PROMO Project Feedback from Ireland: Executive Summary.

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PROMO Project: Best Practice in Promoting Mental Health Amongst Socially Marginalised People in Europe

Feedback from Ireland: Executive Summary

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1. Introduction

Promoting mental health and preventing mental ill health amongst socially marginalized people is a major challenge to European societies. There are various policies and services to achieve this in member states, but information on what constitutes best practice is fragmented and consistent guidelines do not exist.

The focus of the PROMO project (Best Practice in Promoting Mental Health in Socially Marginalised People in Europe) is on the delivery of health and social care for people with mental health problems who belong to one of the six following groups: (1) Long-Term Unemployed (LTU); (2) Homeless; (3) Sex Workers (4) Refugees and Asylum Seekers; (5) Illegal Immigrants/Undocumented Migrants; (6) Travellers. The project, which is funded by the European Commission, is coordinated by Professor Stefan Priebe from Queen Mary University of London. The project is being conducted in the capital cities of 14 EU member states, in the period of September 2007 to December 2010. The Health Promotion Research Centre at the National University of Ireland Galway is the participating partner for the Irish section of the study.

The aim of the PROMO project is to formulate policy recommendations and identify best practice for the promotion of mental health amongst socially marginalised people in Europe.

Objectives of the PROMO Project:

1. To review policies and legislation in each participating country related to promoting mental health and preventing mental ill-health amongst socially marginalised groups.

2. To select the two most deprived areas in each of the 14 participating capital cities and within these areas to: a) obtain information on services providing health and social care for marginalised people with mental health problems; b) assess the overall quality of care for marginalised people with mental health problems.

2. Methodology

A review of all relevant policies and legislation relating to mental health care in Ireland for the six target groups was undertaken via consultation with individual experts in the field and a through a review of all relevant policy documents.

The two most deprived areas in Dublin City were identified using the Haase Deprivation Indices (An Pobal). However, as both identified areas did not meet the required catchment area population levels (80,000-150,000) for the study, the HSE catchment areas which they are situated in, namely Dublin North Central and Dublin West, were selected as the two target areas.

Services in both areas, which potentially provide health and social care to individuals from any of the six target groups with mental health problems, were identified. Each service was contacted and the level of service provision was assessed via a structured phone interview with designated staff members. The assessment covered the following areas:

(1) Provider and funding information
(2) Staffing
(3) Service accessibility
(4) Profile of clients
(5) Services provided to target groups
(6) Coordination with other services
(7) Service evaluation

Services situated outside the target areas, but which could potentially have a large number of marginalised clients attending from the target areas, were also assessed.

In order to assess the overall quality of service provision, semi-structured interviews with experts in mental health/social care provision for each group were conducted. One interview was conducted in relation to each target group in both areas, leading to 12 interviews in total. The semi-structured interviews consisted of (1) case vignettes which sought to determine the pathways to care and treatment available, including questions relating to the barriers to receiving that care and treatment, and how these barriers can be overcome; and (2) general questions regarding service provision, including their strengths and weaknesses, and level of co-ordination.

3. Results

3.1 Legislation and policy review

There is no specific legislation mandating provision for any of the target groups in relation to mental health care. However, the following policy documents provide strategic guidance in relation to mental health care for one or more of the target groups:

a) Government policy documents (relevant groups covered)

- A Vision of Change: Report of the Expert Group on Mental Health Policy 2006 (LTU, homelessness)
- The National Action Plan for Social Inclusion 2007-2016 (homelessness, refugees and asylum seekers, travellers)

b) Other policy documents

- National Economic and Social Forum: Mental Health and Social Inclusion 2007 (homelessness, refugees and asylum seekers, travellers)

c) Group specific policy documents

Homelessness

- A Key to the Door: A homeless agency partnership action plan on homelessness in Dublin (2007-2010)
- The Way Home: A strategy to address adult homelessness in Ireland (2008-2013)
- Pathway to Home: New configuration of homeless services in Dublin 2010 (Homeless Agency Partnership, 2010)

d) Other policy documents with reference to marginalised groups with mental health problems:

- The National Disability Strategy (2004)
- Reach Out (2005) is a National Strategy for Action on Suicide Prevention
- The National Intercultural Health Strategy (2007-2012)

There is no specific reference to provision for sex workers or illegal immigrants in any of the policy documents reviewed.

3.2 Assessment of services

Overall, 87 services were identified and 80 agreed to participate in the study - 54 in Dublin North Central, 18 in Dublin West and 8 outside both areas.

Table 3.2.1: Number of services assessed according to area and service type

Service Typology	*Area 1: DNC*	*Area 2: Dublin West*	*Outside Area*	Total
Group specific mental health services	3*	0	3	**6**
Generic mental health services	17	12	1	**30**
Group specific social care services	29	3	3	**35**
Generic social care services	3	3	0	**6**
Group specific general health services	1	0	1	**2**
Generic general health services	1	0	0	**1**
Total	**54**	**18**	**8**	**80**

*Two of these services are pilot projects

Table 3.2.2: A selection of results from the Irish target areas and a comparison with the equivalent results from the European target areas**

		Ireland (n=80)		Europe (n=513)	
		N	%	N	%
Does service engage in *active outreach?	***Yes***	44	55.0%	157	30.7%
Does service engage in *case finding?*	**Yes**	23	28.8%	110	21.5%
***Does service accept *self-referrals*?**	***Yes***	40	50.0%	431	84.7%
***Is service provided by the *State or NGO*?**	**State**	40	50.0%	177	37.1%
	NGO	40	50.0%	300	62.9%
***Does service have *mental health staff*[1]?**	**Yes**	41	51.3%	339	67.8%
***Does service have *social care staff*[2]?**	**Yes**	26	32.5%	316	63.3%
***Does service provide any *mental health therapy*[3]?**	**Yes**	35	43.8%	403	79.8%
Does service provide any *addiction type programmes*[4]?	**Yes**	24	30.0%	151	29.7%
Does service provide *social type programmes*[5]?	**Yes**	60	75.0%	418	82.6%
****External supervision* for staff at least once a month?**	**Yes**	15	18.8%	247	49%
*** Socio-demographic characteristics of clients systematically collected?**	**Yes**	53	66.3%	450	88.4%
***Data on input and attendance systematically collected**	**Yes**	50	62.5%	427	84.1%
***Outcome data on satisfaction and experience systematically collected**	**Yes**	26	32.5%	242	47.2%
***Does the service have any exclusion criteria[6]?**	**Yes**	30	37.5%	256	53.8%

***Significant differences (P<0.05)**

****data from two of the participating countries was omitted from the analysis due to the low quantity of services assessed in these countries

[1] psychiatrists, psychologists, counsellors or mental health nurses
[2] either an occupational therapist or a social worker
[3] counselling or psychotherapy (group or individual)
[4] detoxification treatments, drug addiction treatments or alcohol addiction treatments
[5] social welfare support, housing support, legal advice and support or job coaching/finding
[6] lack of motivation, command of language of host country, addiction, criminal history or aggressive behaviour

Table 3.2.3: Service provision across group specific services (n=43)

	LTU (n=7)	Sex Workers (n=3)	Homeless (n=19)	Refugees & Asylum Seekers (n=8)	Illegal Immigrants (n=1)	Travellers (n=5)
	Yes	Yes	Yes	Yes	Yes	Yes
Active outreach	**5** *(71.4%)*	**3** *(100%)*	**8** *(42.1%)*	**5** *(62.5%)*	**0**	**4** *(80.0%)*
Case finding	**4** *(57.1%)*	**2** *(66.7%)*	**8** *(42.1%)*	**0**	**0**	**3** *(60.0%)*
State Sector	**3 (***42.9%)*	**1** *(33.3%)*	**6** *(31.6%)*	**5** *(62.5%)*	**0**	**2** *(40.0%)*
NGO	**4 (***57.1%)*	**2** *(66.7%)*	**13** *(68.4%)*	**3** *(37.5%)*	**1**	**3** *(60.0%)*
Does your organisation accept self-referrals?	**7** *(100%)*	**3** *(100%)*	**6** *(31.6%)*	**4** (*50.0%)*	**1**	**4** *(80.0%)*
Services with mental health staff[7]	**2** *(28.6%)*	**1 (***33.3%)*	**7** *(36.8%)*	**3** *(37.5%)*	**0**	**1** *(20.0%)*
Services with social care staff[8]	**0**	**1** *(33.3%)*	**10** *(52.6%)*	**4** *(50.0%)*	**0**	**1** *(20.0%)*
Do services provide any mental health therapy?[9]	**1** (*14.3%)*	**2** *(66.7%)*	**5** *(26.3%)*	**2** *(25.0%)*	**0**	**2** *(40.0%)*
Do services provide any addiction programmes?[10]	**1** (*14.3%)*	**2** *(66.7%)*	**5** *(26.3%)*	**1** *(12.5%)*	**0**	**2** *(40.0%)*
Do services provide social programmes[11]	**7** (*100%)*	**3** *(100%)*	17 *(89.5%)*	**5** *(62.5%)*	**1**	**4** *(80.0%)*
Do services have any exclusion criteria[12]	**4** (*57.1%)*	**0** *.0%*	**11** *(57.9%)*	**2** *(25.0%)*	**0**	**3** *(60.0%)*
Socio-demographic characteristics of clients systematically collected?	6 (85.7%)	1 (33.3%)	16 (84.2%)	6 (75%)	1	3 (60%)
Data on input and attendance	6 (85.7%)	3 (66.7%)	13 (68.4%)	5 (62.5%)	1	3 (60%)

[7] psychiatrists, psychologists, counsellors or mental health nurses
[8] either an occupational therapist or a social worker
[9] counselling or psychotherapy (group or individual)
[10] detoxification treatments, drug addiction treatments or alcohol addiction treatments
[11] social welfare support, housing support, legal advice and support or job coaching/finding
[12] lack of motivation, command of language of host country, addiction, criminal history or aggressive behaviour

3.3 Overall quality of mental health service provision

The semi-structured interview data were assessed by thematic analysis, grouping similar responses within each question into categories. The following are the main categories of responses:

- **Initial Contact:** Family and friends are most likely to notice and initiate help for someone with a severe mental health problem who is isolated and not in contact with the services, followed by a passer-by/police and street outreach services, none of which are mental health specific.
- **Outreach Services:** The services most likely, once informed, to go out and contact the individual are street outreach services (the majority being homeless related services), followed by primary care services e.g. social worker or GP.
- **Referrals:** Most referrals from this point would be to a GP and then to the psychiatric services if necessary. The individual may also be referred to A/E or may go there of their own volition.
- **Care Pathways:** The most frequent further care pathways are the generic mental health services and group specific mental health services which are available for Homeless people and Refugees & Asylum Seekers.
- **Information on Services:** GP's were the most prominent response in relation to where an individual who is seeking help might get information on where they can get help, and what services they can approach.
- **Perceived Barriers to Treatment and Care:** A variety of barriers to receiving the aforementioned care and treatment were described. The most prominent categories were continuity of care (e.g. seeing a different psychiatrist at each appointment); accessibility of services; prejudice in the services towards the target groups and the effects of stigma (both related to the effects of being marginalised and the stigma surrounding mental health problems). A high proportion of the barriers reported were specific to each group.
- **Overcoming Barriers:** Some of the responses in relation to how to overcome barriers were as follows: employment programmes including elements on hygiene & diet for LTU; for Sex Workers more multi-disciplinary teams and to see the same psychiatrist each time; for Refugees & Asylum Seekers training in cross cultural mental health care for service providers, psychological services for Refugees & Asylum Seekers and good basic information available in English regarding services; for Homeless clearer policies with regard to catchment areas; for services to acknowledge cultural differences amongst Travelers and awareness raising around mental health issues in the Travelling community; for Illegal Immigrants a channel where vulnerable people can be regularised in order to receive the treatment they need.
- Lack of **co-ordination** amongst the relevant services was a common theme.

- **Service Strengths:** A limited number of service strengths were reported for LTU, Homeless and Refugees & Asylum Seekers.
- **Service Weaknesses:** Weaknesses reported are mainly specific to each group. For example, for LTU there is a lack of co-ordination between the HSE and the community rehabilitation programmes; for Sex Workers and Travellers there is the inaccessibility of the mental health services; for homeless there are issues with the catchment area system; for Refugees & Asylum Seekers there is a lack of trained interpreters and cultural issues; and Illegal Immigrants are entitled to emergency care only.
- **Service Improvements:** When asked what are the two things that would most improve the quality of mental health care provided for the target groups the most frequent response was more information/knowledge regarding the mental health services, mostly in relation to provision for our target groups but also for non-statutory service providers.

4. Discussion

In terms of legislation and policy, the main mandate for provision of mental health services for socially marginalised groups is in national mental health policy documents, both statutory and otherwise, such as a 'Vision for Change' and policy documents for specific groups such as the homeless.

In relation to service provision, the services assessed in both Irish target areas reported significantly higher levels of active outreach in comparison to the services assessed in other participating countries. However, of the six group specific mental health services identified, only two engage in active outreach and none engage in case finding. The Irish services were assessed as being significantly less likely to offer the possibility of self-referral. There is an equal balance between services provided by the state sector and NGO's in the Irish target areas, which is in contrast with that reported in the other the European capitals, where services are significantly more likely to be provided by NGO's.

The services assessed in both Irish target areas reported significantly lower levels of mental health and social care staff when compared to the other European services assessed. The Irish services reported lower levels of psychiatrists, counsellors and occupational therapists and significantly lower levels of psychologists/psychotherapists and social workers. Irish services were also assessed as being significantly lower in the provision of mental health therapies, in particular counselling and group psychotherapy.

In essence, the potential care pathways for our target groups are the same as for the rest of the population – an initial contact with a GP and from there referral to the generic mental health services if necessary. Many will attend A/E, often because they do not have access to a GP or a medical card, or because they are unaware of the importance of accessing a GP initially. There are some group specific outreach services for homeless people and sex workers,

although only one service is mental health specific. Respondents reported that there is little co-ordination of services and few service strengths were reported. Barriers to accessing services and the weaknesses of service provision are reported as being mainly specific to each group.

The results suggest that, in comparison to the other assessed capital city areas in Europe, there is a high level of fragmentation in the services for socially marginalised groups across both areas in Dublin. The results also suggest that many of the needs identified in terms of service accessibility and provision of care are group specific.

In interpreting the findings from this study, it must be borne in mind that the assessment of service provision is based on reports from service staff in the designated areas. Validation of responses, in terms of access to actual service data or the views of service users from the target groups, was beyond the remit of this study.

For a more in-depth description of the results please see the main report of the Irish findings and also the overall generic PROMO report at the official PROMO website: http://www.promostudy.org