was that the doctors in the hospital didn't want to listen. They were saying to me, "This is a drug-induced psychosis". That's exactly the words they used. They were saying that they'd seen it before, that it was a drug thing and it'd wear away in a few days and he'd be fine.

But I knew different. I said to them, "I know him for years. I know him. I'm watching him. I know he hasn't taken any drugs in weeks because he doesn't leave the house. And there's some of us sitting with him all the time". But it was very hard to get them to listen. They were very quick to dismiss. They were saying it was a drug thing. We were begging them to keep him in. They did keep him in for one night but the next day they let him out. One of my brothers found him walking on the bridge. We don't know what his intentions were.

The next time he was admitted to hospital, he self-harmed in the hospital. He almost burned himself to death. And it was just at that time that they listened. And they did take care of him then, I have to say.

But it was very hard to get them to listen. At the finish, they did listen and they did give him top care. But it was getting them to listen. People have died where they haven't listened.

Sarah: *Yeah. Medical professionals not listening. I've had similar experiences. I'd been in my workplace in Dublin and had been contemplating jumping off the balcony. I was taking so much drugs, and my own brother had died from a heroin overdose, so I was spiralling. I rang my dad. He said, "Come home. Go to the GP". And that's what I did.*

And I was telling the GP how I felt I didn't fit in anywhere, that I didn't fit in on the gay scene, I didn't fit in outside the gay scene, so I was taking lots of drugs. And he told me it was "the most ridiculous thing" that he'd ever heard. And because I was socially anxious as well, I just left.

The effect was probably another five years of active addiction. So it probably could have been a shorter road than it actually was.

I think any experiences I've had with mental health, you know GPs or psychiatrists, they didn't listen. So I've just have to hit rock bottom and seek therapy myself.

Margaret: *You're already unwell, that leads to drugs. The depression has already started. They (the hospital doctors) were trying to say it was the drugs that were bringing it on. But I was explaining to them it was depression as he was growing up that led to his addiction.*

Sarah: *That's it. In my experience, the addiction is only ever a symptom of something.*

Margaret: *Exactly.*

Noel also tells the following story of his experience of being dismissed or turned away by a psychiatrist and GPs before he came out:

Noel: *When I was feeling another darkness coming on, being weak, lethargic, not wanting to eat, drink or talk to anyone, I was more or less told to "snap out of it" by my first consultant in the hospital. And by my GP. He would have been one of the older GPs. He said, "It's only a phase". Twenty years! And it's only "a phase". When I finally did come out, I had a new GP. But I had to more or less teach her, because she had no idea about mental health issues let alone how to deal with a gay man. Especially in a rural area. But she was willing to learn. She did take it seriously. So I taught her. The transgender community have been going through the same thing for a long time now, having to educate professionals about their needs.*

Therapeutic Listening: Some Cultural Considerations

The following contributions from Fatima, Ellen and Sarah illuminate the power relationships at stake in inter-cultural mental health contexts. All draw attention to how specific issues of culture heighten the importance of the quality of the therapeutic relationship.

Fatima's contribution attends to questions of language. She describes how important a particular relationship (with a worker in BRIDGE) was for her at a time when she was "lonely and depressed" and had "no English". Her account has broader implications for therapeutic and other language-dependent mental health settings. On the one hand, it is important to acknowledge the silencing effects of English language dominance for those for whom English is not their first language[13]. This is a particular concern with regard to voicing experiences which may be already elusive, even in one's own first language[14]. Of special interest here is Fatima's emphasis on how non-linguistic relational considerations become primary – "the way how she talked to me".

Ellen's response to Fatima also affirms the significance of the quality of the therapeutic relationship. She emphasises the importance of listening and a willingness to help. She then discusses the reluctance of many Travellers to attend counsellors which she locates in a historical context of children being removed from Traveller families. For her, this historical context underlines the importance for counsellors of building trust with Travellers.

Ellen describes her own positive experience with a particular counsellor, a work colleague she already trusted.

This exchange is followed by a contribution from Sarah who describes the difference a particular therapist's understandings of LGBT+ culture makes to her therapeutic process.

Fatima: I had no English. It was the way how she talked to me. She made me feel comfortable. You know when you are very lonely and depressed, the way how she talked to me she made me feel very nice.

Ellen: Well, that makes an awful lot of difference. You know when you sit down and know that this person you're talking to will listen and will help as much as they can. You have to listen. If you don't listen, you don't know what's going on.

A lot of Travellers will not see a counsellor. They don't want to see anyone like that because they think that their kids will be taken. Years ago the same thing happened. It used to be the Cruelty Man one time. Even a doctor, they wouldn't bring a child to the doctor because if a child went in with any kind of sickness, you brought it on, and then what'd happen the children would be taken. The Travellers had their own cures. There's a lot of healers in the Travellers.

It's all down to trust. You need to build up trust with someone before a Traveller will open their mouth to them to say anything. If they don't trust you, you might as well be talking to the chair.

Margaret: And also it's a stigma.

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[13] *Of course, these power-relations are also at work in the current project. Clearly, the English-language medium of the focus group and narrative interviews has implications for Fatima's participation and expressive possibilities.*

[14] *These considerations also underline the importance of appropriately trained interpreters – see Recommendations.*

Ellen: ...I went to see a psychiatrist for seven or eight weeks. She was alright, but my mental health was, like what do you do when you lose a child? I'd often lock myself in a room and just cry and cry and cry and cry ...And then one day I said I just have to get out of this because I've other children there. And I rang (a counsellor I knew in the Adult Counselling Service), and she says, "Come up straightaway. Get someone to bring you up".

When I first went to see her, everyone says you shouldn't be going to counsellors. I says, I don't care. I work with her. I know her. I trust her. So I went up and I told her what I was thinking, what was in my heart. And I said it's not only me that I should be thinking of - it's my other kids that are at home. And all my kids got counselling. I was strong enough to do it. I said no way was it going to destroy the rest of the children. It's not being fair on them. They see me down and out, they're going to be down and out.

About six weeks after seeing her I was grand. Well, not over it all but at least I knew that I was able to look after the rest of the kids that was there.

Siobhán: What was the difference that that made?

Ellen: It made an awful lot of difference. Just sitting down listening to what she was saying to me, and she listening to you. You're putting your story to her. I'd worked with her for years before that so we got on well. I think if there wasn't something done I'd be dead.

It didn't take away the loss, but I felt a bit better than I was. It was just after a few weeks of seeing her then that I got all my children seeing a counsellor, not in the hospital but privately.

Sarah: Talk therapy is always key. It's just helping me to process what's going on in my head instead of just letting it fester and having to self medicate because I don't want to deal with what's going on in my head. Once you kind of just talk it out, it doesn't become that muddled mess. I have a good one now (therapist). I've never had to explain anything about being gay or about the culture or anything. It's just like its normal. She just gets it. I don't know why or how but she just gets it and that's what makes a huge difference. I don't have to spend a couple of sessions explaining why I feel the way I do in relation to who I am. It's just I can get straight to the issue.

Women and Mental Health

Unfortunately, the gender balance of contributors we had hoped for in this project did not transpire. However, the female dominance may be regarded as indicative of some important cross-cutting gendered aspects of mental health for all minority communities.

A central issue here is the gendered burden of care, or perhaps more accurately, 'love labouring', primarily associated with women (see Lynch, 2007). This is a clear theme throughout the contributions above. The labour of loving has particular mental health consequences for many women in the diverse familial circumstances of members of ethnic minority and LGBT+ groups, given often difficult social and economic contexts.

Noel pays tribute to his own mother's ongoing care during a particular time when he desired to withdraw from the world – a situation which resonates with Margaret regarding her care of her brother. Noel also regretfully recalls his own verbally abusive behaviour towards his mother at this time:

Noel: For a couple of months I shut myself in my room. I think my mother is a saint now but I used to give out to her. She used to come in and check on me. Once a mother, always a mother. And I was in my thirties at this stage. I smoked like a chimney but I wouldn't have the courage to go out and go to the shop at that stage. I wasn't eating properly anyway so I'd probably collapse. But she'd make sure I'd have cigarettes and she'd make sure there was food easily ready. If she prepared something for me I wouldn't eat it, but I'd come out like a mouse in the night and grab what I wanted. But if it wasn't for her - she saw my depression episodes coming before I did.

Margaret: You pick it up even before the person themselves maybe realises that they're unwell.

Noel: I ate the head off her so many times.

The issue of domestic violence is explicitly raised by Ellen in responding to a question about getting through hard times:

Siobhán: What are people's ways of getting through hard times?

Ellen: It's nothing new to me and I'm as tough as nails. My father was very cruel to us and to our mother. He'd beat my mother. And then I married a man that was very cruel as well. Everything he gave me I gave him back.

Domestic Violence, of course, characterises both majority and minority cultures. However, the specific challenges for women from minority communities in accessing culturally appropriate supports must also be recognised since their experiences of domestic and sexual violence are compounded by their social marginalisation (Pavee Point, 2011; 2019; Akidwa, 2008, 2012; RCNWI, 2016).

Beyond the Professionals

A discussion of ways of getting through hard times generated various responses which highlight resources and possibilities of sustenance outside formal mental health contexts. The members of the focus group identified work, music, exercise, nature, eating, talking, family relationships and contributing to their community as important in this regard.

Siobhán: What are people's ways of getting through hard times?

Fatima: Music brings happiness to me. Music makes me happy if I'm very sad. Music brings good memories. I'm not listening all of the time but I have a few when I'm very upset that I play and try to get good memories. It makes me feel happy so I can see things clear after. It makes me think, oh I'm going to do this.

Sarah: Exercising is definitely key. I need to get out running and in nature if I'm starting to feel a bit shit. And eating well.

Margaret: Family relationships. It's what kept me strong for my brother. It's because I'm the eldest of thirteen and my parents were elderly. I seen them falling to pieces and I had to be strong for them as well as for the rest of my brothers and sisters. I just had to do it and I had to get him better, I had to meet with the doctors all the time because I felt the rest of them weren't strong enough so I had to do it.

Ellen: Work is key. I was sitting at home for three days with the child, no-one else in the house. My nerves were getting very bad because I had no-one there to talk to. I nearly went mental. That'd really drive you into the unit. You're better off inside in work. Because you're talking to other people. You're mixing with other people.

Noel: Oh I talk. I even talk when I'm not going through a hard time. With my volunteer work that's part of it. I volunteer with the helpline LGBT Ireland. I listen to calls and online chats and also volunteer with Amach and Galway Pride events. It probably shouldn't make a difference to me, but when I hear a call and I have a positive effect on that person, that picks me up ten times more. To be there for someone in the moment when they come out, sometimes after months of building up the courage to tell someone, to be that someone is an honour and a privilege.

For Mary who had to leave early, her parting comments to other members of the focus group also highlight the importance of peer support:

Mary: Keep me informed because I think it's an interesting conversation. Especially with all of us, we can relate to each other because we've all been there. And it's nice to have people to share it with. That support.

Conclusion

The stories and reflections shared by the six participants in the focus group are of course partial and situated perspectives – no claims are made with regard to their generalisability. However, engaging with the insider knowledge of mental health issues and services with members of the Traveller community, the LGBT+ community and the asylum seeking and refugee communities, developed on their own behalf and/or with family members, has produced a range of powerful and moving insights.

The focus group participants evoke a world of subjectivity which is inextricably linked with the social world of other people, including family, community and mental health professionals. All these relationships are situated in specific social, cultural and political contexts. The participants variously describe some effects of loss and bereavement (in the case of all three Traveller participants), of stress and anxiety (in the case of the migrant woman participant) and of silences around sexual identity (in the case of the lesbian and gay participants). The withdrawal from others is an important theme here, both physical and psychological. The metaphor of the mask evokes a sense of a divided self: on the one hand, an active struggle to cope and manage relationships by presenting a certain face to the world, and on the other hand, an acute sense of alienation. An important point here is how, for some people, this struggle to cope can turn into addiction to drugs or alcohol which then becomes the surface manifestation of the mask. There is also a gendered dimension at stake here with regard to women's socially assigned caring roles.

Mental health professionals and their associated promises of help and support also become part of these social worlds. The process of waiting for support has its own effects. On the one hand, waiting can intensify existing feelings of stress, anxiety and isolation. On the other hand, a prompt response provides the basic existential affirmation, one might say, that a person and their concerns matter. Of course, the nature of actual responses is crucial too. It

would appear that all too often, the response is medication. Although medication can be helpful to some people in some instances, it is clear that this is not always so, particularly in the long-term. For these participants, being listened to by mental health professionals is the all-important factor. Such listening, however, is not a neutral activity. Listening to the voices of members of minority groups through the ears of majority cultures is saturated with questions of power relationships. A language barrier is already present for asylum seekers and refugees for whom English is not their first language. For many members of the Traveller community, therapeutic encounters cannot be separated from a historical legacy of institutionalised racism and distrust of services. In both cases, this is even before addressing the question of a listening attuned to cultural specificities and histories of trauma. Similarly, for members of the LGBT+ community, being heard through the filters of heteronormativity is not a hearing at all; support possibilities are compromised when the person looking for support carries the burden of explaining and educating about LGBT+ identities and cultures. Notably, the participants describe a range of initiatives outside of professional interventions including care of the body, music, family, and social engagement in work and community contexts.
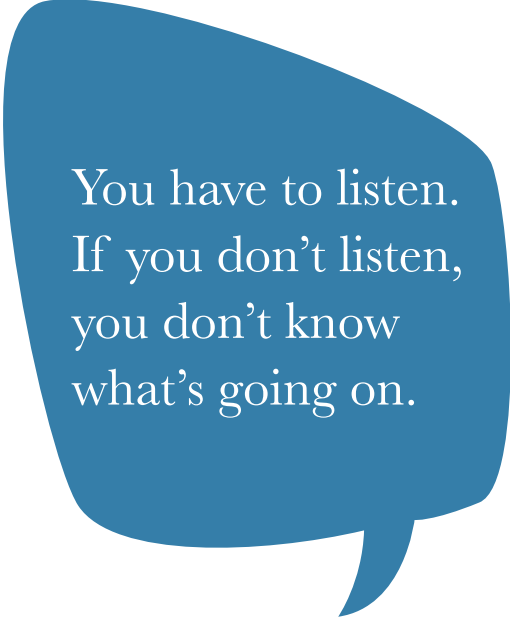
The emergent nature of the process is perhaps equally as important as the particular contributions themselves. The knowledge and insights presented here have been co-produced in dialogue with each other as particular contributions deepened and enriched each other. For readers, too, these contributions might spark curiosity and generate more questions. There is, after all, always more to be said.

The next chapter briefly introduces the stories of Sarah, Fatima and Margaret and the narrative inquiry methodology.

Chapter 3
Listening to Stories:
A Narrative Approach

> You have to listen.
> If you don't listen,
> you don't know
> what's going on.

Ellen's words in the focus group open up a powerful challenge to ideas of knowledge and knowers: a mental health profession which does not listen to the people who look to it for support simply does not know what's going on. This applies all the more to members of minority groups whose stories have for so long been silenced, diminished, or pathologised by dominant mental health narratives.

Ellen's words also point to the key source of expertise: the person telling the story. This cultural shift in the ownership of mental health knowledge set the terms for the round table discussion. Sarah from the LGBT+ community, Fatima from the asylum seeking and refugee community, and Margaret from the Traveller community (introduced to readers in Chapter 3) told their stories. Their knowledge and insights provided the basis for engaging with the question: *How can the mental health services respond to the needs of minority groups and achieve cultural competence?*

But can one really hope to properly respond to a question of such magnitude by listening to three individual stories? After all, the story of one person can never represent an entire community. None of these communities are homogenous. The LGBT+ community already carries in its name the diverse positionings of lesbian, gay, bisexual, transgender and, of course, the openness of "+". Despite shared struggles within a culture dominated by heteronormativity, the needs of the transgender community are markedly different from those of lesbians, gay men and bisexuals, even as these differ also from each other. The incredibly diverse range of cultures and histories reflected in the asylum seeking and refugee community also cautions against any attempts to generalise about the migrant experience. Neither is the Traveller community one homogenous grouping. Indeed, recognising the diversity of each community is critical to any respectful engagement, and in particular realising the complex intersections of ethnicity, sexuality, gender, class, disability, age and so on.

Given such complexities, one might reasonably claim that stories cannot hope to provide the proper 'overview' of what is at stake for the mental health needs of minority groups. Surely, one might insist, an 'evidence-based' response requires a statistical analysis with clear categories, disaggregated data, correlation patterns, and predictions of risk. Yet, however useful such forms of knowledge might be, they obscure the fact that everyone has their own particular story.

Listening and attending to this particularity opens possibilities for newly appreciating the complexities of experience, identities, knowledge and skills, and how these are shaped by social, cultural and political contexts. The personal, in other words, is not statistical but political.

The narrative approach we adopt here is based on the collaborative narrative practices developed by Michael White and David Epston (White and Epston, 1990; White, 2007). This approach recognises that our identities are social and relational, bound up with the stories we tell and which are told about us. Nor can one singular story tell who I am. A central assumption is that our identities are multi-storied so that there are many possible stories that can be told. In our story-telling practices, the emphasis is on co-constructing stories through practices of 'double listening' (Denborough, 2008; White, 2003, 2004). This involves an inquiry which facilitates a full acknowledgement of the effects of dominant practices and meanings, but which also supports the telling of alternative stories of response and resistance. These alternative stories are usually only thinly known. However, practices of double-listening involve listening for openings to counter-narratives, and then thickening these by drawing out a rich account of the person's values and purposes in life and their social histories.

While our recorded conversations[15] began with an inquiry into each person's hopes for contributing their story to the project, my questions thereafter were not based on a prepared 'interview schedule'. Instead, they were informed by a sense of curiosity with regard to particular expressions and purposes. The conversations were recorded and transcribed by me. An overall framework for the public retelling of the story was agreed with each woman. I then documented a draft of the story in the person's own vernacular, with attention to agency and purpose. Reading her own story in draft form was an emotional experience for each woman, and each agreed to the representation of her story.

These are stories which shine a light on possibilities unavailable through the official language and jargon of dominant mental health discourses. Nowhere in the pages of the *Diagnostic and Statistical Manual of Mental Health Disorders*, for example, will one find a reference to the story of 'The Ugly Duckling'. Yet, it is her childhood reading of this story which Sarah remembers when pondering the question of how she steadfastly refused to conform to norms of gender expression and sexual identity. The message Sarah draws out from this story sustains the hope of a community of beautiful swans, finally realised for her through her involvement in Amach!

> These are stories which shine a light on possibilities unavailable through the official language and jargon of dominant mental health discourses.

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[15] *Ethical considerations were established first with regard to the purposes of the discussion, confidentiality, the right to withdraw consent at any stage of the process, and the control and authorship of each person in regard to her story and its representation.*

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"My social anxiety was caused by societal norms", she says. *"But I thought it was my issue. I didn't know that it was society's issue."* Sarah's account of the transformation of her social anxiety from "my issue" to "society's issue" provides a salutary lesson on the politics of mental health. On the one hand, it highlights how the social anxieties of the majority community about sexuality and gender are normalised, in part, by being personalised as "mental health issues" for members of the LGBT+ community. (The social anxieties of the majority community about asylum seekers, refugees and the Traveller community show a similar dynamic at work). On the other hand, finding her "flock" helps Sarah to put the issue back out to where it belongs – in society. Hers is a beautiful account of the critical role of collective community action in creating alternative affirming social realities, so that, *"Now, I never wear earphones outside. I want to engage with society. I want to be able to hear if someone's calling me on the street."*

The struggle to keep hope alive for herself and her children is also a theme for Fatima. While her journey to Ireland implies a larger context of North-South global inequalities, the specific local context of Fatima's story is the system of Direct Provision, notwithstanding the kindnesses of staff: *"The small things were very big for us"*, says Fatima, *"so just to make the hope a little bit easy."* The struggle to survive is nothing new for Fatima, but now she must adapt to the challenges of family separation and loneliness in Ireland. These challenges are intensified because of not yet being able to understand English.

The counselling supports she receives from mental health services are vital to her and her children. However, they are undermined and contradicted by the family-unfriendly system of Direct Provision. Fatima's story provides a glimpse into that psychological and social world. The following exchange with her GP which she reports exposes the inextricable link between mental health issues and Direct Provision. It is also suggestive of a public policy managed through the almost routine medicalisation of asylum seekers:

> *I said to the GP, I want to reduce my medication. She said, I won't reduce now because you still live in the Eglinton. You're going to feel depressed. When you move from the Eglinton, then we will see how it's going. And she said, don't stop taking the tablets.*

Conversely, when Fatima independently reduces and then comes off her medication, her GP affirms her positive mental health: *"Keep doing what you're doing now"*. What Fatima is doing is breaking the rules: working illegally and furtively cooking, aromatically reclaiming her family life from Direct Provision with her rice cooker and her two smuggled pots.

Love and family bonds also imbue Margaret's story with purpose, this time in the cultural context of the Traveller community. It is this love which prompts her declaration that *"The issue of mental health services is something very close to my heart"*. Whilst fully acknowledging the "top" psychiatric care eventually received by her brother, we hear a detailed account of the "nightmare" effects on her and her family of initially not being listened to:

"I felt like climbing the walls. I felt that I was lost". In particular, when Margaret insists that *"I knew"*, her story opens up multiple relational, social, cultural and political strands of that knowledge. *"I'm the eldest of thirteen and I helped rear them"*, she explains, *"I've a family of my own. There's a lot of big families like mine in the Traveller community. When you know a family member, you know them as a person".*

Margaret's moving story of grief and loss provides devastating insight into the spiralling effects on the Traveller community of the loss of family members – *"and also the loss of culture"*. She carries both her own pain and the pain of family members. For Margaret, living on a halting site is a crucial part of what helps to keep her going: *"The loss of culture has a huge effect on mental health. I know myself if I ever was told that I had to leave my bay, I'd crack up. If I was told I had to into a housing estate or an apartment, I'd feel insecure. I'd feel a bit fearful."* Margaret's central message is one of equality and inclusion: *"The mental health services need to be educated about Traveller culture and the effects of loss, racism and discrimination on our mental health. And definitely they need to be educated in the fact that, let it be Traveller or settled, when a person knows something is not right, to listen to them".*

By opening an alternative future for the mental health services, Margaret underlines how the telling of these stories does not mean they are finished. As Sarah says, *"It's been a long journey. I wouldn't even say it's over. But I think that I'm at a place now where my story is something that should be told".* The metaphor of a journey is apposite. It speaks to the dynamic nature of identities which cannot be contained. Such journeys are reflected, for instance, in the wonderfully

> "It's been a long journey. I wouldn't even say it's over. But I think that I'm at a place now where my story is something that should be told"

named *Gender Odyssey Support Service And Information Project* (**GOSSIP**), the Galway-based peer support group for trans people living in the West of Ireland. The notion of a journey also registers the multiple journeys and border-crossings undertaken by members of the asylum seeking and refugee communities, journeys of both geography and psyche. It resonates too with the nomadic culture of the Traveller community; honouring this culture in the present is bound up with the mental health of the Traveller community. Finally, the notion of journeys signals how these stories have the power to move others and to promote learning, reflection and action for change. This project then is an invitation to mental health professionals to join with members of the LGBT+, Traveller and asylum seeking and refugee communities on their journeys for social justice, respect and freedom.

The next three chapters present in turn Sarah's story, Fatima's story and Margaret's story. The final chapter reports recommendations from the round table discussion, as well as from the three organisations in their questionnaire feedback.

We hope that this report helps to offer answers, provocation, and inspiration in what we anticipate will be an ongoing dialogue between members of minority groups, community organisations and the mental health services in Galway.

PART 2
The Round Table Discussion

Chapter 4
Sarah's Story: A Voice from the LGBT+ Community
By 'Sarah'

My name is Sarah. I'm on the board of Amach. I'm originally from Arklow in Co. Wicklow and have been living in Galway since 2007. I have a Masters in Health Promotion.

As a child, I dressed and acted differently to "normal" little girls. I preferred boys' clothes and felt much more comfortable wearing a suit or trousers rather than a dress. But to others, it was like I wasn't normal.

At the end of my conversation with Siobhán, she asked me how I continued to dress as I did and to resist conforming when it had caused a lot of hurt and pain to always feel different.

What was it from my childhood that gave me the strength to be true to myself even when society told me I was wrong?

Reflecting on this question afterwards brought me back to my favourite story from childhood – 'The Ugly Duckling'. Even before I could read, I loved the story. And as I grew to love books, I ended up with about five different editions of it. I always felt like I was the Ugly Duckling - not fitting in with those around me, always being different, the one people pointed at and laughed at for not being like everyone else. I didn't realise it at the time but the Ugly Duckling ingrained in me was the belief that I needed to be my true self, and that one day I would find my flock and realise I was a beautiful swan all along.

And that's exactly what happened when I became involved with AMACH! LGBT+: I finally found my flock.

It's been a long journey. I wouldn't even say it's over. But I think that I'm at a place now where my story is something that should be told. It was mainly me finding my way on my own as opposed to having access to services and being supported by people.

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At the end of every day, I have always needed to be able to look in a mirror and see me.

But for many years, I thought I didn't have a place in society because I didn't dress the way society thought I should dress.

I tried my best to navigate the outside world, whether it was by not looking at people, or by my rule that I would have to meet people three times before I would actually talk to them.

As a child and a teenager, I was clearly depressed; but all people would say is, *"stop feeling sorry for yourself"*.

My social anxiety was caused by societal norms.

But I thought it was my issue. I didn't know that it was society's issue.

I didn't realise until I got involved with Amach that I could be a part of society and dress whatever way I wanted.

I grew up in a council estate, your typical living-under-the-poverty-line story.

My mother had a lot of mental health difficulties.

I remember when I was four, a psychiatric nurse used to visit my mother. She asked me how I was. This attention was not something that I was used to.

I did really well in the local primary school with friends from similar backgrounds.

A few years ago, I met two of my primary school teachers who remembered me as a really intelligent child, top of the class.

They were so surprised to hear I had failed my Leaving Cert. They were like, *"what happened?"*

....

What happened was the disastrous transition of moving to the local convent all-girls secondary school.

I was in a classroom with all these really rich people! I was from the local council estate. Sometimes I didn't even have lunch. This fed my social anxiety.

Being from the background I was, it was just presumed that *"these people don't want to learn"*. Or maybe *"they don't have the ability to learn"*.

I was blatantly told that I was stupid. One teacher told me that she'd still get her cheque at the end of every month, and I'd end up packing her shopping bags.

Calling someone a lesbian was one of the biggest insults. If there was even a rumour that someone was gay, they wouldn't come back to the school. There was such shame attached to it.

I wouldn't have been honest with myself about my sexuality at that stage.

But I didn't have any language to describe who I was. There was no internet. There was no knowledge. It wasn't a thing. It was an insult.

At thirteen, I started drinking. At fourteen, I was taking drugs.

But it was important to me to somehow express myself as being different. I became a grunger, listening to alternative music, and having a different hairstyle. I became friends with some cool older girls who were different like me.

Very arty. All individuals. They dyed their hair against the rules. Were late for class. When Kurt Cobain died, we refused to go into class because we were all in mourning.

I failed my Leaving Cert.

I hightailed it out of there and went to Dublin.

I was this person who failed their Leaving Cert, and who would spend the rest of her life as a care worker, not having to think much about anything. I felt that the teachers were right and that I was stupid.

I came out when I was twenty-one, joined the gay scene and we partied with drink and drugs from Thursday to Monday.

I think taking drugs was a way for me of trying to fit into the gay scene.

I believed I was stupid until I was twenty-five.

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I remember that moment vividly. I was with the party group, but we were just having intelligent political conversations.

And I was a part of this.

I remember saying things, and people listening, and it sparking their thought processes.

And I remember having to remove myself and go up to the bathroom.

I was going, oh my God, to myself in the mirror. There is intelligent conversation happening down there. And I'm able to be a part of it. So maybe I'm not stupid!

It was a light-bulb moment.

I would have had political conversations with my father. But it was my first time to have them in a group of people who had a university education.

From that moment, I knew I wasn't stupid. I thought, I actually have something to say that people will listen to. That people won't just tut and roll their eyes at.

....

But shortly after that, my brother died from a heroin overdose.

And I just spiralled completely.

I was constantly on some kind of substance.

I remember definitely two instances of going to sleep unsure as to whether I would wake up or not. And I didn't care.

I wanted to jump off the balcony in the workplace.

I ended up hitting the rock bottom.

I was off sick for about two months, sitting in my room drinking loads of whiskey with valium tablets.

And I thought, I can continue this, and I will be dead in twelve months. Or I'm going to have to completely change my life.

And I think a part of why I didn't just continue on and die, was because I saw what my family went through when my brother died. And I thought, I can't do that to them again.

....

I came home and went to my GP.

I told him about all the drugs I was taking. And he said, well why are you taking drugs?

I was like, well I'm gay, I'm on the gay scene, there's a lot of drugs, and I'm trying to fit in.

He said, this is the most ridiculous reason I've ever heard for somebody taking drugs.

Not just "ridiculous". But the most ridiculous reason.

I felt stupid again.

It was a very familiar feeling. And I guess no coincidence that it happened in my home town. There's always that judgement of who you are and where you come from. I'd question if he'd have done the same with somebody from a more affluent background.

He didn't understand what it was like trying to fit in on a scene where you're told that these are your people, this is your community. And you go there. You don't fit in. So you're taking drugs and trying your best to fit in.

He didn't question that I was depressed. He didn't question that I was anxious.

I think if I had gotten all the supports I needed at that time, my journey would have been a lot shorter.

But he did refer me on for six sessions of grief counselling.

I was willing to try anything. And, I thought, it's not you. It's somebody else.

....

Therapy was a strange new experience. At first, I wasn't sure - what does she want me to say?

But it was also a familiar experience. I'd had it at four with that psychiatric nurse who was interested in how I was.

Somebody wanted me to listen to how I was feeling.

Someone listening is an acknowledgement that you're actually talking, that you're speaking, that you're existing.

But like any therapy, it's just scratching the surface at the beginning. The grief for my brother was just the most recent layer that she helped me to pare back.

I remember feeling exhausted after each session. I was so out of touch with my emotions. I dulled everything with drugs.

But it helped me to be able to listen to my own thoughts. For someone who's very anxious, you get so many thoughts and you dismiss so many thoughts, it's hard to have a clear moment with that little voice in your head.

And listening to my own thoughts, I realised that I needed to engage my brain in a positive way, rather than just numbing it. I now knew I wasn't stupid. So I thought, well maybe I can go back to college and try the whole education thing again.

So I applied to go to Dublin colleges. As an afterthought, I put down NUIG as my last option.

On an acid trip, I decided to move to Galway.

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That was a strange moment. I was partying with my friends and I had taken acid.

In that moment, I felt so annoyed by everybody. Stuck in this cycle of party party party. Were we really having a good time?

It was a moment of clarity, that I needed to get away from all the drugs and all the people that I loved very much, but who I knew weren't going to stop taking drugs.

The next day, I changed the CAO option and put Galway at the top.

I had a purpose now. Galway. College. The end is not nigh!

I think a sense of purpose is key to anybody's grasp on life. If you don't have a purpose, then you just feel what's the point? You're just floating around. It's what grounds us in our life I think. To have a purpose, a pathway and a goal.

So I moved to Galway where I didn't know anybody to do a degree in Archaeology.

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The first semester, I loved being in college. But around winter-time, I started to feel really low.

So I went to the student counselling.

I remember the counsellor questioning me once as if I had gender identity issues because of the way I dressed. And having to explain on the most basic level. Explain that I'm not straight. Explain that I'm not transgender. Explain that I'm completely fine with my gender identity as a woman. Explain what it is to be a lesbian who dresses in comfortable clothes.

One day, I was talking about how I didn't feel that I belonged anywhere. And she said, well it sounds like you're depressed. Until then, nobody had ever acknowledged that I was depressed.

It was definitely a turning point. A recognition that all my previous feelings were not just me feeling sorry for myself. This was a medically recognised condition.

But that was the fault in it as well. It became focused on finding the right little pill that you can take on a daily basis that will fix you. And that's just like putting a plaster over it. You can't just stop something if you don't know what has caused it.

The counsellor recommended that I go to see a doctor. So I did.

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The first anti-depressant he prescribed made me feel fantastic! But the side effect was that I was always eating, I put on weight and started to feel shit again.

Then he put me on Lexapro. But it had no impact on my mood at all.

I was referred to a psychiatrist.

At first, he didn't even listen.

I said, this medication isn't helping.

He said, we'll double the dose.

I said, it's not doing any good.

He said, sure we'll double it and come back next week.

I remember thinking, what's the point of going to this guy who is clearly not listening to me? I know how I feel. This tablet has zero effect. But what choice do I have? This is the person with the medical degree and the prescription pad. But there's no collaboration. How can you help somebody's mental health if you're not listening to them?

So I definitely started to drink more after that.

I went back to him after the week. I said, it's not working and now I have tinnitus. So then he put me on Cymbalta.

Initially, it helped me.

I finished my degree. I was working as a care worker, a job that still didn't engage my brain.

My doctor kept me on that anti-depressant for seven years, increasing it every winter.

I thought, this is it now. I thought I'd be like my mother, on and off medication for her entire life. This is me now on that road.

I was living on my own. I was drinking a lot, smoking weed a lot.

I was so lonely.

I'd made some great friends, but had started to isolate myself from them.

Over those seven years, I'd got separated from my own thoughts.

Then I had another rock bottom moment.

I thought, you will die alone.

Or you need to create a life for yourself.

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I stopped drinking. I started eating healthily. I bought a bike and started exercising. I'd cycle into town so I was seeing people a lot more.

I came off the medication. I didn't ask the doctor. I thought I'm not going to go near him again. What's he going to do? Put me on a different medication? So I just stopped taking it.

Which I would never advise. But I didn't trust that he would listen to me, that this is what I wanted to do.

Like most changes that I'd made in my life, I just made a decision and did it myself.

But now I needed to engage my brain again. So I went back to college to do the Masters in Health Promotion.

For my thesis, I looked into the mental health and social inclusion of LGBT+ people.

I was looking for participants. And that's how I finally found my own flock of beautiful swans in Amach.

Before Amach, I thought the LGBT+ community was a party scene. I didn't know there could be another side to it. But Amach was opening Teach Solais, a drug and alcohol-free space.

I was invited to come onto the board of Amach and I did.

Amach has been life-changing for me. I just fit in. You don't have to explain yourself. There's no heteronormativity. Everybody is different but we're all different together. You are who you are in this community.

It has given me a huge sense of identity, and of belonging in a community. And not just the gay community but the Galway community.

Even though I've lived in Galway since 2007, I've never felt this connected to Galway before.

My anxiety has reduced enormously. I'm more confident walking down the street. For years I walked looking at a spot on the ground in front of me. All of a sudden, I was looking up and seeing people and seeing buildings.

I used to not be able to leave the house without earphones. Not seeing or hearing anybody was how I could get from one place to another. Now I never wear earphones out. I want to engage with society. I want to be able to hear if someone's calling me on the street.

And I've a therapist who just gets it. I guess you'd call her culturally competent. There are no assumptions. I don't have to explain myself, or the gay scene or any of that stuff. I imagine that that's what it's like for straight people to go into therapy or who seek medical advice. They don't have to explain themselves. They don't have to explain why they wear the clothes they wear.

It's been a long journey for me. But the steps could have been a lot shorter if I'd had help. I've done it all myself.

Mental health services need to have an awareness of minority groups. That lack of awareness is itself a barrier to people accessing services. People think, what are they going to say? Are they going to understand who I am?

People who come into services shouldn't have to explain where they're coming from. When a straight person goes in, do they have to spend so many sessions explaining who they are?

We need a more holistic approach to mental health. Medication on its own is not a solution. For me, it was psychotherapy that helped me to find words for what had happened over my life course, and that has helped me to tell my story.

Chapter 5
Fatima's Story: A Voice from the Asylum Seeking and Refugee Community
By 'Fatima'

My name is Fatima.

I am a survivor of many things. One of these things is the Direct Provision system.

I arrived in Ireland in 2009 from Pakistan[16]. I had no English. Only *"Hello. How are you?"* and *"I love you"*.

My two girls were in my country. My oldest was nine and was with her grandparents.

My youngest was seven and was with my best friend.

I did not know that I would not see them again for five years. My third daughter was born in Ireland.

I was given Leave to Remain in Ireland in 2017.

All of us in the Direct Provision system have stories of our lives, and of the steps we took to apply for asylum to create a life for ourselves and our families.

The first thing for me is always my kids.

This is only a very little bit of my story. My hope is to encourage other single mothers and other people who struggle through difficult times.

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My life in my country was not easy. I always had to look for ways to survive and bring in food. I worked all day in a factory, and I had no family to help me.

My older daughter was taken by her father when she was three, and lived she with his parents. My youngest daughter was with me. At six years old, she washed her uniform by hand. She washed the dishes and did her homework and waited for me to come home. Two days a week, my older daughter was with us.

We suffered from hunger. Some weeks I didn't have food to give my girls, just eggs because they are cheap and nutritious, and salt to kill the hunger.

My own mother gave me away when I was one year and two months. That family treated me like a slave. I was not allowed to play, to watch television, to do anything except clean. That's how I know how to clean.

When I was twelve years old, I tried to kill myself by taking all the medicines in the house. The lady said to me, next time make sure you do a good job.

I got my first paid job when I was seventeen.

I spent my first salary on a radio with a CD player because she didn't care if I had a radio in my room. I was looking for music for teenagers. But when I went into the shop to buy a CD, a different music was playing.

I felt a strange feeling I had never experienced before.

I felt calm.

I bought the CD. It was Kenny G. He plays saxophone and blue jazz.

That music helped me to deal with all the things that were going on at that time.

Because at that time I wanted to kill myself.

The only thing I had was the music.

It gave me hope.

The music gave me the power to go ahead.

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[16] *Some biographical details have been changed to protect Fatima's identity.*

I arrived in Ireland on the 30th December 2009 from Pakistan with ten other people.

It was not my plan to come to Ireland. My plan was to go to London, find work and bring my two girls to stay with me.

My hope was for a better life.

I got through immigration okay.

The group paid for my B+B in Cork, but if you wanted to eat breakfast you had to pay. So I only ate biscuits and tea.

A friend in London sent me money to go to London. But twice I was refused at Shannon Airport because I had no visa.

I was now twenty-four days without food.

The third try would be the last time my friend could send me money.

I bought a one-way ticket from Shannon to London,

With the last money, I paid the bus ticket from Cork to Shannon Airport. I had only two euro coins in my pocket to call my friend in London to pick me up.

If I didn't get to London, I would go back to Pakistan.

. . . .

I arrived at Shannon Airport at seven o'clock in the morning. The snow was very bad.

They said, you need a visa to go to London. You can't check in.

I was very upset. I was very hungry.

Where do I go now?

I went to the garda station in Shannon Airport. I didn't know how to talk with the police to say I wanted to go to my country. And they said, no no, go. They threw me out of the airport because they were closing.

I went to the bus-stop outside.

I wanted to go back to Cork to help me communicate. I knew the refugee centre had someone who spoke Urdu.

The bus came at eleven in the morning. I said, no money. I just showed the coins.

The bus driver said, no. You need fourteen euro to pay for the ticket to Cork.

Every bus that came said no. I stayed outside all day in the cold.

I wanted to cry. But I thought if I am crying, nobody will stop.

People started shouting at me saying, why did you come to Ireland without money?

What kept me going that day was my girls.

Because I always show them that everything I plan to do, I do. No matter how, no matter when, I will do it. Sometimes I get so frustrated when I am not doing that. But I always do it and that's why I am here.

At 8 o'clock that night, the last bus came. I remember the face of that bus-driver very well.

He said, no you need fourteen euro, sorry. As I saw the last bus going farther away, my heart was getting sore because my hope was going. I turned around and started crying. What could I do now?

But the bus just turned around. It came back to pick me. I didn't understand too much English but in that moment, I understood what the bus driver said. He said, look, if someone asks you if you bought the ticket you have to say yes. If you don't, I am in trouble.

I wanted to pay for the ticket with the two euros I had and he said no, it's okay.

I cried all the way from Shannon to Cork.

I arrived at nearly 12 o'clock in the night. And I went to the women's refugee centre.

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They gave me food. They asked how could they help. And I said I want to go home.

But when I rang my friend in Pakistan, she said you won't have this opportunity again to look for a better life. You have to think about your kids. Do you want to come here again to suffer hunger?

So I went into the office and said, I don't want to go. But the next day I wanted to go again.

And she said look, take your time. So after three days, I said, okay. I want to stay in Ireland.

So I applied for asylum. And then I discovered I was pregnant. It was a very stressful moment. Because it was not my plan to have a baby.

After one month in Dublin, they sent me to Lisbrook House in Galway.

My main worry was my kids back home.

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I was only given €19.10 every week.

I spent one euro on phone calls every day, just to know how my children were.

My older daughter had the support of her grandparents, but I was very worried about my younger daughter. When I didn't send money in three months, my friend gave her away to other people.

That person was always asking me for money to look after her.

The money I got every month, I sent to her.

But she wouldn't let me talk with my daughter.

I nearly went crazy at that time because I was so worried about her.

....

And I was lonely and depressed. I didn't want to talk with anybody. I had only one friend from my country. She was in Dublin and for many weeks I didn't want to talk with her.

The only person to listen to me and support me during that time was Suzanne in the Galway Partnership. The way she listened to me even though she didn't understand what I said made me feel important.

I was worried too because my baby didn't want to come out.

The contractions were coming and going. The doctor said I had to walk around the stairs to make the baby come out or we would have to do an induction.

I only knew one stairs. It was where Suzanne worked at the Galway Partnership.

I walked from Lisbrook House. My belly was so big, so heavy. And I was so skinny,

As I was going inside to the office, a lady asked me, are you okay? And I said, no English. Sorry no English. She said, where are you from? I told her. And she said, oh I speak Urdu!

The next day, I called my friend. I said, I've found someone in Galway who speaks Urdu. She is from Pakistan. And she's helping me. And I started telling my friend about how worried I was for my daughter.

We came up then with a plan to get my daughter to a safe place.

....

I gave birth to my little girl. When she was three months old, I started working as a cleaner to get money to bring my other two girls to Ireland. I paid a babysitter in Lisbrook house.

It was illegal for asylum seekers to work, but I had always worked to survive.

When people said, you're not allowed, I said, how else can I survive on €19.10?

When Lisbrook House closed, I was moved to Ballyhaunis. Then I got depressed because I needed to work.

I decided to travel back to Galway. My baby and I lived with a friend for six months. After six months, this was stressful.

My GP recommended anti-depressants. I said no because many people told me that when you take too much anti-depressants you can get crazy.

But one day, I got very very angry at the bus stop.

My baby was sick and I didn't sleep all night. When I came to the bus stop it was very late. And the next bus didn't stop. It meant I had lost my money.

I got so angry, I wanted to kick the seat at the bus stop.

In that moment, I realised that this was not me.

Because I was always very calm. And it was so hard to make me angry.

I think the anger was saying to me to stop thinking. Because I was all the time thinking about what I have to do, where I'm going now, how I'll fix this, how I'll find the money.

But it was impossible to do everything.

So that is why I decided to take the anti-depressants.

You have side-effects. You get sleepy. You get very dizzy. But after that, they made me calm.

But if I forgot to take them for one or two days, my mood changed and I got very nervous and angry.

....

I moved then to the Eglinton Hotel, the Direct Provision centre for asylum seekers.

It was the same staff as were in Lisbrook House. They made me laugh and made me feel comfortable.

But it is very stressful for the residents. Everybody is waiting for an answer from Immigration. Everybody feels stress. We fight about the washing machine. We fight about the drier. Everybody is in stress.

I tried many times to bring my two girls from my country to Ireland.

Finally, after five years, they were coming to join me and my youngest daughter.

My GP recommended increasing the anti-depressants.

Because you are already in a lot of stress, she said, and your girls are going to arrive to the place where you live.

And I said, yes I think I need that.

It was a good feeling to have my other daughters coming. I was planning good things.

....

But after five years, they didn't know me. I was a stranger to them.

They thought that I had left them in my country and that I didn't care about them.

People had told them that I'm here, I have a good life, I have a new daughter, and that I didn't love them.

And they had a new school where they didn't speak English and didn't have friends. They were being bullied.

The GP organised for the four of us to have family therapy together. That was very helpful.

But even though the staff in the Eglinton were very nice to us, the Eglinton was not a good place for a family.

The four of us lived in one room with one toilet.

The only place where you could lock yourself away and have your privacy was the toilet.

We fought every morning because the first teenager to the toilet sometimes didn't want to come out or to open the door for anyone.

Breakfast is from 8.00 o'clock to 10.00 o'clock. If you woke late, the kitchen is closed. No breakfast. Christmas time, the same.

Sometimes the food was okay. But with the same food every day, you get tired.

One of my daughters likes to eat healthy food. Sometimes when we went in, the vegetables were all gone, so all we had was rice, chips and chicken. The rice had no salt, no flavour. It was like eating paper.

And that gave my daughter stress.

We are not allowed our own cooking facilities. We are allowed to have a fridge. But cook no.

And people are shouting outside. People are fighting outside.

All the time my children say, when, when mammy are we out? When?

I got very depressed. But if I sat down in my room crying, nothing is going to change. And my girls would see me crying and feel more depressed. So I had to put boundaries on my feelings to keep moving,

Putting boundaries on your feelings helps you to move on and to show everybody that everything is okay. But it's not helping you personally. Because when everybody goes to bed, you just feel so tired.

And sometimes when you don't have friends, you don't go out, and so you can't talk about everything, it just keeps making everything heavy.

You have to move on but you feel so heavy with what you're carrying.

....

So my GP recommended increasing the anti-depressants again.

But I said no.

My planning was not to take anti-depressives.

Because living in the Eglinton, I could see how it was for people who take anti-depressives for a long time.

An Irish friend who speaks Urdu said, why are you taking anti-depressives? He showed me a book, and I saw that when you do exercises you have a happy hormone that makes you feel better.

So when the GP said, I am going to increase the anti-depressives, I said no, I don't want to. I'm going to do exercise.

So I started doing exercise. I was walking and working. And I was cooking.

I bought a rice cooker and two pots. I hid my cooker in the room and we cooked food.

If the staff smell food, they can take away the cooker from you. So you have to wait until 9 o'clock in the night to cook. And you have to have a good relationship with the security.

I started by cooking rice. Then I brought chicken from the restaurant and we started eating chicken with rice. One day the restaurant had African food for dinner. We don't eat African food. So I said, let's make a stew!

In one pot I did the rice. And in the other I made the stew. I fry the oil with garlic into the rice. Then it becomes aromatic. When the rice is soft, I cook the stew in the other pot.

The small things were very big for us. It made my children happy to have their mammy's cooking. It was very important.

I was trying to help with the hope. Because we didn't know how long we had to wait until we had the decision. So just to make the hope a little bit easy.

....

I said to the GP I want to reduce my medication. She said, I won't reduce now because you still live in the Eglinton. You're going to feel depressed. When you move from the Eglinton, then we will see how it's going. And she said, don't stop taking the tablets.

But I started reducing the tablets.

One day I went into the GP. She asked me, are you taking the anti-depressives? I told her yes. She took a blood test. And then she called me and said, okay. I know you are not taking them. You don't need to anymore. And she said, keep doing what you're doing now.

The day I got my papers in November 2017, I didn't feel anything.

Some people start shouting and jumping with happiness. I just looked at the paper and I said, okay.

Because now I needed to worry about finding a house. Many landlords don't want to rent to the people from Direct Provision. They just say, okay we'll call you. And then the next week they say, sorry we gave it to other people. Some people were living in the Eglinton for another year because they couldn't find a place.

At the beginning of December, the girls were very upset because we had our papers, we had everything, and we were still in the Eglinton. They wanted to have a family Christmas. They wanted to have a dinner from our country and family time.

We found a house in time for Christmas. It was only then that I felt free.

Sometimes it is hard for me to believe where I am now. I have my own cleaning company and I am studying Business Studies.

Maybe it is hard to believe because of the time I had when I was a child. Sometimes I wake very positive. Sometimes things pull me down. When I'm very sad, or nervous and I want to calm down, I always listen to Kenny G.
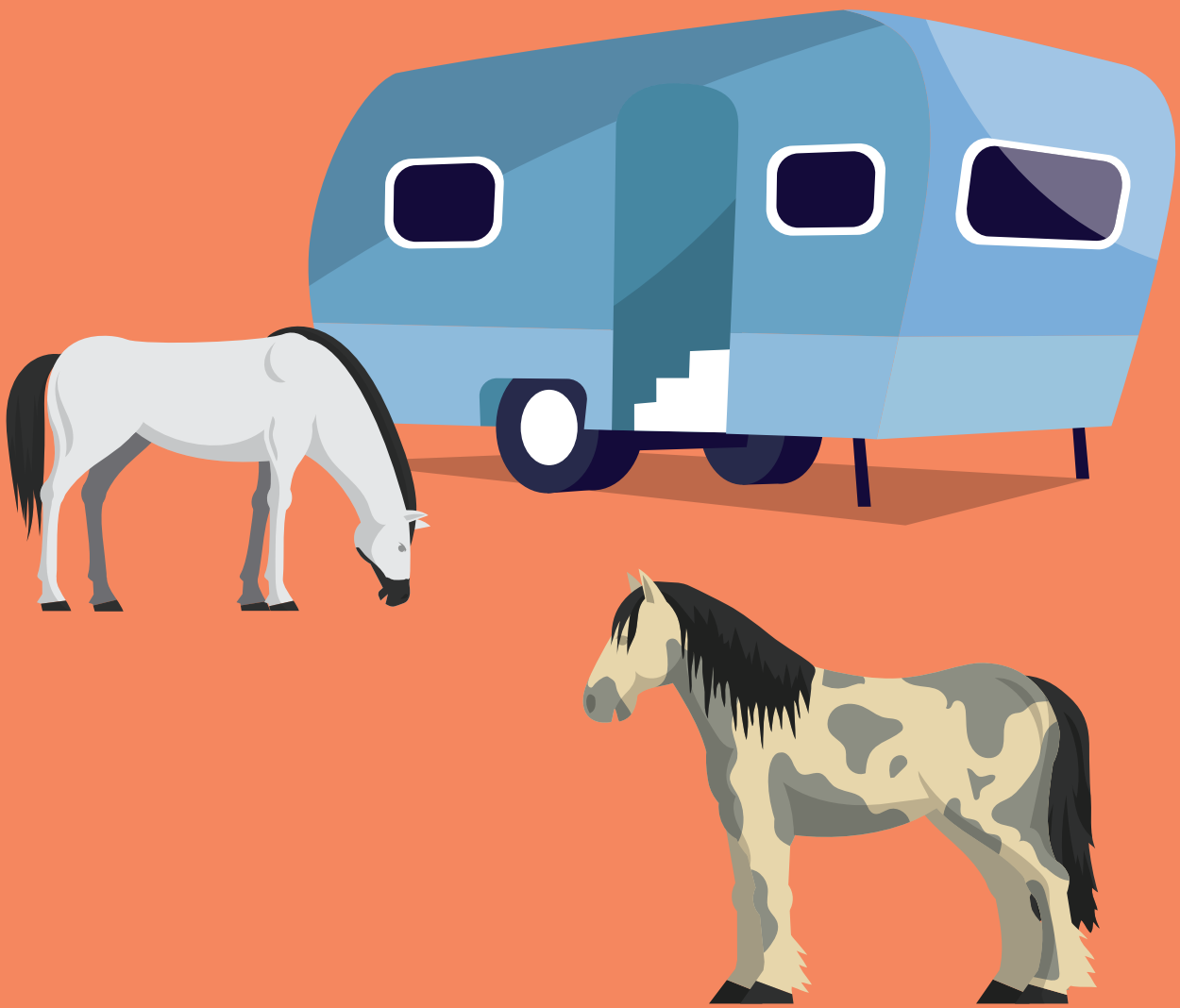
It is good to be reminded of the things that I did for my kids, and to remember the things I passed through and where I am now.

I think for asylum seekers and refugees, it's very important to find someone to listen to us. That is key.

Chapter 6

Margaret's Story: A Voice from the Traveller Community

by 'Margaret'

My name is Margaret. I am a member of the Traveller community. I live on a halting site on the Tuam Rd in Galway city. I am the eldest of thirteen children, eleven now living.

The issue of mental health services is something very close to my heart.

My story is based on my own personal experience of the mental health services, through supporting a family member.

About three-and-a-half years ago, one of my brothers became very unwell mentally.

But we, his family, were initially not listened to by the Psychiatric Department of University College Hospital Galway.

My story is about our struggle to be listened to.

It is also about the effects of loss and depression on the Traveller community.

My message to the mental health services is about the importance of listening to family members.

It is also about recognising Travellers' knowledge and experiences.

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My brother lives with my parents in Tuam. He used to make us all laugh. He'd often slag my mother. He'd put on different voices and play a comedian with her. He cared for us all. On numerous occasions, he would get an elderly person across the road. All the cars would be beeping and he'd say, would ye shut up!

Over the years, he had a history of alcohol abuse. In his thirties, he became addicted to drugs.

I know that the reason he started with the abuse in the first place was because of a childhood trauma. When he was ten, another eight-year-old brother died of leukaemia. They were very close.

At the time, he seemed to cope with it. But as he came into his thirties, he seemed at different times lost. He started messing with drugs.

Then ten years ago, our twenty-four-year-old brother died because of an accidental drug overdose. This added to the trauma of the other brother.

Seven or eight years ago, he was taking so many drugs, there were times we thought he would have died. We'd say to him, why are you taking drugs? You could die. Look what happened already.

And he'd just look at us lost.

Around three-and-a-half years ago, we noticed something different about him.

He didn't want to go outside the door. For at least two weeks, he touched no drugs at all, because he wouldn't go anywhere to get them.

We'd seen drug-induced episodes with him before. This was different.

He started getting very quiet and kind of staring. He started saying that his phone was tapped. That the neighbours were spying. That people were talking about him on the television. This went on for a few days.

Then he started getting an excessive amount of energy. He'd run up and down the stairs. He started cleaning. He was sweating.

So on this day anyway, he pulled the mattress out the back, set it on fire and tried to jump in on top of it. My brothers caught him on time.

They rang me. My poor parents screaming on the phone crying. They said, this is not right.

Myself and my husband drove to Tuam.

We got the doctor and the guards to the house. The guards were good. And our own GP in Tuam was very good. He knew of the addiction. He acknowledged that there was something more going on here than a drug-infused thing.

This was terror for the family.

....

We got him that night to the hospital in Galway. They assessed him in casualty and got him seen by a psychiatric doctor after waiting so many hours.

Myself and one of my sisters were in a room with him. He was quiet for a while. Then he started hitting his head off the wall. I ran out to the nurses for help. They got security in to hold him. They had to sedate him with an injection. It calmed him after twenty minutes. This is what we're on about, I said.

So then they brought him to the psychiatric ward.

In the psychiatric ward, they were very nice to us.

They said, this happens with drugs. We've seen this. He'll be alright after twenty-four hours, forty-eight hours.

But I was trying to explain to them it was two weeks since he took any drugs.

I was practically begging them to listen, because he'd tried to set fire to himself at the house in Tuam.

We knew this was really really serious.

They said they'd hold him in that night. And they'd get the consultant to look at him the next day.

Next day, I was over bright and early because I was afraid he'd get out. You know how they can walk out if they're not detained.

But when I went to the hospital, this is what scared me. And this is what, I suppose at the time, annoyed me.

He was pacing up and down the corridor with his head down. He was lost.

I said to some of the nurses, look this is not right. Why is he doing that? And the words they said to me were, oh that's a comedown from all the drugs he has taken.

And I said, I know he has abused drugs.

But in the last two weeks, he hasn't touched drugs.

This is something else that's coming on him. I don't know what it is but it's very dangerous.

I was actually saying to them, please believe me.

I said will you just ring me if you're letting him home? If he's not kept in, we need someone to collect him. I don't want him out on his own. Because I don't know what he's going to do to himself.

I expected they'd ring me if they were letting him home.

They didn't.

I got a phone call from one of my brothers that went up to see him. He had left the hospital because they felt they couldn't detain him.

That brother found him walking at the bridge near the cathedral. He thought it was no use bringing him to the hospital. So he brought him to Tuam.

That evening, I went to Tuam. They had a dinner ready but he thought the food was poison.

We watched him for another day or two. It got worse. He tried to set fire to himself in the house.

I went and I got the doctor. He came into the house. He said, I think he needs to be detained. He's very sick.

I said, what if they don't keep him in?

Look, he said, I'm going to write that he needs to be kept in. He's very unwell.

....

So we got him to the hospital again. You have to go through casualty every time. It wasn't easy. Myself and one of my siblings stayed with him. They assessed him again. And they asked him to come down to the psychiatric ward with them.

He did because he was kind of very frightened. I think he was terrified of everybody.

Again they were saying to me, are you sure he didn't take more stuff when he went home?

But if he had, I would obviously have told them.

So they kept him in again that night.

I rang the next morning. They said we're going to get the psychiatric doctor to assess him. There's a good chance he'll be let home again.

I said, please, I am begging ye, will ye please try and detain him this time.

Because I know he's not safe.

If he starts to burn the house, not only will he burn himself, he'll burn my parents dead. They're in their seventies.

I told them he wasn't safe to be on his own.

I told them I was the eldest of thirteen and that I would die for my brothers and sisters. That I lost two brothers already. Please, I said, he's going to die. He's going to kill himself. Please listen to me.

I was rushing at home to get over to the hospital.

At this stage, I was ready to get down on my knees to the doctor.

But before I got to the hospital, I got a phone call from one of my other brothers who was at the hospital.

He said, Margaret, are you sitting down? And I said, just tell me what's after happening.

He said, he's okay. He's alive. But he's lucky to be alive.

He'd been wandering around the hospital on his own. He went into one of the toilets. Someone saw smoke coming from under the toilet. They had to get security and kick the doors in. When they got him, he had almost burnt himself to death.

He had a lot of burns, but he was conscious.

Then they knew that this was serious.

Now, I have to say that the aftercare they provided was great.

They bandaged him, and kept him in a room with a special nurse whose role was to watch him twenty-four/seven.

He was diagnosed as having depressive psychosis. A very, very serious mental illness.

They explained that with a psychotic state he was out of reality. Sometimes a person might not feel pain until afterwards.

He was fourteen weeks in hospital altogether.

I visited him twice every day. I'd leave the hospital crying because he was so lost.

The consultant was top, and very nice to me.

She had a long chat with me. I told her the history.

She kept at it until she got him on the right anti-psychotic treatment. He's on a monthly injection now to keep him some way alright.

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But the point I'm making here is: why did it take until he burned himself in the hospital for them to listen to us?

I trusted the medical professionals to listen to us. I trusted them to listen to me when I explained this was different to a drug thing.

I know there's a law about detaining people, the Mental Health Act. I understand that. But I felt that this was a time where they could act and could hold him. Because I knew he was a danger.

Did they think we wanted to get him locked up? That was far from the truth.

I couldn't bear to think of our brother locked up.

We loved him. We wanted him to be safe.

I didn't want him to kill himself and my parents watch it. We lost two already. My parents would die if anything happened him. We wanted to get him well and find out what was his problem? What treatment did he need?

That day he burned himself in the toilet in the hospital, it's not that he did it in the right place. But at least the security were there to knock the doors down. But if he had done it in the house with my parents, they wouldn't have been able to save him. Or save themselves.

They kept saying to me it was drugs. I felt they weren't interested in him because he was a drug taker.

My knowledge and concerns were completely ignored. Was it something to do with me being a Traveller?

It was a nightmare. They kept saying it was drugs.

And especially in the psychiatric unit, when he was pacing up and down the corridor, I felt like climbing the walls.

I felt that I was lost.

....

I only went to sixth class myself. But I've a lot of knowledge and experience because I'm the eldest of thirteen and I helped rear them. And because I've a family of my own.

There's a lot of big families like mine in the Traveller community.

When you know a family member, you know them as a person.

I was six or seven when my brother was born. I remember holding him. When I was ten or eleven, I'd bring him back from school. And not just him, but the rest of my sisters and brothers.

I remember when my other brother got sick when he was four. My mother persisted with the doctor, this is not right. They got him to hospital. But she knew. He was her child. And my father knew.

And at fourteen I knew. Because I watched the other fellows getting colds and bugs and getting better. I knew this was different.

When he was diagnosed with leukaemia. I knew it was a very bad disease. I heard my mother saying to my father, oh my God, it's not leukaemia.

It was the first time I heard of it.

I have the knowledge of rearing my brothers and sisters through that time when my parents went to the hospital every day.

And when my parents said to me, do you want to come with us to the hospital? I did go. Because he was my pet.

I remember meeting doctors with my parents. So I listened to a lot of medical knowledge at fourteen.

He went into remission for three years. He died in Dublin in St. James.

My parents moved to Dublin with two caravans to be beside the hospital. They brought the whole gang, apart from me and my sixteen-year-old brother. It was hard for about six weeks in Dublin in just a camp. They often had to walk to the hospital. They didn't have the money for the bus.

It was very hard watching our eight-year-old brother die.

We got no support. There was no counselling in Ireland in the eighties, for either Travellers or settled.

He just died and got buried.

We just had to deal with it.

I was heartbroken. I still miss him. There's nothing I wouldn't do to see him again.

Everyone handles things different. Some of my brothers and sisters took it worse than the others.

And I suppose I have the knowledge of watching them.

I'd cry for their pain as well as my own pain.

Because I watched this particular brother over the years. I knew he was in a low mood at different times. He'd have a photograph of the younger brother in the room. I'd see him crying. I'd say, are you okay? That's a lovely photograph. And he'd say yeah. And I'd say, you remember, don't you? Of course I do, he'd say, sure I was ten.

And I'd go out and cry for the pain that I was watching.

I explained that trauma to the consultant. And she didn't dismiss that. She said, these things can give a depression.

....

Now I'm not going to say the Travellers are any different to when settled people lose people. It's horrendous on anybody that loses somebody.

But there are such big families in the Traveller community. And when they were growing up, they'd be very close.

My family was very close growing up, I suppose because we were staying in a caravan in Tuam.

You just never get over the loss of losing. It affects the family through the years. Not just when it happens. Through the years. Through life.

There's an awful lot of suicide in the Traveller community. And unfortunately, it's increasing. I'm sure a lot of it is to do with depression and a feeling of loss.

A loss of family members.

And also a loss of culture.

The loss of culture has a huge effect on mental health. I know myself if I ever was told that I had to leave my bay, I'd crack up. If I was told I had to into a housing estate or an apartment, I'd feel insecure. I'd feel a bit fearful.

But all over the city, people are blocked in. In apartments. In terraces of houses. That is causing an awful lot of depression, especially for Travellers. I know that from my own family. And not just my family.

There is a loss around travelling. Because there's always a longing to go away for a few weeks in the summer and travel. But because of the trespass law, you're not allowed to travel anymore.

And there are still restaurants and pubs in Galway where you will be refused because you're a Traveller.

There are certain family members I can to talk to about it who'll say *"We have to stand towards this. We have to make a stand for it".*

Others say, *"what's the point? It'll never change".*

You can feel very low. It messes up with your self-esteem, your confidence.

That's why some end up with drink and drugs. Some end up thrown into jail where there's no right help.

So when I explained to the hospital about the drugs, unfortunately, I had a lot of experience.

I never took drugs myself, but I've watched family members abuse alcohol and drugs.

I knew that drugs can bring on something that could last a couple of hours.

But I knew this was different. I knew this was something really really serious.

My other sisters and brothers say to me, maybe it's because I was the eldest that I've been strong towards it all. But if I break, who's going to take care of the rest? Who's going to do the things that has to be done?

It's not so much I feel it was my duty but, how could I live with myself if I wasn't there for them? Because I love each and every one of them dearly.

My religion has helped me to cope. Because I believe I will see my two brothers again. Some of the family members say to me, look what God has done. He took two of our brothers. And you still believe.

But I have to because when I need them, I talk to my two brothers.

It has helped me to have our little bit of space on the halting site with our two big walls. It's our little bit of freedom and space. Where you come out your front door you can breathe.

And my husband has been there with me all the time. When I've been knocked, he'd pick me up. And many's the time I did fall down crying. I was just lucky to get a good man.

And my children are a great support as well.

And my friends in Galway Traveller Movement where I work have supported me through good times and bad times. Even if you only talk about it, you'll go out feeling a lot better. Because the load is kind of lifted. Both the Traveller and settled workers are like my family. It's important to have friends in the settled community.

My mother had great friends among the settled people. And so had my father. Seeing my parents having friends in the settled community was very important to me as a child. Because it showed the respect they had for each other.

I would like the mental health professionals to become friends with the Traveller community.

They need to be educated about Traveller culture and the effects of loss, racism and discrimination on our mental health. And definitely they need to be educated in the fact that, let it be Traveller or settled, when a person knows something is not right, to listen to them.

I would like my story to change the way the psychiatric services look at people when they're presented with a mental health issue. Listen to the family members. Do not dismiss it. If the person has an addiction, look at that person as a person.

We need more grief counsellors. We need addiction counsellors. We need a proper counselling service in the prisons.

My brother has never fully been the same since that episode. But I can ring him every day and have a conversation. We have him alive. And he's okay.

Chapter 7

'How can the mental health services respond to minority needs and achieve cultural competence?'

Recommendations

Social Analysis of Mental Health

1. Mental health develops and exists within social contexts. Therefore, there is a need to identify and acknowledge the social and political roots of mental health concerns.

2. Minority groups are not homogenous and a one-size-fits-all is inappropriate. A social analysis of mental health issues requires an understanding of the diversity of social cultures and the intersectionality of gender, sexuality, ethnicity, disability, age, etc. It must also be informed by an anti-racism perspective and a critique of heteronormativity.

3. A social analysis of mental health should be developed through a community work approach which respects the particular knowledge and experiences of members of minority groups. This would also support the development of culturally specific languages of mental health issues which resonate with people themselves e.g. the language of 'depression' can sometimes turn community members off.

4. A social analysis of mental health should also be informed by international human rights standards, recognising the indivisibility of economic, social, cultural, civil and political rights.

Principles of Mental Health Practice

1. Mental health professionals cannot be neutral about social policies, inequalities and discrimination which are impacting on people's mental health. There is a need to acknowledge the limitations of the current strategy of giving people coping skills before they are sent back into an oppressive environment. Members of minority groups need a champion in the mental health services.

2. Members of the Traveller, LGBT+, and asylum seeking and refugee communities need a service that really listens and responds to the people who use it, and that involves them in decision-making about their mental health. This includes listening to family members.

   Listening and responding should be based on recognising the uniqueness of individuals and their histories, with a critical awareness of the power-relationships of inter-cultural mental health contexts.

3. More holistic mental health supports need to be developed and made locally available - it is not acceptable to be just handed a GP script for medication. A holistic approach should include greater flexibility about treatment, and the provision of supports at the levels of individual, family and community.

4. Users of mental health services have a right to a cohesive, transparent prompt service that listens to the people who use it, with shorter waiting times.

5. Mental health professionals are duty bearers with regard to international human rights standards.

6. Mental professionals must be accountable to the people they serve, including members of minority groups.

7. The crucial role of community organisations in supporting positive mental health needs to be recognised. This includes their roles in facilitating the voices of the Traveller community, LGBT+ community, asylum seeking and refugee community, and in social and political transformation.

9. A community development approach to mental health needs to be developed, based on meaningful collaborative relationships with community organisations and support groups.

Training in Cultural Competence for Mental Health Professionals

1. Mandatory cultural competence training should be part of the training of all mental health professionals in order to facilitate a better understanding of all minority cultures and their diversity. This should include training in equality issues, anti-bias approaches and a critical awareness of power-relationships.

2. Cultural competence training should be developed in collaboration with members of minority groups. Members of minority groups should be trained to deliver cultural competence workshops and work placements for mental health professionals should be arranged within minority community settings.

3. Models of good practice of quality cultural competence training should be identified from other international settings and adapted to an Irish context.

4. Members of minority groups should be supported to pursue third-level education and training in becoming mental health professionals e.g. training more Travellers to deliver services like Torie, GTM's culturally informed counselling service for Travellers.

A Community Development Approach to Mental Health

1. More collaboration needs to be developed between community organisations and mental health services through a model of co-production that facilitates minority groups to voice their experiences and work with mental health service providers as equals.

   This work should draw on and build upon the knowledge and skills of current collaborative relationships, such as those based on suicide prevention work.

2. Structured dialogue should be facilitated which bring representatives of mental health services and community organisations together regularly.

3. Mental health professionals and services also need to foster relationships of mutual trust and respect with members of minority communities through informal engagements in people's own communities e.g. by going out to Traveller halting sites.

4. A Working Group should be established with regard to a plan for implementing the above. This should include attention to the social and political context of mental health issues and also acknowledges the challenges of ongoing engagement.

5. Community organisations and mental health services need to be properly resourced for a community development approach to mental health issues.

Quality Culturally Competent Mental Health Services for Minority Groups

1. Specially trained and vetted interpreters need to be made available.

2. More provisions for counselling services for community-specific groups e.g. LGBT+ groups; greater availability for psychologists for transgender members of the community.

3. More availability and flexibility with regard to addiction counselling and treatment, including residential facilities where necessary.

4. More availability of alternative forms of therapy and specialised therapy such as art therapy, PTSD therapy, Equine Assisted Therapies and Sustainable Green Prescribing.

5. Apply social models of mental health e.g. through developing peer support in services and community participation.

6. Recognise the inappropriateness of the Accident and Emergency Department for people experiencing mental health difficulties; a special place to be admitted or to meet a doctor privately needs to be provided for at hospital reception.

7. People and communities need clear information with regard to who are the mental health services, and transparency regarding available services and referral pathways.

8. Mental health services must be planned by design and equality proofed to ensure quality outcomes for members of minority groups according to human rights standards. This includes an ethnic identifier to support equality outcomes for the Traveller community, ongoing Review and Evaluation informed by a community development approach; accountability for professionals in their practice of cultural competence.

Political Action and Public Awareness

1. Mental health professionals should join with community organisations to use their knowledge in a political sense i.e. by contextualizing mental health issues as symptoms of wider policy issues and responding on that basis.

2. It is necessary to reach out to people in positions of power and decision-making at a public service delivery level as well as various core mainstream avenues, e.g. schools etc.

3. The stigma of mental health is still prevalent. More workshops and public conversations on mental health are required which facilitate understanding through a social, cultural and political lens. In this regard, personal stories told through this lens are powerful and need to reach more professionals and members of the public.

4. In particular, mental health professionals should speak out about the detrimental effects of the Direct Provision system on people's mental health, and how it has stripped people of their identity. The Direct Provision system needs to be urgently improved e.g. by providing for people to do their own cooking. In the medium term, it needs to be ended.

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Appendix 1
Questionnaire Cultural Competence in Health and Wellbeing Research

Funded by Healthy Ireland Fund

Questionnaire for community organisations working with minority communities

PART A: Background

1. Name of your organisation

2. Aims of your organisation

3. Please indicate which of the following communities are regularly supported by your organisation (circle yes or no):

    (a) the asylum seeking community in Direct Provision   Yes or No

    (b) the Traveller community   Yes or No

    (c) the LGBTQI+ community   Yes or No

    Any comments or clarifications _____

4. Supports provided by your organisation

Information   Yes or No

Counselling   Yes or No

Referral   Yes or No

Social activities   Yes or No

Education and training   Yes or No

Advocacy   Yes or No

Political campaigning   Yes or No

Other _____

5. What, if any, is the nature of your contact or engagement with HSE mental health services? (write 'yes' beside each statement which applies).

    (a) We sometimes refer people we work with to a HSE mental health service.

    (b) HSE mental health services refer people they work with to us.

    (c) We sometimes accompany a person to a HSE mental health service.

    (d) We receive feedback from community members about their experiences with HSE mental health services.

    (e) Other (describe) _____

6. To your knowledge, what HSE mental health services, if any, have been approached by the minority group(s) above?

PART B: Experiences of HSE Mental Health Services

7. Based on your organisational experience, could you briefly describe the positive aspects of dealing with the HSE mental health services experienced by the communities indicated above?

8. What would you say the effects of these positive experiences are:

    (a) on the people looking for support from the mental health services?

    (b) on the support worker(s) in your organisation?

9. Can you briefly describe the negative aspects of dealing with the HSE mental health services experienced by the communities indicated above?

10. What would you say the effects of these negative experiences are

    (a) on the people looking for support from the mental health services?

    (b) on the support worker(s) in your organisation?

11. Please rate your response to the following statements:

    (a) *"In our experience, the HSE mental health services in Galway provide an excellent service to members of the asylum-community living in Direct Provision."* (Leave blank if you are not sure.)

    Strongly disagree   Strongly agree

    0   1   2   3   4   5   6   7   8   9   10

(b) *"In our experience, the HSE mental health services in Galway provide an excellent service to members of the Traveller community."* (Leave blank if you are not sure.)

Strongly disagree   Strongly agree

0   1   2   3   4   5   6   7   8   9   10

(c) *"In our experience, the HSE mental health services in Galway provide an excellent service to members of the LGBTQI+ community."* (Leave blank if you are unsure.)

Strongly disagree   Strongly agree

0   1   2   3   4   5   6   7   8   9   10

11. Would you like to make any recommendations for change in the mental health services?

12. Any other comments

Thank you for taking the time to complete this questionnaire.

Are you willing to have your comments attributed to your organisation in the research?   Yes/No.

**Please email your response to me, Siobhán Madden,
at siobhanjmadden@gmail.com**

Appendix 2
List of Participating Agencies and Organisations

Amach/Teach Solais

BRIDGE

Child and Adolescent Mental Health Services, Galway

Galway City Partnership

Galway Recovery College

Galway Samaritans

Galway Traveller Movement

GROW

Health Service Executive West

Health Service Executive Community

Healthcare West

Helplink Support Services

Jigsaw Galway

Pieta House

Travellers in Prison Initiative

University of Sanctuary

Notes