



**PROMO PROJECT**

**Good Practice In Mental Health Care For Socially  
Marginalized People In Europe:**

**Report on Findings**

**Queen Mary University of London**

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## SECTION 1: INTRODUCTION

### 1.1 BACKGROUND

It has been well documented that people from the groups who experience social marginalisation are more likely than the rest of the population to experience mental health problems. They are also more likely to be over-represented (in terms of their proportion of the population) in psychiatric hospital admissions. The health promotion literature shows that individuals who are socially marginalised have restricted lifestyle choices and fewer and less effective means of coping with psychological distress. It has been recognised that factors such as lack of money, discrimination, social exclusion, lack of education and poor housing standards have a major impact on their mental health<sup>1</sup>.

Actions undertaken by Governments, whether federal or regional, in different Member States to deal with the link between social marginalisation and mental health have been patchy and inconsistent. It is not clear how much priority this issue has been given, and whether EU States have policies and services in place to lessen the risk of socially marginalized people developing mental illness, or to ensure their access to appropriate care.

This report presents the findings of the PROMO project (DG Sanco: 2007 – 2010). The project assessed and described services that provide mental health and social care in the capital cities of the 14 EU member states to people from socially marginalised groups who suffer from mental illness. The quality of care was investigated and the components of good practice identified. The relevant policies and legislation in the participating countries were also identified and reviewed.

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<sup>1</sup> Commission on Social Determinants of Health. CSDH Final report: Closing the Gap in a Generation: Health Equity Through Action on Social Determinants of the Social Determinants of Health. Geneva, Switzerland: World Health Organisation; 2008.

## **1.2 AIMS**

The aim of the PROMO project was to identify good practice in promoting mental health amongst the socially marginalised groups and inform relevant policies. The focus 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; (2) homeless; (3) street sex workers; (4) asylum seekers/refugees; (5) irregular migrants; (6) travelling communities.

## **1.3 SPECIFIC OBJECTIVES**

The specific objectives of the project are:

1. to review policies and legislation related to the provision of mental health care for socially marginalised groups,
2. to select two highly deprived areas in each of 14 European capitals and
  - a) obtain information on services providing health and social care in these areas for marginalised people with mental health problems, including information on how the work of services is linked and coordinated,
  - b) assess the overall quality of care in these areas for marginalised people with mental health problems,
  - c) analyse the data to identify components of good practice on the level of services and systems of health and social care.

## 1.4 PARTICIPANTS

The project was coordinated by the Unit for Social and Community Psychiatry, Barts and the London School of Medicine and Dentistry, Queen Mary, University of London and conducted in collaboration of the 14 partners in different EU states:

<b>EU Country</b>	<b>Name of the participating institution</b>
Austria	Ludwig Boltzmann, Institute for Social Psychiatry, Vienna
Belgium	Université Catholique de Louvain, Brussels
Czech Republic	Univerzita Karlova v Praze, Prague
France	Etablissement Public de Santé Maison Blanche, Paris
Hungary	Hungarian National Institute for Health Development, Budapest
Germany	Universitätsmedizin Charite, Campus Mitte, Berlin
Ireland	National University of Ireland, Galway
Italy	Agency for Public Health, Lazio Region, Rome
Netherlands	Academic Medical Centre Amsterdam
Poland	Institute of Psychiatry and Neurology, Warsaw
Portugal	University of Porto Medical School, Porto
Spain	Madrid Salud, Madrid
Sweden	Karolinska Institute, Stockholm
United Kingdom	Queen Mary University of London

## **SECTION 2: METHODOLOGY**

### **2.1 LEGISLATION AND POLICIES**

Policies and legislation relevant to the project were identified through document research (internet, published materials, libraries) and direct contact with the experts from relevant statutory and voluntary agencies in the each participating country. The analyses of these documents included both descriptive and qualitative components. Data was presented in a matrix showing which countries and capitals have relevant policies and/or legislations and to which aspect of social marginalisation these documents refer to. A critical qualitative review was conducted to provide a comprehensive overview of the identified policies and legislations.

### **2.2 IDENTIFICATION OF THE TARGET AREAS IN 14 CAPITAL CITIES**

A total of 28 geographic areas were selected for the PROMO assessment, two in each participating capital. The most deprived areas were chosen as a focus of PROMO assessment because of the particular relevance of social marginalisation in these settings. They were identified by using the relevant local indices of public health and social deprivation. The population of each area was between 80,000 and 150,000 inhabitants, with some flexibility to accommodate different local contexts. The target areas are presented in Table 1.

**Table 1. Target areas identified for assessment in 14 EU capital cities**

<b>COUNTRY/ CAPITAL</b>	<b>AREA 1</b>	<b>AREA 2</b>
<b>Austria/ Vienna (2008)</b>	District 16	District 20
1.680.170	94.735	82.369
<b>Belgium/ Brussels (2007)</b>	Schaerbeek+St Josse.	Molenbeek
1.031.215	113.493+ 23.785	81.632
<b>Czech Republic/ Praha (2006)</b>	Praha 3 +Praha 7	Praha 8
1.188.126	69.939+ 39.425	100.255
<b>France/ Paris (2006/ 2007)</b>	The northern half of the 19th arrondissement of Paris, corresponding to the Secteur Flandre psychiatric sector	La Courneuve / Aubervilliers in Seine Saint Denis
2.193.031 (2007) (Ile de France: 11.598.844) (2007)	102.387 (2006)	37.347+ 73.506 (2006)
<b>Germany/ Berlin (2006)</b>	Wedding (the sub area of "Schillerpark" removed to achieve target size)	Kreuzberg
3.340.897	123.191	147.798
<b>Hungary/ Budapest (2001)</b>	District VIII.	District VII. and IX.
1.776.385	81.787	64.137+ 62.995
<b>Italy/ Rome (2007)</b>	District 7	District 15
2.705.603	117.479	146.090
<b>Ireland/ Dublin (2006)</b>	Dublin North Central	Dublin West
1.187.176	126.572	134.020
<b>Netherlands/ Amsterdam (2006)</b>	Bos en Lommer + De Baarsjes + Geuzenveld-Slotermeer	Amsterdam Zuid Oost
779.167	30.045+ 33.767+ 41.314	78.922
<b>Poland/ Warsaw (2006)</b>	Praga Polnoc	Wola
1.700.536	73.207	142.025

<b>Portugal (2001)</b>	A group of smaller areas*	Marvila+ Santa Maria dos Oliváis
564.657	85.177	82.753
<b>Spain/ Madrid</b>	Villaverde	Centro
3.205.334	146.859	149.797
<b>Sweden/ Stockholm (2010)</b>	Rinkeby-Kysta + Spånga-Tensta + Skarpnäk	Södermalm
837.000	45.500+ 36.000+ 40.000	118.000
<b>UK/ London (Greater London Urban Area) (2001)</b>	Hackney	Tower Hamlets
8.278.251	202.824	196.106

\*Lisbon Area 1: Anjos, Castelo, Encarnação, Graça, Madalena, Mercês, Pena, Penha de França, Santa Catarina, Santa Engrácia, Santa Justa, Santiago, Santo Estêvão, Santos-o-Velho, São Cristóvão e São Lourenço, São José, São Miguel, São Nicolau, São Paulo, São Vicente de Fora, Sé, Socorro.

### 2.3 ASSESSMENT OF SERVICES IN 14 EU CAPITAL CITIES

The aim of PROMO assessment of services was to assess all mental health, social care and general health services that potentially serve individuals with psychological/psychiatric disorders and who belong to the six PROMO target groups. The assessment was focused on the selected most deprived areas, however, key services serving these population areas but located outside these areas were also assessed.

The assessments were carried out by PROMO researchers either face-to-face with service representatives or over the phone, using a specially developed questionnaire.

### **2.3.1 PROMO TOOL FOR ASSESSMENT OF SERVICES**

The PROMO tool for assessment of services was developed in an extensive Delphi process involving all partners (see Appendix 1). It was translated into all relevant languages and 3 pilot interviews were carried out in each participating country. The PROMO tool was designed to assess the following aspects of service provision:

1. Provider and funding information
2. Characteristics of staff
3. Service accessibility
4. Characteristics of clients
5. Programmes provided to clients from target groups
6. Co-ordination with other services
7. Service evaluation

### **2.3.2 PROMO TYPOLOGY OF SERVICES**

All identified services were classified according to the PROMO typology which was based on service self-definition and clients' profiles:

- A1)** Mental health services specific to PROMO target groups
- A2)** Generic mental health services
- B1)** Social care services specific to PROMO target groups
- B2)** Generic social care services
- C1)** Physical health services specific to PROMO target groups
- C2)** Generic physical health services

They were additionally categorised according to target group within the group-specific services (A1, B1, and C1). The aim of the PROMO typology was to provide a comprehensive overview of service provision for the target groups across 14 EU capital cities and to aid the process of the identification of good practice.

## **2.4 ASSESSMENT OF THE QUALITY OF MENTAL HEALTH CARE IN 14 EU CAPITAL CITIES**

The assessment of the quality of mental health care in the identified areas was carried out by conducting semi-structured interviews with health and social care professionals with knowledge and experience of providing mental health, health or social care to clients from the PROMO target groups. The aim was to conduct one interview for each target group in each identified area, resulting in a total of 12 interviews in each participating city. The relevant professionals identified during the assessment of services in each area were then invited to participate in the assessment of the quality of mental health care. The semi-structured interview schedule consisted of two case vignettes and general questions regarding the quality of mental health care. (see Appendices 2a-2f). The aim of the case vignettes was to illustrate pathways into and types of mental health care available to the clients from each target group

## **SECTION 3: FINDINGS OF THE PROMO PROJECT**

### **3.1 CRITICAL REVIEW OF EXISTING POLICIES AND LEGISLATIONS REGARDING MENTAL HEALTH CARE FOR MARGINALISED GROUPS**

This information is based on reports provided by the PROMO project leaders of each partner institution. Data collection took place in each of the partner institutions and involved consulting experts in the field as well as juridical experts and documents/tools. The focus of this report is to establish what effect government policies and legislation can have on mental health care for the six target groups identified in the PROMO study, namely long-term unemployed, sex workers, homeless, refugees/asylum seekers, irregular migrants and travelling communities.

A questionnaire compiling all the information was developed by the coordinating centre and send out to the individual partner sites. The answers were structured according to:

#### Section I

- 1) Background information on the national health care system with regards to (a) general principles, (b) first point of contact, (c) organisational structure and (d) funding structure.
- 2) The role and structure of social care in each country.
- 3) How mental health care and marginalisation have been addressed in government policy and legislation in these countries.

In Section II, policies relating to the six PROMO target groups were reviewed according to their effect on mental health care for those specific cases.

### 3.1.1 Introduction

Although the connection between mental health care and marginalisation has been widely acknowledged, it has not been established as a separate policy area. Depending on the perspective, different policy-making arenas come into play. In mental health care policies, the issue of marginalisation is addressed when occurring as a result of mental illness. There tends to be little mentioning of how mental health care is provided for people in a situation of marginalisation, or how specific marginalised living conditions can affect engagement with mental health services.

While mental health *care* specifically has been defined by most countries as part of health care, social care treats marginalisation as a living situation caused by mental illness. One is concerned with the *treatment* of an illness; the other with the social aspect of mental illness in providing *support and care*, in order to live a dignified life in the community.

In addition, the question arises of how marginalisation manifests itself in daily living conditions, and how this can affect access to and engagement with services. This consideration is reflected in the choice of groups for the PROMO project. Since there is often an overlap between different aspects of marginalisation, such as housing or long-term unemployment, especially for people with mental illness, several government policies may apply to one case.

How country policies address the question of mental health care for marginalised groups may often depend on which perspective is addressed: the danger of marginalisation for people with mental health problems or the impact of marginalisation on people's mental health.

## **3.1.2 Mental Health Care and Marginalisation**

### **3.1.2.1 Level of regulation**

In the majority of countries, the social aspects of marginalisation have not been directly addressed in the mental health care policy. Issues for engagement within the communities that can result from mental illness are mostly addressed with policies that question social exclusion, deprivation and anti-discrimination. In the majority of cases, these issues are mentioned as questions of social care. Mental illness is recognised as a disability in all the participating countries.

Mental health care remains a question of health care. Specific mental health related needs as part of care have not been directly defined in the social care policies of most countries.

The increasing tendency towards community oriented psychiatry deems mental illness a social care question. In Poland, the Mental Health Act and National Mental Health Programme (2007-2015) emphasise both health care and social care components in provision of care for people with mental illnesses. One of the strategic objectives in the Programme specifies a need for complex, and integrated care, based on the community model of mental health, and including social support and social and vocational integration.<sup>2</sup>

Across all the countries investigated, both health care and social care operate on a variety of policy levels. In the majority of countries that operate a federal system, such as Germany, the general health care agenda has been set out on a national level, while management has been distributed to regional governments. In countries that operate a centralised system, such as France, territorial division of health care is common, and mental health care is divided into sub-sections in line with a community-oriented approach.

In Poland, policy in health care and mental health care is provided on a national level, but regions are obliged to develop their own policies. Regional authorities are also obliged to develop and supervise the network of mental

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<sup>2</sup> Mental Health Act of 19 August 1994 (J. of L. No 111, Item 535, as currently amended).

health care services, organisation and management is run by the local communities.

The definition of social care policy itself varies between countries, which makes it difficult to compare different policy approaches. While some countries report the inclusion of welfare and housing as part of the social care policy, these are distinct policy sectors in other countries. Consequently some partner institutions, such as those in Italy, found it difficult to identify one social care policy instead describing it as ‘a complex construct of regional and local community operations with general principles set out on a national level’.

In addition not-for-profit organisations form part of a network that provides social care. (e.g. Poland, Austria<sup>3</sup>)

When it comes to the level of regulation social care in the narrow sense of providing ‘assisted living’ is regulated on a local community level, for the majority of countries included in this project.

Health care and social care funding structures vary substantially between countries. To begin with there is often a very complex structure of insurance and voluntary contributions involved.

In most cases health care and social care represent two separate areas of government funding. The actual distribution of funds tends to take place on a municipal level for social care, while the distribution of the health care budget is mostly directed at wider areas such as regional governments.

In some countries, the organisation of outpatient psychiatric settings takes place as a separate sector within health trusts (e.g. Italy, Ireland, UK, Belgium) since catchment areas within the communities may differ from the scope of health trusts.

### **3.1.2.2 Access to mental health care**

An essential policy question is how regulations can affect access to mental health care amongst marginalised populations. Mental health has been explicitly included in the in the scope of the ‘Right to Health’.<sup>4</sup> Although the

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<sup>3</sup> Often interlinked with church organisations.

<sup>4</sup> “*The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*”

'Right to Health' has generally been acknowledged as an overall principle, regulations differ on a practical level that ultimately affects access to health care.

In principle measures ensuring 'health care for all' have been implemented by all countries, but the practical implications of these measures differ substantially amongst them. Administrative procedures provide obstacles in accessing mental health care. Those obstacles are different for each of the six marginalised groups, and are in essence dependent on the regulations for: emergency care, access to primary care, as well as the referral structures within the national health system.

One administrative barrier is that some countries (such as Austria, Belgium and Germany) make access to primary health care dependent on insurance contributions. In countries such as Italy or Ireland a standard fee applies at primary or secondary care level. There are ways to be exempt from those costs on a means-tested basis, such as with the Medical Card in Ireland, the benefits-related coverage in Germany, or income-based registration with the local health trust in Italy. However the administrative requirements for being granted exemption, such as presenting an official residency permit (e.g. Italy, Ireland) or entitlement to benefits (e.g. Germany), are often not met by the six groups because of the specific type of marginalisation, such as lack of permanent residence or official residency permit. The assessment of means-based needs itself is often dependent on administrative procedures, the criteria for which the target groups cannot meet (e.g. definition within catchment area; lack of permanent residence).

In countries such as United Kingdom the idea of universal health care coverage is interpreted as *free of charge* for all 'lawful residents'. In practice this means that access to primary care and consequent referrals are free of charge.

There are other administrative barriers apart from financial ones at the primary care level, such as having to provide 'proof of address' (e.g. a utility bill in the United Kingdom) or an official resident permit (e.g. France), which may prevent marginalised populations from accessing health care.

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Article 12,1 International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966. Art. 24 UDHR; Article 152 Treaty of Amsterdam.

Depending on the administrative procedures in place in the country some marginalised groups might be affected more than others. This depends on whether de-facto permanent residency (critical for the homeless population), or a legal permanent residency (critical for irregular migrants) is required. The difference lies between having a stable residency or the *right* to legally reside in the country.

Another aspect is at what level of care mental health care is provided. In the United Kingdom, for example, a new system has been put into place to provide low-intensity psychological treatment (IAPT) at the primary care level. In Portugal the National Health Plan (2007-2016) defines 'Promote the integration of mental health care in health general system, at primary care level, hospitals and continuous care, in order to increase access and reduce institutionalisation' as a specific target. In Germany psychiatric outpatient clinics are now being integrated into general hospitals.

In some cases the only option is emergency care in urgent cases. A 'mental health emergency' has not been defined by any of the participating partner institutions. A generally accepted definition is that of 'being a danger to oneself or others'. Otherwise, the inclusion and length of psychiatric treatment in emergency care varies significantly among countries.

Emergency care may include preventative and curative treatment defining mental health care as 'urgent medical aid' (e.g. Belgium) whereas in other cases (e.g. Austria) a concrete 'life in danger' is the prerequisite.

### **3.1.2.3 Social Inclusion /Anti-discrimination**

Marginalisation itself is addressed in a variety of policy sectors. There is a general tendency in Europe towards including people with mental health problems into the community in an attempt to prevent social exclusion. This extends to areas of management within the local communities (e.g. Community Mental Health Teams in the United Kingdom or outpatient mental health centres in Italy) and as a specific policy of de-institutionalisation (e.g. France, Portugal). Others address the question of fighting discrimination

against people with mental illness to promote the development of specific programmes that further this integration (e.g. Portugal, Poland).

Another area that relates to the question of social exclusion is when people fall within the remit of disability policy. In Germany, a defined goal is 'autonomous participation in public life and removal of obstacles to their equal opportunities'. However, practical implications of equal opportunities policies are defined within other policy sectors, depending on which area of public life is in question (e.g. employment).

Whether a mental health problem qualifies as a disability and therefore provides an entitlement to social care benefits is not specifically defined in most cases and needs to be considered on a case-by-case basis.

Finally, the development of preventive policies that concern the population's mental health are emerging and these link in with questions surrounding marginalisation. The *National Mental Health Plan (2007 – 2016)* of Portugal specifically mentions the reduction of risk factors for the development of mental disorders, and the promotion of the population's mental health as a central objective. In the Polish National Mental Health Programme (2007-2015) social marginalisation is specified as a risk factor for developing mental disorders.

### **3.1.3 Group-specific policies and legislations**

#### **3.1.3.1 Long-term unemployed**

There is no distinct mental health care policy for long-term unemployed in any of the participating countries. In some countries, such as the Netherlands, there are policies that emphasise that occupational training should be combined with psychological counselling. In Austria, such a programme is managed by cooperation programmes between the employment agency and not-for-profit occupational training projects.

In addition, long-term unemployment has been identified as a high risk factor for social exclusion by national agendas promoting social integration. In countries such as Poland this has been implemented as part of the

employment policy. Once registered, clients become entitled to free health insurance and various programmes that provide re-integration into work life, including vocational training, psychological counselling and employment advice.

However, as it has been observed in the United Kingdom, that could mean people need to register as 'fit to be employed', which is in conflict with an entitlement to disability benefits.

In some countries such as France, anti-discrimination policies have adopted regulations that place the responsibility on companies to employ a certain percentage of people with disabilities (6%). Employment training that is tailored to the specific needs of people with mental health problems has been explicitly mentioned in the report by the Irish expert group on mental health policy *A Vision for Change (2006)* on social integration of people with mental health problems. In Austria, within the framework of the 'Employment Promotion Law' the Public Employment Service (AMS), usually sends long-term unemployed people up to once a year to skills and/or social training and job promotion programmes. Some of this training is specifically tailored to people with mental health problems as well. Under the Social Employment Act in Poland, long-term unemployed and people with mental illnesses are also supported by 'Social Integration Centres', the 'Supported Employment Market' and 'Social Cooperatives'. These are co-funded or supported by public funds to enable specialised working conditions for people at risk of social exclusion.

### **3.1.3.2 Sex workers**

There is very little evidence of policies in the PROMO countries addressing mental health needs particular to sex workers.

#### ***Regulations regarding sex work***

In general policies that relate to sex work are created with a view to protect sex workers as victims of exploitation. Street sex work in public spaces per se, however, is specifically criminalised in the United Kingdom and Ireland.

In Italy and Belgium sex work as the activity of selling sex on private premises is not explicitly identified as a criminal offence. In those cases the law does not consider prostitution an individual activity, but as an organisation that seeks to exploit the individual.

As such policy perspectives on prostitution mainly treat the sex worker as a victim. Recent developments in the United Kingdom recognise that health and mental health concerns have been neglected in the policy towards sex work which up to that point has mainly been addressed from a criminal justice perspective.<sup>5</sup> Legal implementation of this recommendation has not taken place to-date.

In countries where access to health care is dependent on registration with the statutory health insurance system<sup>6</sup>, the employment status attached to sex work affects this access according to each particular country.

In Belgium and Austria, sex workers have the right to register as self-employed, which qualifies them for registration with the statutory health insurance system. In Germany this applies to the specific status of self-employment<sup>7</sup> for sex workers in principle; however access may be restricted as sex workers fall into the 'high risk' category of insurance providers.

From a policy perspective the profession of sex work itself does not pose any obstacles for accessing mental health care.

### ***Victims of trafficking***

Since human trafficking has gained increasing media attention, policies have addressed its elimination as a primary issue. In Portugal, specialised training for health and social care professionals regarding the psychosocial effect on victims of human trafficking has been formulated in the *National Plan Against Trafficking of Human Beings (2007-2010)*. In France, the 'Law on Internal Security (No 2003-239)' explicitly states the right to 'public protection and

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<sup>5</sup> "Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse" (2006).

<sup>6</sup> e.g. Belgium, Germany, Austria.

<sup>7</sup> Defined as 'seemingly' self-employed (scheinselbststaendig).

assistance' for victims of human trafficking<sup>8</sup>, including placement in 'social housing and rehabilitation centres.'<sup>9</sup> The *National Programme to Prevent and Combat Trafficking in People 2009-2010* in Poland aims to establish a model of 'social and vocational reintegration' for victims of trafficking. In Austria victims of human trafficking are granted access to psychosocial support in addition to a legal representative during the entire criminal trial<sup>10</sup>.

In France, Poland and Italy, being a victim of trafficking may qualify as a humanitarian ground for granting a temporary residence permit (minimum six months in France and Italy; three months in Poland) that allows access to health care and social services.

### **3.1.3.3 Homeless**

Homelessness in particular appears as a primary issue within policies that address social marginalisation. The majority of countries in the PROMO study have presented an agenda to specifically combat homelessness (e.g. Ireland, Sweden, Poland, Italy, Netherlands, Austria). Nonetheless, only a few governmental institutions, such as in Ireland, specifically mention mental health care for the homeless population. In France, the establishment of specialised psychiatric mobile teams for people in a situation of social deprivation<sup>11</sup> is primarily aimed at the homeless population.

Although difficulties for the homeless population in accessing mental health care services have been recognised by social exclusion policies, a permanent residence still represents one of the main requirements for registering with the health care system. This manifests itself either as a requirement to present a de-facto 'proof of address' (e.g. United Kingdom) or proof of being a legal resident of the country.

Although the entitlement to free health care for those in social exclusion is guaranteed by most of the countries investigated, the administrative barriers prove particularly high for the homeless population.

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<sup>8</sup> Art 42 Law on Internal Security (No 2003-239) (2003).

<sup>9</sup> Art 43 Law on Internal Security (No 2003-239) (2003).

<sup>10</sup> Psychosoziale Prozessbegleitung

<sup>11</sup> Circulaire DHOS/O2/DGS/6C/DGAS/1A/1B no 2005-521.

In Belgium, the sickness fund premium is reimbursed when income is lower than the 'integration income'. Similarly, in Italy, registration is required to qualify for reimbursement for the chargeable 'ticket' in order to access secondary care; and the 'Medical Card' in Ireland. In Germany, reimbursement of the insurance premium is dependent on reception of welfare benefits. The process of registering in order to obtain these benefits is exacerbated by the fact that allocation is organised by catchment area and therefore a permanent address is required, posing an additional administrative barrier for the homeless population.

#### **3.1.3.4 Refugees/Asylum Seekers**

For the purpose of this analysis it is important to differentiate between regulations for asylum seekers as opposed to refugees.

The *Convention relating to the Status of Refugees as amended by the 1967 Protocol* provides the definition of a refugee:

Article 1:

*"A person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.."*

An asylum seeker has made an application for asylum on the basis of those grounds.

Since their status is defined as 'awaiting the outcome of a legal process' it is temporary by definition.

In a two phase process, asylum seekers are assigned the responsible authority to deal with their case. Specific reception conditions vary among countries. They deal with housing, access to the labour market, welfare

support and health care, among others. In most countries asylum seekers are referred to private accommodation, however, there are cases, in which they remain in accommodation centres throughout the asylum procedure (e.g. Sweden and Hungary).

## **Refugees**

In principle, refugee status creates equal entitlement to health care. Differences in access, therefore, arise from insurance-related questions. In general, there are welfare schemes in place to ensure health insurance coverage for refugees.

In Hungary, health insurance is guaranteed for uninsured refugees after they have been granted their status.<sup>12</sup> In Poland, access to health insurance, as well as psychological support and language classes, is provided through participation in a so-called Individual Integration Programme.<sup>13</sup>

Within mental health care, the recognition of issues specific to the refugee population falls into the general strategy of care provision for migrants as part of the national integration strategy (e.g. Portugal and Cataluña). In addition, specific mental health needs for refugees may also include direct reference to the effects of persecution on mental health (i.e. the well-founded fear as defined in the Geneva Convention). In the United Kingdom, this has been specifically recognised and outlined in the information pack published by the Department of Health 'Meeting the health needs of refugees and asylum seekers in the UK (2002)'. In Ireland, specific mental health needs of refugees have been defined as part of the Mental Health and Social Exclusion strategy<sup>14</sup>. The Irish National Intercultural Health Strategy is one example

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<sup>12</sup> 2007. évi LXXX. törvény a menedéjogról 301/2007. (XI. 9.) Korm. rendelet a menedéjogról szóló 2007. évi LXXX. törvény végrehajtásáról 1989. évi 15. törvényerejű rendelet a menekültek helyzetére vonatkozó 1951. évi július hó 28. napján elfogadott egyezmény valamint a menekültek helyzetére vonatkozóan az 1967. évi január hó 31. napján létrejött jegyzőkönyv kihirdetéséről.

<sup>13</sup> Act of 13 June 2003 on Granting Protection to Aliens within the Territory of the Republic of Poland (Journal of Laws of 2003, No 128, item 1176).

Resolution of Ministry of Social Policy of 29 Sept. 2005 on Providing Aid to Refugees.

<sup>14</sup> National Economic and Social Forum: Mental Health and Social Inclusion (2007).

where anti-discrimination is specifically mentioned as a way to improve the mental health of migrants.

### ***Asylum seekers***

For asylum seekers, entitlement to mental health services varies substantially across countries. As for refugees, the difference is often dependent on whether there is universal health coverage for all citizens or whether it is dependent on access to welfare and insurance schemes. In Germany, asylum seekers have limited access to health services. The treatments to which they are entitled extend to acute or painful diseases only.<sup>15</sup> Full health coverage can only be obtained after three years of residency in Germany. In France, on the other hand, universal health coverage (CMU) is ensured from the beginning of the asylum application. This represents an exception to the usual minimum three months residency requirement.<sup>16</sup> In Poland, asylum seekers receive health treatment, including mental health, which is funded by the Ministry of Internal Affairs and the Central Administration<sup>17</sup>.

In Portugal, entitlement includes primary and emergency care which specifically extends to mental health care.<sup>18</sup>

It should be noted that this entitlement can be dependent on compliance with the asylum procedure. This becomes especially relevant in countries where residency in an accommodation centre is obligatory (e.g. Sweden). In Belgium, mental health care is provided in accommodation centres.

In addition, reception centres provide health screenings at the initial stage of the asylum procedure. In countries such as Poland, a psychologist is present in reception centres. In the Czech Republic, a mental health specialist must be present in reception centres.<sup>19</sup> Counselling services are provided in reception centres in Germany, the United Kingdom and Ireland.

Finally, the outcome of an asylum application may actually be affected in instances where an applicant suffers from mental illness. In France, a

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<sup>15</sup> Art. 4 AsylbLG.

<sup>16</sup> Article R380-1 of the Social Security Code.

<sup>17</sup> Act of 13 June 2003 on Granting Protection to Foreigners within the Territory of the Republic of Poland (Journal of Laws of 2003, No 128, item 1176 with further amendments).

<sup>18</sup> Portaria 30/2001, January 17th

<sup>19</sup> Act no. 325/1999 Coll.

'temporary residency permit for medical reasons' can be issued in cases where appropriate treatment cannot be provided in the country of origin<sup>20</sup>. This regulation also applies to mental health treatment.<sup>21</sup> In Germany temporary residency may be issued for treatment of PTSD.

### 3.1.3.5 Irregular migrants

The general pattern throughout all the countries investigated is that irregular migrants have access to emergency services only. Interpretations of when a mental health problem constitutes an emergency vary substantially across countries. In Belgium, emergency care is 'urgent, preventative and curative'<sup>22</sup>. That includes mental health care, but excludes stays in psychiatric hospitals. In Austria, an emergency is assumed when there is a concrete threat to someone's life<sup>23</sup>. In Poland, the definition of 'someone's life and health being in danger' applies.<sup>24</sup>

Primary care may represent another option in accessing mental health services for irregular migrants. In the United Kingdom the so-called 'Improving Access to Psychological Therapies' (IAPT) scheme has recently been implemented at primary care level. Registration at primary care level takes place at the discretion of a GP, with the main proof of address being a utility bill.

Another distinct factor in accessing health care in the case of irregular migrants is whether payment is required prior to treatment; or whether there is any danger of legal consequences (such as being reported to the authorities). In Germany, bills for emergency treatment in hospitals are sent to the welfare office which could potentially pose a threat of deportation. In Spain, only registration with the municipality is required for a foreigner to access health services. However, police forces have been granted access to the local

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<sup>20</sup> Loi n° 2006-911, Code d'entrée et de séjour des étrangers, Article 313-11- juillet 2006.

<sup>21</sup> Although, according to EPS Maison Blanche Social Services, this possibility is increasingly difficult to obtain in reality.

<sup>22</sup> Royal Decree (R.D.) of the 12th of December 1996.

<sup>23</sup> Krankenanstalten- und Kuranstaltengesetz §22 (2) + (4) and §23(1).

<sup>24</sup> The Act of 8 September 2006 on National Emergency Health Care (J. of L. 2006 No 191 item 1410).

registrar since 2003. In Italy, access to urgent, essential but continuative care for irregular migrants is possible through registration as a ‘temporarily present foreigner’<sup>25</sup>, a procedure that does not record any personal data.

### **3.1.3.6 Travelling communities**

A legal framework that identifies mental health care for the travelling population could not be identified. This is related to the fact that the travelling community represents a very diverse population even within specific countries. Whereas in some cases travelling communities may be migrants (e.g. Roma emigrating from Eastern Europe), they may be indigenous to the country of origin in others (e.g. Ireland). Although some groups have rights that derive from an ethnic minority status, this does not directly impact the right to health care. Therefore regulations on mental health care provision can be derived from those identified for the other marginalised groups analysed for the PROMO study.

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<sup>25</sup> Straniero Temporaneamente Presente.

## **3.2 FINDINGS OF THE ASSESSMENT OF SERVICES IN 14 EU CAPITAL CITIES**

We identified services providing health and social care for any of the six marginalised groups in the two target areas of each capital city. Interviews were conducted with representatives of the services to assess the following organisational components: providers and funding, characteristics of staff, accessibility, characteristics of clients, programmes provided, coordination with other services, and evaluation. In total, 617 services were assessed in the 14 EU member states and categorised according to the PROMO typology: 350 services were generic (221 mental health, 84 social care and 45 physical (general) health); 267 services were specific to the PROMO target groups (45 for the long-term unemployed, 111 for the homeless, 28 for street sex workers, 58 for asylum seekers and refugees, 13 for irregular migrants and 12 for travelling communities).

### **3.2.1 Characteristics of services**

Between 61.5 % and 75% of group specific services describe themselves as belonging to not-for-profit organisations, compared to 47.4 % of generic services.

In terms of accessibility, over 80% of group specific services accept self-referrals, with the exception of services for street sex workers (53.6%). The percentage of services that report being open outside normal office hours from Monday to Friday is relatively low in group specific services for the long-term unemployed (31.1%), asylum seekers & refugees (25.9%), irregular migrants (15.4%) and travelling communities (33.3%), and somewhat higher in services for the homeless (53.3%) and for street sex workers (64.3%). A proportion of group specific services require “out of pocket” fee payment, ranging from 8.3% of services for travelling communities to 36% of services for the homeless.

Less than 45% of group specific services employ a psychologist and/or psychotherapist, and less than 20% employ a psychiatrist.

The services provide a wide variety of programmes for clients with psychological/psychiatric disorders. However, levels of provision of services such as active outreach, case finding and home visits are low in both group specific and generic services. The only exceptions are the services for street sex workers and travelling communities which reported somewhat higher rates of these activities (above 50% in most cases).

In terms of coordination, a substantial proportion of group specific services operate routine meetings at least once a month (between 50% of services for travelling communities and 78.6 % of services for street sex workers), which is comparable to generic services (64%).

With regard to data recording and consequent evaluation, a substantially lower number of services reported systematically recording client satisfaction compared with recording socio-demographic characteristics and attendance / activities. This was true for both group specific and generic services. 40.5% of services for the homeless, 50% of those for travelling communities and 71.1% of services for the long-term unemployed reported recording this type of data. The same was reported by 44.6% of generic services.

Public availability of the results of this evaluation is markedly low in generic services (30.3%). In group specific services, it is somewhat higher but not substantially, ranging from 40% in services for the long-term unemployed to 61.5% in services for irregular migrants.

The selection of the characteristics of services is presented in Table 2.

**Table 2. CHARACTERISTICS OF SERVICES PROVIDING CARE TO CLIENTS FROM SOCIALLY MARGINALISED GROUPS WHO SUFFER FROM PSYCHOLOGICAL/PSYCHIATRIC DISORDERS**

Aspects of service provision	Number of services specific to PROMO target groups						Generic services	Total services
	Long-term Unemployed	Homeless	Street Sex Workers	Asylum seekers/refugees	Irregular Migrants	Travelling communities		
	N= 45	N=111	N=28	N=58	N=13	N=12		
Not-for-profit organisations	32 (71.1)	79 (71.2)	20 (71.4)	39 (67.2)	8 (61.5)	9 (75)	167 (47.7)	354 (57.4)
Accepting self referrals	39 (86.7)	89 (80.2)	15 (53.6)	25 (89.3)	13 (100)	11 (91.7)	273 (78)	492 (79.7)
Open outside office hours Monday-Friday	14 (31.1)	58 (52.3)	18 (64.3)	15 (25.9)	2 (15.4)	4 (33.3)	159 (45.4)	270 (43.8)
Open any time at weekends	9 (20)	67 (60.4)	12 (42.9)	7 (12.1)	4 (30.8)	1 (8.3)	152 (43.4)	252 (40.8)
Services requiring "out of pocket" fee payment	5 (11.1)	40 (36)	3 (10.7)	8 (13.8)	3 (23.1)	1 (8.3)	138 (39.4)	198 (32.1)
Employing psychologists/ psychotherapists	15 (33.3)	24 (21.6)	10 (35.7)	25 (43.1)	5 (38.5)	1 (8.3)	173 (49.4)	252 (40.8)
Employing psychiatrists	1 (2.2)	12 (10.8)	3 (10.7)	9 (15.5)	2 (15.4)	-	120 (34.3)	146 (23.7)
Provision of active outreach	12 (26.7)	42 (37.8)	23 (82.1)	15 (25.9)	2 (15.4)	7 (58.3)	108 (30.9)	209 (33.9)
Provision of case finding	15 (33.3)	30 (27)	19 (67.9)	11 (19)	3 (23.1)	5 (41.7)	59 (16.9)	142 (23)
Provision of home visits	7 (15.6)	46 (41.4)	16 (57.1)	25 (43.1)	4 (30.8)	6 (50)	201 (57.4)	305 (49.4)
Provision of counselling	32 (71.1)	70 (63.1)	17 (60.7)	38 (65.5)	8 (61.5)	2 (16.7)	248 (70.9)	415 (67.3)
Provision of individual psychotherapy	4 (8.9)	18 (16.2)	10 (35.7)	26 (44.8)	8 (61.5)	2 (16.7)	167 (47.7)	235 (38.1)
Provision of group psychotherapy	5 (11.1)	7 (6.3)	3 (10.7)	15 (25.9)	3 (23.1)	-	117 (33.4)	150 (24.3)
Operating routine meetings at least once a month	33 (73.3)	85 (76.6)	22 (78.6)	43 (74.1)	9 (69.2)	6 (50)	224 (64)	422 (68.4)
Systematic recording of socio-demographic characteristics of clients	40 (88.9)	97 (87.4)	22 (78.6)	50 (86.2)	12 (92.3)	8 (66.7)	294 (84)	523 (84.8)
Systematic recording of attendance and care input/activities	38 (84.4)	85 (76.6)	21 (75)	41 (70.7)	11 (84.6)	9 (75)	291 (83.1)	496 (80.4)
Systematic recording of clients' satisfaction and experience	32 (71.1)	45 (40.5)	12 (42.9)	24 (41.4)	6 (46.2)	5 (50)	156 (44.6)	281 (45.5)
Results of evaluation publicly available	18 (40)	54 (48.6)	14 (50)	32 (55.2)	8 (61.5)	7 (58.3)	106 (30.3)	239 (38.7)

### **3.3 QUALITY INDEX OF SERVICE ORGANISATION (QISO)**

The Quality Index of Service Organisation (QISO) was developed to facilitate identification of the components of organisational good practice in the provision of mental health care for socially marginalised people. The measure comprises six domains: Accessibility, Supervision, Multidisciplinary Team, Programmes provided, Coordination and Evaluation. Total scores ranged from 0 to 15. Each domain accounts for a proportion of the total score, with the final quality score being the sum of scores for each of the six domains. However, the emphasis, in terms of weighting, is on issues relating to 'Accessibility' as a reflection of its importance in the provision of care for marginalised groups. Details of each component, including the weighting system, are available in Appendix 3.

A total of 617 services were assessed in the two most deprived areas of the 14 capital cities participating in the PROMO study. The Quality Index of Service Organisation was applied to 593 (96%) of these services.

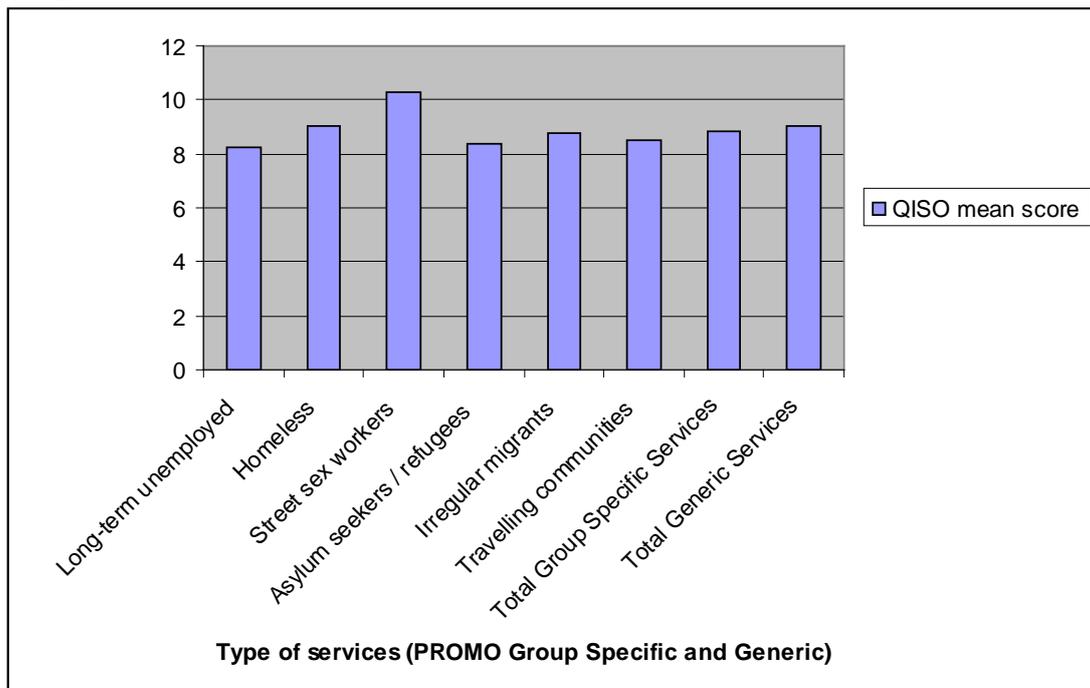
All services were classified according to the PROMO typology which was developed to aid the process of the identification of good practice. The total number of services assessed, the mean scores and standard deviations of the QISO measure for the different types of services assessed are shown in Table 3.

**Table 3. QISO MEAN SCORES FOR DIFFERENT SERVICES ACCORDING TO PROMO TYPOLOGY**

<b>TYPE OF SERVICE</b>	<b>N</b>	<b>Mean</b>	<b>SD</b>
<b>GROUP SPECIFIC MENTAL HEALTH SERVICES</b>	50	8.54	1.84
Mental health services for the long-term unemployed	3	9.33	.58
Mental health services for the homeless	19	8.68	1.95
Mental health services for street sex workers	1	10.00	-
Mental health services for asylum seekers / refugees	23	8.22	1.98
Mental health services for irregular migrants	2	9.00	0.00
Mental health services for travelling communities	2	8.50	2.12
<b>GENERIC MENTAL HEALTH SERVICES</b>	215	9.09	2.33
<b>GROUP SPECIFIC SOCIALCARE SERVICES</b>	182	8.91	2.06
Social care services for the long-term unemployed	41	8.14	1.94
Social care services for the homeless	81	9.12	2.20
Social care services for street sex workers	20	10.50	1.50
Social care services for asylum seekers / refugees	26	8.62	1.58
Social care services for irregular migrants	5	8.40	1.14
Social care services for Travelling communities	9	8.11	1.96
<b>GENERIC SOCIAL CARE SERVICES</b>	80	8.78	1.96
<b>GROUP SPECIFIC HEALTH CARE SERVICES</b>	25	9.16	2.12
Health care services for the long-term unemployed	-	-	-
Health care services for the homeless	8	9.13	1.13
Health care services for street sex workers	7	9.71	2.81
Health care services for asylum seekers / refugees	4	7.75	1.89
Health care services for irregular migrants	5	9.00	2.34
Health care services for Travelling communities	1	12.00	-
<b>GENERIC HEALTH CARE SERVICES</b>	42	9.10	1.59

The mean QISO scores for the different group specific services are similar in value (8.23; SD 1.90 to 9.05; SD 2.09), apart from somewhat higher score for services for street sex workers (10.29; SD 1.86). Mean scores of the QISO measure for group specific and generic services are graphically displayed in Figure 1.

**Figure 1. Quality Index of Service Organisation (QISO) mean score for group specific and generic services**



### **3.4 FINDINGS OF THE ASSESSMENT OF THE QUALITY OF MENTAL HEALTH CARE IN 14 EU CAPITAL CITIES**

In addition to assessing services, we identified and interviewed a total of 154 health and social care experts with knowledge and experience of the provision of mental health, physical (general) health or social care for clients from the six PROMO target groups. Interview transcripts were analysed using thematic analysis to identify barriers to mental health care and ways to overcome them for each target group.

#### **3.4.1 Barriers to mental health care for clients from marginalised groups: summary of main themes**

- Limited entitlements to health care for asylum seekers and irregular migrants.
- Administrative barriers to obtaining health care for members of marginalised groups who present without health insurance/GP.
- Multiple needs and limited ability to engage, because marginalised people often live in poor socio-economic circumstances, inadequate housing, and social isolation, not having adequate information on health services.
- Barriers linked to language and culture with a shortage of resources for trained interpreters (and a reluctance to use them where available) and often very different explanatory models for mental health problems.
- The organisation of services can contribute to further barriers when they are rigid in their administration and approach, especially if they fail to provide non-intrusive mental health outreach in the community and are poorly co-ordinated.
- Negative attitudes in health services towards some of the marginalised groups can lead to substandard treatment or rejection of clients, which is particularly relevant in the case of travelling communities, street sex workers and the homeless.
- Lack of trust in and even fear of health professionals, which may be associated with previous negative experiences with services (sometimes in other countries).

### **3.4.2 Ways to overcome barriers to mental health care for clients from marginalised groups: summary of main themes**

- Building a relationship of trust with clients from marginalised groups by providing mental health outreach and maintaining regular contact.
- Improving administrative flexibility of health services regarding health insurance requirements, referrals, opening hours and other admission procedures.
- Raising awareness amongst mental health and social care professionals about the needs of the different marginalised groups and the issues they face.
- Provision of mental health awareness training for frontline staff in different services working with marginalised groups.
- Good collaboration between mental health, social welfare services and services providing specialist care for marginalised groups including the development of joint protocols.
- Addressing socio-cultural issues by providing professional interpreters and bi-lingual mental health professionals.

## **SECTION 4: ASSESSMENT IN THE 13 NON-PARTICIPATING EU COUNTRIES**

### **4.1 INTRODUCTION**

Assessment of care available to the clients from the PROMO target groups was also conducted in the capital cities of the 13 EU member states which did not directly participate in the project: Denmark, Slovenia, Slovakia, Luxembourg, Estonia, Lithuania, Latvia, Cyprus, Malta, Greece, Bulgaria, Romania and Finland. The experts from these countries were asked to provide feedback on the following:

1. The structure of services for people with psychiatric/psychological problems from the PROMO target groups,
2. The pathways to care for people from the target groups with mental health problems, the barriers to receiving care and the ways to overcome them,
3. The strengths and weakness of the care provided and how care is co-ordinated.

### **4.2 METHODOLOGY**

One expert was identified in each country (n=13) to participate in the assessment. Of the resulting 13 experts, eight were identified through recommendations from partners from the participating countries and five through internet searches of appropriate European mental health websites such as Mental Health Europe. Respondents came from a variety of backgrounds: academics, mental health professionals, researchers, people from social services or people working in relevant non-governmental organisations.

Six web-based questionnaires were developed, one for each target group. They were based on the main themes emerging from the thematic analysis of the semi-structured interviews carried out in the 14 participating countries. Each expert was e-mailed a link to the questionnaires, which were then completed online. The overall response rate was 91%. Nine of the thirteen experts completed all six questionnaires.

## **4.3 FINDINGS**

### **4.3.1 Types of services**

When asked to describe the structure of services available to clients from each PROMO target group in their capital city, the most frequent response was 'generic mental health services only' (72.5%); followed by 'a combination of group specific and generic mental health services' (26%); and then 'group specific mental health services only' (1.5%). In terms of the type of provider, the services were distributed as follows: State sector (66%), NGOs (27%) and Private sector (7%).

### **4.3.2 The two most frequently reported barriers to care for specific marginalised groups**

***Long Term Unemployed:*** 'Lack of outreach services' and 'The difficult entry criteria and lack of places in rehabilitative services'.

***Homeless:*** 'Problems related to drug and alcohol abuse' and 'Barriers in terms of accommodation provision'.

***Street Sex Workers:*** 'A lack of awareness in the mental health services regarding the issues facing street sex workers' and 'No multidisciplinary teams or mental health professionals within street sex worker specific health and social services'.

**Refugees and Asylum Seekers:** 'A lack of information and knowledge amongst refugees and asylum seekers regarding the mental health services' and 'Language barriers - interpreting services are not always available'.

**Irregular migrants:** 'Lack of knowledge amongst irregular migrants on the structure of the health services and which services they are entitled to access' and 'irregular migrants are afraid to initially approach services because of fear of deportation'.

**Travelling communities:** 'Lack of awareness amongst health services staff about the cultural needs of travelling communities' and 'Insufficient specialised mental health service provision for travelling communities'.

#### **4.33 The two most frequently reported ways to overcome barriers to care for specific marginalised groups**

**Long-Term Unemployed:** 'Awareness-raising regarding services and anti-stigma campaigns in the community' and 'More case finding and outreach work for long-term unemployed'.

**Homeless:** 'More collaboration between mental health services, social care services and homeless not-for-profit organisations' and 'Training and for health care staff in mental health care for the homeless'

**Street Sex Workers:** 'Empower clients to take more control of their situation e.g. getting themselves informed on the services that are available' and 'More multi disciplinary teams operating in health and social services aimed at street sex workers'.

**Refugees and Asylum Seekers:** 'Early identification of torture survivors and those that have suffered other traumas' and 'Training for health service staff in cross cultural health care'.

***Irregular Migrants:*** 'Providing information for irregular migrants on organisations that could help them and the possible solutions to their problems' and 'For the individuals to engage more with services who can help them e.g. not-for-profit organisations involved with migrant issues'.

***Travelling communities:*** 'Training for mental health service staff in relation to the cultural needs of travelling communities' and 'Providing information for travelling communities on mental health services'.

## **SECTION 5: COMPONENTS OF GOOD PRACTICE**

The findings of the assessment of services and the assessment of the quality of mental health care were used to identify the components of good practice in providing mental health care for clients with psychological/psychiatric problems who belong to the PROMO target groups.

### **5.1 Components of good practice for all marginalised groups**

The collected evidence suggests four main components of good practice that apply across all marginalised groups:

- Establishing outreach programmes for marginalised groups to identify, engage with and help individuals with mental health problems.
- Facilitating access to general health services that include expertise and treatment programmes for mental disorders (providing different aspects of health care in one service and reducing the need for further referrals).
- Coordinating services for marginalised groups, strengthening their collaboration and sharing of expertise.
- Disseminating information on health services available to marginalised groups to both the marginalised groups themselves and to other services.

## **5.2 Components of good practice for specific marginalised groups**

In addition to the good practice components for all groups, there also are more specific components for each group:

### ***Long-term unemployed***

- Training staff in unemployment agencies (e.g. job centres) to be aware of the prevalence and implications of mental disorders.
- Establishing close collaboration between unemployment agencies (e.g. job centres) and mental health and social care services.
- Providing long-term and flexible training and employment schemes to accommodate the specific needs of people with mental disorders.

### ***Homeless***

- Reducing administrative barriers to accessing mental health care (especially for those without insurance or without a permanent address).
- Including mental health expertise in outreach teams for appropriate assessments and referrals.
- Training mental health professionals to use a particularly flexible and non-intrusive approach.
- Training staff in frontline services for homeless people, including accommodation/housing services, to increase awareness of mental health problems.

### ***Street sex workers***

- Including mental health expertise in the outreach services for street sex workers.
- Establishing effective collaboration between specialised outreach services and mental health services to facilitate access to care.

### ***Asylum seekers/refugees***

- Funding of and facilitating access to competent interpreting services.
- Providing culturally appropriate mental health care services.
- Developing good collaboration between mental health services and other organisations involved in providing care for asylum seekers/refugees such as migrant organisations, not-for-profit organisations, asylum authorities and social welfare organisations.
- Clear information for mental health services on the entitlements of asylum seekers and refugees to care.

### ***Irregular migrants***

- Funding of and facilitating access to competent interpreting services.
- Providing clear information to migrant organisations on available services and on the entitlements of irregular migrants to use them.

### ***Travelling communities***

- Providing a specialised point of entry into health care either with mental health expertise (e.g. cultural mediators, specialised health care staff) or with close collaboration with a mental health service.
- Fostering cooperation between mainstream mental health services and non-governmental organisations specialising in care for travelling communities

The supporting themes for each component of good practice for specific marginalised groups are presented in Appendices 4a - 4f.

## SECTION 6: CONCLUSION

Practice in mental health care for marginalised groups varies substantially across Europe. Despite these differences, there are some common barriers to good care for these groups. PROMO also identified components of good practice, based on what is already in place or has been suggested as improvements. They apply across health and social care systems in Europe, and may guide future policies to improve mental health care for socially marginalised groups. In addition to sufficient resources, this requires the appropriate organisation of both individual services and the way services in one area are co-ordinated and collaborate, training programmes for staff in different services, the provision of information material, and positive attitudes of health and social care professionals towards socially marginalised groups.

For more information visit our website: [www.promostudy.org](http://www.promostudy.org)

## **SECTION 7: APPENDICES**

**APPENDIX 1: PROMO TOOL FOR ASSESSMENT OF SERVICES**

# Best Practice in Promoting Mental Health in Socially Marginalised People in Europe

## PROMO Tool for Assessment of Services

### 1. About your service/institution

1.1 General information about service/institution	
1.1.01	Identified area name:
1.1.02	Service/Institution name:
1.1.03	Service/Institution address:
1.1.04	Service/Institution website:
1.1.05	Brief description of the service: (If there is a mission statement available, please enclose it with questionnaire)

### 2. Provider and funding information

2.1 Who is the provider of the service/institution? Please tick one option.							
2.1.01	State sector or equivalent		2.1.02	Not-for-profit private sector		2.1.03	For-profit private sector
2.1.04	Other, please specify						

2.2 What is the source of funding for your service/institution? Please tick all that apply, if more than one applies, please give approximate percentages.							
2.2.01	Local/ Community/ Municipality		%	2.2.04	Donations/ Fundraising		%
2.2.02	National/ Regional		%	2.2.05	Insurance companies		%
2.2.03	Official project grants		%	2.2.06	Other, please specify		%

### 2.3 What was the total annual budget of your service/institution in the last budget year?

Please state approximate amount in local currency

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### 2.4 What was the system of funding for your service/institution in the last budget year?

Please state percentages - they should add up to approximately 100%

2.4.01	Lump sum for the budget	%
2.4.02	Payment related to number of clients served	%
2.4.03	Payment related to specific activities with clients	%
2.4.04	Other, please specify	%

## 3. Staffing

### 3.1 Staffing levels

Please state numbers as Whole Time Equivalents (WTE)

3.1.01	How many WTE paid staff do you employ?	
3.1.02	How many WTE unpaid staff do you have?	

### 3.2 What are the professional backgrounds of the employees within your service/institution? Please state numbers as Whole Time Equivalents (WTE)

Professional background		Number of WTE staff
3.2.01	Administrative staff	
3.2.02	Counsellors	
3.2.03	Medical doctors (non-psychiatric)	
3.2.04	Nurses	
3.2.05	Occupational (work) therapists	
3.2.06	Psychiatrists	
3.2.07	Psychologists/ Psychotherapists	
3.2.08	Social workers	
3.2.09	Other, please specify	

**3.3 Do the majority of your staff with direct client contact have a protected time (60 minutes or more) for supervision, either individually or in a group, at least once a month?** Please tick.

Type of supervision		Yes	No
3.3.01	Internal supervision		
3.3.02	External supervision		

## 4. Accessibility

**4.1 When is your service/institution open to clients?** Please tick all that apply.

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
4.1.01	Within normal office hours							
4.1.02	Anytime outside the normal office hours							

**4.2 Do clients have to pay an "out-of-pocket" fee for any aspect of care provided by your service/institution?** Please tick.

Yes       No

**4.2a If yes, please specify what the payment is for.**

--

**4.2b Is there anything different for any of the target groups regarding the payment of an "out- of-pocket" fee in comparison to other clients?** Please specify.

--

**4.3 Is there a waiting list for any aspect of care provided by your service/institution?**

Please tick.

- Yes       No

**4.4 How many minutes walking distance is your service/institution to public transport?**

Please state time in minutes

--	--

**4.5 Do you arrange access to professional interpreting services for clients, if needed?**

Please tick one option.

- Always       Sometimes       Never       There has never been a need for an interpreter

**5. Clients**

**5.1 Number of individual clients who used the service/institution in the last year.**

Please state number and/or tick option that applies

		Number based on: (please tick only one option)			
		Number of clients	Based on records	Estimated number	Number not known
5.1.01	How many individual clients used this service/institution in the last year?				
5.1.02	How many of those clients were experiencing psychological/psychiatric disorders?				
5.1.03	How many new accepted referrals did you receive in the last year?				
5.1.04	What is the 12 month period that the information above refers to? Please state the month and year when the period ends.	Period ending: month <input type="text"/> <input type="text"/> year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

**5.2 Which of the following form part of the inclusion criteria for your service/institution?**

Please tick.

Inclusion criteria:		Yes	No	If Yes, please specify			Yes	No	If Yes, please specify
5.2.01	Age				5.2.05	Gender			
5.2.02	Location (i.e. catchment area)				5.2.06	Diagnosis			
5.2.03	Specific social problem				5.2.07	Ethnic group			
5.2.04	Manifest mental health problem (which type and degree?)				5.2.08	Other, please specify			

**5.3 In addition to meeting the specific inclusion criteria, which of the following form part of the *exclusion* criteria for potential clients?**

Please tick.

Exclusion criteria		Yes	No	Exclusion criteria		Yes	No
5.3.01	Lack of motivation			5.3.04	Criminal history		
5.3.02	Command of language of host country			5.3.05	Aggressive behaviour		
5.3.03	Addiction			5.3.06	Other, please specify		

**5.4 Are clients (either former or current) involved in the delivery of care or any other work in the service/institution? Please tick.**

		Yes	No	If YES please specify the number of clients involved and nature of their role
5.4.01	Work other than direct contact with clients (e.g. management) ( <b>paid role</b> )			
5.4.02	Delivery/direct contact with clients ( <b>paid role</b> )			
5.4.03	Work other than direct contact with clients (e.g., management) ( <b>unpaid role</b> )			
5.4.04	Delivery/direct contact with clients ( <b>unpaid role</b> )			

## 6. Services provided to target groups

**6.1 How many clients from the following groups used your service in the last year?**

Please state number and/or tick option that applies.

		Number based on (please tick only one for each group)			
		Number of clients	Based on records	Estimated number	Number not known
6.1.01	Long-term unemployed				
6.1.02	Sex workers/Prostitutes				
6.1.03	Homeless				
6.1.04	Refugees/Asylum seekers				
6.1.05	Illegal immigrants				
6.1.06	Travelling population				
6.1.08	How many clients belong to any of the target groups? (given that a client can belong to more than one target group)				
6.1.07	What is the 12 month period that the information above refers to? Please state the month and year when the period ends.	Period ending: month <input type="text"/> <input type="text"/> year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

**6.2 Does your service/institution directly provide any of the following programmes/activities to clients with psychological/psychiatric disorders (including substance misuse disorders)?**

Please tick yes or no. Also, tick if clients are helped to access these programmes elsewhere.

Type of service		Yes	No	Clients helped to access these programmes elsewhere	Type of service		Yes	No	Clients helped to access these programmes elsewhere
6.2.01	Active outreach				6.2.12	Alcohol addiction treatment			
6.2.02	Case finding				6.2.13	Direct practical help in clients' homes			
6.2.03	Home visits				6.2.14	Befriending			
6.2.04	Counselling				6.2.15	Leisure activities support			
6.2.05	Psychotherapy Individual				6.2.16	Mental health advocacy			
6.2.06	Psychotherapy Group				6.2.17	Social welfare support			
6.2.07	Self – help support				6.2.18	Housing /accommodation advice and support			
6.2.08	Occupational (work) therapy				6.2.19	Legal advice and support			
6.2.09	Medication				6.2.20	Job coaching / finding			
6.2.10	Detoxification and acute withdrawal treatments				6.2.21	Mental health promotion measures			
6.2.11	Drug addiction treatment				6.2.22	Other, please specify			

**6.3 Does your service/institution have any written care policy?**

Please tick.

Yes       No

**6.3a If yes, do you have a specific written care policy for any of the following target groups? Please tick.**

		Yes	No	If YES, please briefly describe the policy
6.3a.01	Long-term unemployed			
6.3a.02	Sex workers/Prostitutes			
6.3a.03	Homeless			
6.3a.04	Refugees/Asylum seekers			
6.3a.05	Illegal immigrants			
6.3a.06	Travelling population			

**6.4a If yes, please specify the relevant groups and what the programme/activity is.**  
Please tick.

		Yes	No	If YES, please specify what the programme is
6.4a.01	Long-term unemployed			
6.4a.02	Sex workers/Prostitutes			
6.4a.03	Homeless			
6.4a.04	Refugees/Asylum seekers			
6.4a.05	Illegal immigrants			
6.4a.06	Travelling population			

**6.4 Does your service/institution have a specific programme/activity for any of the target groups? Please tick.**

Yes       No

## **7. Coordination with other services/institutions**

**7.1 Does your service/institution have routine meetings (at least once a month) with other services/institutions concerning the care of clients? Please tick.**

Yes       No

**7.1b If yes, which services/institutions does your service have routine meetings with? Please specify the names and types of the services/institutions the meetings are held with.**

--

**7.1a If your service/institution has routine meetings with other services/institutions, please state whether any of these meetings are specific for any of the following target groups. Please tick.**

		Yes	No	If YES, please specify the names and the types of the services/institutions the meetings are held with
7.1a.01	Long-term unemployed			
7.1a.02	Sex workers/Prostitutes			
7.1a.03	Homeless			
7.1a.04	Refugees/Asylum seekers			
7.1a.05	Illegal immigrants			
7.1a.06	Travelling population			

**7.2 Did your service/institution receive referrals from other services/institutions in the last year?**

Please tick.

- Yes       No       Not known

**7.4 Did your service/institution refer clients to other services/institutions in the last year (whether they are discharged or not)?**

Please tick.

- Yes       No       Not known

**7.2a / 7.4a If yes, did your service/institution receive any referrals *from* or make any referrals *to* other services/institutions involving clients who belong to any of the following target groups in the last year?**

Please tick.

		Yes	No	Not known	If YES, please specify the names and the types of services/institutions which were the main sources (FROM) and main destinations (TO) of referrals for clients from the specific target group. Please indicate the number of referrals for each.
7.2a.01	Long-term unemployed				FROM:
7.4a.01					TO:
7.2a.02	Sex workers/ Prostitutes				FROM:
7.4a.02					TO:
7.2a.03	Homeless				FROM:
7.4a.03					TO:
7.2a.04	Refugees/Asylum seekers				FROM:
7.4a.04					TO:
7.2a.05	Illegal immigrants				FROM:
7.4a.05					TO:
7.2a.06	Travelling population				FROM:
7.4a.06					TO:

**7.2b If information on the referral of clients from the target groups is not available, can you specify the names and the types of the 3 main services/institutions that you generally received referrals from in the last year (across all client groups)?**

Please indicate the number of referrals from each.

**7.4b If information on the referral of clients from the target groups is not available, can you specify the names and the types of the 3 main services/institutions that you generally referred your clients to in the last year (across all client groups)?**

Please indicate the number of referrals to each destination.

**7.3 Does your service/institution accept self-referrals?**

Please tick.

Yes       No

**7.3a If yes, please specify whether your service/institution received self-referrals from clients belonging to any of the following target groups in the last year. Please tick.**

		Yes	No	Not known	If YES, please specify the number of self-referrals in the last year
7.3a.01	Long-term unemployed				
7.3a.02	Sex workers/ Prostitutes				
7.3a.03	Homeless				
7.3a.04	Refugees/Asylum seekers				
7.3a.05	Illegal immigrants				
7.3a.06	Travelling population				

## 8. Evaluation

**8.1 Does your service/institution systematically collect and enter into a database any of the following data? Please tick.**

	Types of data	Yes	No	If YES, please specify the type of data collected
8.1.01	Socio-demographic characteristics			
8.1.02	Data on input and attendance			
8.1.03	Outcome data on satisfaction and experience			
8.1.04	Other outcome data			

**8.2 Does your service/ institution document whether a client belongs to one of the following groups? Please tick.**

		Yes	No
8.2.01	Long-term unemployed		
8.2.02	Sex workers/ Prostitutes		
8.2.03	Homeless		
8.2.04	Refugees/Asylum seekers		
8.2.05	Illegal immigrants		
8.2.06	Travelling Population		

**8.3 Are the results publicly available? Please tick.**

Yes  No

**9. Further general comments**

**APPENDICES 2a – 2f: PROMO TOOL FOR ASSESSMENT OF  
THE QUALITY OF MENTAL HEALTH CARE**

## APPENDIX 2a: PROMO TOOL FOR ASSESSMENT OF THE QUALITY OF MENTAL HEALTH CARE – Long-term unemployed

### PROMO tool for assessing the quality of mental health care for long-term unemployed

#### 1) Case vignettes for long-term unemployed

The case vignettes will be administered in order to illustrate pathways into mental health care services for long-term unemployed people within an identified area, the difficulties they encounter and ways to overcome them.

##### ***Vignette 1***

A 30-year old male, unemployed since leaving education, hears voices and appears disturbed. He is socially isolated, talks using incoherent sentences, has poor personal hygiene, and has *not* tried to get in contact with services.

1. Who would be likely to notice his problems and initiate help?
2. Which services/organisations would, once informed, go out and contact him?
3. What care would they provide, or how would they refer the person on?
4. What are the further care pathways and/or treatment options for him?
5. What are the barriers for him to receive that care and/or treatment?
6. Are there any ways to overcome these barriers?
  - a) Are there any ways for the *client* to overcome these barriers?
  - b) Are there any ways for the *service* to overcome these barriers?

##### ***Vignette 2***

A 40-year old female, unemployed for more than 5 years, living alone, depressed, with suicidal ideation. She wants help.

1. How would she find information on how to get help for her mental health problem?
2. Which services/organisations could she approach?
3. What are the further care pathways and/or treatment options for this person?
4. What are the barriers for her to receive that care and/or treatment?

5. Are there any ways to overcome these barriers?
  - a) Are there any ways for the *client* to overcome these barriers?
  - b) Are there any ways for the *service* to overcome these barriers?

## **2) General questions regarding the quality of mental health care for long-term unemployed**

These four questions address the issues regarding the quality of mental health care provided for long-term unemployed people within the identified area:

1. How is mental health care for long-term unemployed people co-ordinated in the area?
  - a) How is it co-ordinated at administrative level?
  - b) How is it co-ordinated at the level of individual patients?
2. In your opinion, what are the strengths of mental health care provided for long-term unemployed people in this area?
3. In your opinion, what are the weaknesses of mental health care provided for long-term unemployed people in this area?
4. What are the two things (in terms of changes in practice) that would most improve the quality of mental health care for long-term unemployed people in this area?

## APPENDIX 2b: PROMO TOOL FOR ASSESSMENT OF THE QUALITY OF MENTAL HEALTH CARE – Homeless

### PROMO tool for assessing the quality of mental health care for homeless people

#### 1) Case vignettes for homeless people

The case vignettes will be administered in order to illustrate pathways into mental health care services for homeless people within an identified area, the difficulties they encounter and ways to overcome them.

##### ***Vignette 1***

A 30-year old male, homeless for more than 2 years and sleeping rough. He hears voices and appears disturbed. He is socially isolated, talks using incoherent sentences, has poor personal hygiene, and has *not* tried to get in contact with services.

7. Who would be likely to notice his problems and initiate help?
8. Which services/organisations would, once informed, go out and contact him?
9. What care would they provide, or how would they refer the person on?
10. What are the further care pathways and/or treatment options for him?
5. What are the barriers for him to receive that care and/or treatment?
6. Are there any ways to overcome these barriers?
  - a) Are there any ways for the *client* to overcome these barriers?
  - c) Are there any ways for the *service* to overcome these barriers?

##### ***Vignette 2***

A 40-year old female, homeless for more than 2 years and sleeping rough. She is depressed, with suicidal ideation, and she wants help.

1. How would she find information on how to get help for her mental health problem?
2. Which services/organisations could she approach?
3. What are the further care pathways and/or treatment options for this person?
4. What are the barriers for her to receive that care and/or treatment?

5. Are there any ways to overcome these barriers?
  - a) Are there any ways for the *client* to overcome these barriers?
  - b) Are there any ways for the *service* to overcome these barriers?

## **2) General questions regarding the quality of mental health care for homeless people**

These four questions address the issues regarding the quality of mental health care provided for homeless people within the identified area:

5. How is mental health care for homeless people co-ordinated in the area?
  - a) How is it co-ordinated at administrative level?
  - b) How is it co-ordinated at the level of individual patients?
6. In your opinion, what are the strengths of mental health care provided for homeless people in this area?
7. In your opinion, what are the weaknesses of mental health care provided for homeless people in this area?
8. What are the two things (in terms of changes in practice) that would most improve the quality of mental health care provided for homeless people in this area?

## APPENDIX 2c: PROMO TOOL FOR ASSESSMENT OF THE QUALITY OF MENTAL HEALTH CARE – Street sex workers

### PROMO tool for assessing the quality of mental health care for sex workers/prostitutes

#### Case vignettes for sex workers/prostitutes

The case vignettes will be administered in order to illustrate pathways into mental health care services for sex workers / prostitutes within an identified area, the difficulties they encounter and ways to overcome them.

##### ***Vignette 1***

A 25-year old female, working as a street prostitute for at least 3 years, hears voices and appears disturbed. She is socially isolated, talks using incoherent sentences, has poor personal hygiene, and has *not* tried to get in contact with services.

1. Who would be likely to notice her problems and initiate help?
2. Which services/organisations would, once informed, go out and contact her?
3. What care would they provide, or how would they refer the person on?
4. What are the further care pathways and/or treatment options for her?
5. What are the barriers for her to receive that care and/or treatment?
6. Are there any ways to overcome these barriers?
  - a) Are there any ways for the *client* to overcome these barriers?
  - d) Are there any ways for the *service* to overcome these barriers?

##### ***Vignette 2***

A 25-year old female, working as a street prostitute for at least 3 years, living alone, depressed, with suicidal ideation. She wants help.

1. How would she find information on how to get help for her mental health problem?
2. Which services/organisations could she approach?
3. What are the further care pathways and/or treatment options for this person?
4. What are the barriers for her to receive that care and/or treatment?

5. Are there any ways to overcome these barriers?
  - a) Are there any ways for the *client* to overcome these barriers?
  - b) Are there any ways for the *service* to overcome these barriers?

## **2) General questions regarding the quality mental health care for sex workers/prostitutes**

These four questions address the issues regarding the quality of mental health care provided for sex workers/prostitutes within an identified area:

9. How is mental health care for sex workers/prostitutes co-ordinated in the area?
  - a) How is it co-ordinated at administrative level?
  - b) How is it co-ordinated at the level of individual patients?
10. In your opinion, what are the strengths of mental health care provided for sex workers/prostitutes in this area?
11. In your opinion, what are the weaknesses of mental health care provided for sex workers/prostitutes in this area?
12. What are the two things (in terms of changes in practice) that would most improve mental health care provided for sex workers/prostitutes within this area?

## APPENDIX 2d: PROMO TOOL FOR ASSESSMENT OF THE QUALITY OF MENTAL HEALTH CARE –Asylum seekers and Refugees

### PROMO tool for assessing the quality of mental health care for refugees/asylum seekers

#### 1) Case vignettes for asylum seekers/refugees

The case vignettes will be administered in order to illustrate pathways into mental health care services for refugees/asylum seekers within an identified area, the difficulties they encounter and ways to overcome them.

##### ***Vignette 1***

A 30-year old male, asylum seeker from Iraq, has been in the country for more than 1 year. He hears voices and appears disturbed. He is socially isolated, talks using incoherent sentences, has poor personal hygiene, and has *not* tried to get in contact with services.

1. Who would be likely to notice his problems and initiate help?
2. Which services/organisations would, once informed, go out and contact him?
3. What care would they provide, or how would they refer the person on?
4. What are the further care pathways and/or treatment options for him?
5. What are the barriers for him to receive that care and/or treatment?
6. Are there any ways to overcome these barriers?
  - a) Are there any ways for the *client* to overcome these barriers?
  - e) Are there any ways for the *service* to overcome these barriers?

##### ***Vignette 2***

A 40-year old female, asylum seeker from Iraq, has been in the country for more than 1 year. She is living alone, and is depressed with suicidal ideation. She wants help.

1. How would she find information on how to get help for her mental health problem?
2. Which services/organisations could she approach?

3. What are the further care pathways and/or treatment options for this person?
4. What are the barriers for her to receive that care and/or treatment?
5. Are there any ways to overcome these barriers?
  - a) Are there any ways for the *client* to overcome these barriers?
  - b) Are there any ways for the *service* to overcome these barriers?

## **2) General questions regarding the quality of mental health care for refugees/asylum seekers**

These four questions address the issues regarding the quality of mental health care provided for refugees/asylum seekers within the identified area:

13. How is mental health care for refugees/asylum seekers co-ordinated in the area?
  - a) How is it co-ordinated at administrative level?
  - b) How is it co-ordinated at the level of individual patients?
14. In your opinion, what are the strengths of mental health care provided for refugees/asylum seekers in this area?
15. In your opinion, what are the weaknesses of mental health care provided for refugees/asylum seekers in this area?
16. What are the two things (in terms of changes in practice) that would most improve the quality of mental health care provided for refugees/asylum seekers in this area?

## APPENDIX 2e: PROMO TOOL FOR ASSESSMENT OF THE QUALITY OF MENTAL HEALTH CARE –Irregular Migrants

### PROMO tool for assessing the quality of mental health care for irregular migrants

#### 1) Case vignettes for irregular migrants

The case vignettes will be administered in order to illustrate pathways into mental health care services for irregular migrants within an identified area, the difficulties they encounter and ways to overcome them.

##### ***Vignette 1***

A 30-year old male, an irregular migrant from Uganda, has been in the country for unknown period of time. He hears voices and appears disturbed. He is socially isolated, talks using incoherent sentences, has poor personal hygiene, and has *not* tried to get in contact with services.

1. Who would be likely to notice his problems and initiate help?
2. Which services/organisations would, once informed, go out and contact him?
3. What care would they provide, or how would they refer the person on?
4. What are the further care pathways and/or treatment options for him?
5. What are the barriers for him to receive that care and/or treatment?
6. Are there any ways to overcome these barriers?
  - a) Are there any ways for the *client* to overcome these barriers?
  - f) Are there any ways for the *service* to overcome these barriers?

##### ***Vignette 2***

A 40-year female, an irregular migrant from Uganda, has been in the country for unknown period of time. She is living alone, and is depressed with suicidal ideation. She wants help.

1. How would she find information on how to get help for her mental health problem?
2. Which services/organisations could she approach?

3. What are the further care pathways and/or treatment options for this person?
4. What are the barriers for her to receive that care and/or treatment?
5. Are there any ways to overcome these barriers?
  - a) Are there any ways for the *client* to overcome these barriers?
  - b) Are there any ways for the *service* to overcome these barriers?

## **2) General questions regarding the quality of mental health care for irregular migrants**

These four questions address the issues regarding the quality of mental health care provided for irregular migrants within the identified area:

17. How is mental health care for irregular migrants co-ordinated in the area?
  - a) How is it co-ordinated at administrative level?
  - b) How is it co-ordinated at the level of individual patients?
18. In your opinion, what are the strengths of mental health care provided for irregular migrants in this area?
19. In your opinion, what are the weaknesses of mental health care provided for irregular migrants in this area?
20. What are the two things (in terms of changes in practice) that would most improve the quality of mental health care for irregular migrants in this area?

## APPENDIX 2f: PROMO TOOL FOR ASSESSMENT OF THE QUALITY OF MENTAL HEALTH CARE –Travelling communities

### PROMO tool for assessing the quality of mental health care for Travelling communities

#### 1) Case vignettes for Travelling communities

The case vignettes will be administered in order to illustrate pathways into mental health care services for Travelling communities within an identified area, the difficulties they encounter and ways to overcome them.

##### ***Vignette 1***

A 30-year old Roma male who has been living with his family. He hears voices and appears disturbed. He talks using incoherent sentences, has poor personal hygiene, and has *not* tried to get in contact with services.

11. Who would be likely to notice his problems and initiate help?
12. Which services/organisations would, once informed, go out and contact him?
13. What care would they provide, or how would they refer the person on?
14. What are the further care pathways and/or treatment options for him?
15. What are the barriers for him to receive that care and/or treatment?
16. Are there any ways to overcome these barriers?
  - a) Are there any ways for the *client* to overcome these barriers?
  - g) Are there any ways for the *service* to overcome these barriers?

##### ***Vignette 2***

A 40-year old Roma female who has been living with her family. She is depressed, with suicidal ideation. She wants help.

1. How would she find information on how to get help for her mental health problem?

2. Which services/organisations could she approach?
3. What are the further care pathways and/or treatment options for this person?
5. What are the barriers for her to receive that care and/or treatment?
6. Are there any ways to overcome these barriers?
  - a) Are there any ways for the *client* to overcome these barriers?
  - b) Are there any ways for the *service* to overcome these barriers

## **2) General questions regarding the quality of mental health care provided for Travelling population**

These four questions address the issues regarding the quality of mental health care provided within the identified area for people who belong to Travelling population:

21. How is mental health care for people who belong to Travelling population co-ordinated in the area?
  - a) How is it co-ordinated at administrative level?
  - b) How is it co-ordinated at the level of individual patients?
22. In your opinion, what are the strengths of mental health care provided in this area for people who belong to Travelling population?
23. In your opinion, what are the weaknesses of mental health care provided in this area for people who belong to Travelling population?
24. What are the two things (in terms of changes in practice) that would, in this area, most improve the quality of mental health care for people who belong to Travelling population?

## APPENDIX 3: QUALITY INDEX OF SERVICE ORGANISATION (QISO)

### Quality criteria for identifying best practice

To identify best practice in the provision of mental health services for the target marginalised groups we have developed quality indicators to be employed at the individual (service) level and the area (system) level. Data for this process are collected via the ‘PROMO tool for the assessment of services’.

#### **Part 1. Individual service level quality indicators**

The individual service level quality indicators are based on the quantitative analysis of data obtained via PROMO services assessment questionnaire. The quality indicators focus on the six domains:

1. Accessibility (8)
2. Supervision (1)
3. Multidisciplinary team (1)
4. Programmes provided (2)
5. Coordination (1)
6. Evaluation (2)

Each domain contributes to the total score (**max 15**).

#### **1. Accessibility**

Quality indicators for individual services			
Key Indicator	Value	Definition	Question #
1. Days open	0	Open less than 5 days/week	4.1.01 – 02
	1	Open every day Mon-Fri	
2. Opening hours			4.1.01 – 02
<i>a. Open outside normal office hours</i>	0	Open within normal office hours only (Mon-Fri)	
	1	Open anytime outside the normal office hours (Mon-Fri)	
<i>b. Open at weekend</i>	0	Not open at weekend (anytime)	
	1	Open at weekend (anytime)	
3. Exclusion criteria			5.3.01-3
<i>a. Lack of motivation</i>	0	Yes to ‘lack of motivation’	

	1	No to 'lack of motivation'	
<i>b. Command of language</i>	0	Yes to "command of language of the host country"	
	1	No to "command of language of the host country"	
<i>c. Addictions</i>	1	No to "addictions"	
	0	Yes to "addictions"	
5. Self-referrals	0	No to self-referrals	7.3
	2	Yes to self – referrals	
<b>TOTAL</b>		<b>Out of 8</b>	

## 2. Staff supervision

Quality indicators for individual services			
Key Indicator	Value	Definition	Question #
Any supervision internal/external	0	No to any supervision (internal/external)	3.3.01 – 02
	1	Yes to any supervision (internal/external)	
<b>TOTAL</b>		<b>Out of 1</b>	

## 3. Multidisciplinary team

Quality indicators for individual services			
Key Indicator	Value	Definition	Question #
Presence of multidisciplinary team	0	No to any combination of mental health and social care professionals (one or the other only)	3.2.01 – 09
	1	Yes to any combination of mental health and social care professionals (at least on mental health and one social care professional)	
<b>TOTAL</b>		<b>Out of 1</b>	

#### 4. Programmes provided

Quality indicators for individual services			
Key Indicator	Value	Definition	Question #
1. Active outreach/home visits	0	No to active outreach and home visits	6.2.01/6.2.03
	1	Yes to active outreach or home visits	
2. Case finding	0	No to case finding	6.2.02
	1	Yes to case finding	
<b>TOTAL</b>		<b>Out of 2</b>	

#### 5. Coordination

Quality indicators for individual services			
Key Indicator	Value	Definition	Question #
Routine meetings with other services	0	No to routine meetings	7.1
	1	Yes to routine meetings	
<b>TOTAL</b>		<b>Out of 1</b>	

#### 6. Evaluation

Quality indicators for individual services			
Key Indicator	Value	Definition	Question #
1. Recording data on input and attendance	0	No to recording data on input and attendance	8.1.02
	1	Yes to recording data on input and attendance	
2. Recording outcome data on satisfaction and experience	0	No to recording outcome data on satisfaction and experience	8.103
	1	Yes to recording outcome data on satisfaction and experience	
<b>TOTAL</b>		<b>Out of 2</b>	

**APPENDICES 4a – 4f: COMPONENTS OF GOOD PRACTICE IN  
THE PROVISION OF MENTAL HEALTH CARE FOR SPECIFIC  
MARGINALISED GROUPS**

**APPENDIX 4a: COMPONENTS OF GOOD PRACTICE IN THE  
PROVISION OF MENTAL HEALTH CARE FOR  
LONG – TERM UNEMPLOYED CLIENTS**

<b>PROMO Components of Good Practice: Long-term unemployed</b>	
<b>1. Training staff in unemployment agencies (e.g. job centres) to be aware of the prevalence and implications of mental disorders</b>	
Supporting themes	Number of capital cities where themes were reported
Mental health awareness training for staff involved in employment process	4
Training on mental health care system and services available for employment services staff	4
<b>2. Establishing close collaboration of unemployment agencies (e.g. job centres) with mental health and social care services</b>	
Supporting themes	Number of capital cities where themes were reported
Developing a network between mental health services, social care services and other organisations involved in caring for long-term unemployed clients with mental illness	9
Collaboration between different types of services in establishing integrated care plan for long-term unemployed with mental health problems	6
Providing integrated social care services or involving social care professionals in employment agencies	6
Providing active support to people with mental health problems according to their individual needs	5

<b>PROMO Components of Good Practice: Long-term unemployed</b>	
<b>3. Providing long-term and flexible training and employment schemes to accommodate the specific needs of people with mental disorders</b>	
Supporting themes	Number of capital cities where themes were reported
Developing alternatives to standard employment schemes taking into account different needs and abilities of mentally ill people	6
Improving continuity of support to clients	6
Providing longer support schemes for getting clients with mental illness back to work	5

## APPENDIX 4b: COMPONENTS OF GOOD PRACTICE IN THE PROVISION OF MENTAL HEALTH CARE FOR HOMELESS CLIENTS

<b>PROMO Components of Good Practice: Homeless population</b>	
<b>1. Reducing administrative barriers to access mental health care (especially for those without insurance or without a permanent address)</b>	
Supporting themes	Number of capital cities where themes were reported
Good collaboration between mental health, social welfare and homeless services	11
Assisting clients in obtaining health insurance	7
Improving flexibility of access and referrals/simplifying administrative procedures	5
Provision of direct access to free health care services regardless of insurance	3
Developing clear guidelines regarding admission and discharge of homeless	2
Provision of dual diagnosis services	2
Provision of low-threshold mental health services	2
<b>2. Including mental health expertise in outreach teams for appropriate assessments and referrals</b>	
Supporting themes	Number of capital cities where themes were reported
Provision of mental health outreach services for homeless	11
Provision of mental health outreach services on the street	9
Provision of mental health outreach in homeless accommodation	5
Provision of a specialised team/professional to work with homeless mentally ill	7

**APPENDIX 4c: COMPONENTS OF GOOD PRACTICE IN THE PROVISION OF MENTAL HEALTH CARE FOR CLIENTS WHO ARE STREET SEX WORKERS**

<b>Promo Components of Good Practice: Street Sex Workers</b>	
<b>1. Including mental health expertise in outreach services for street sex workers</b>	
Supporting themes	Number of capital cities where themes were reported
Provision of mental health outreach services on the street	8
Provision of mental health outreach services in not-for-profit organisations providing care to street sex workers	2
Non-intrusive approach	8
Ensuring continuity / regular contact	8
Joint training between different types of services providing care for street sex workers	4
Provision of specialist teams / professionals to provide health care for street sex workers	3
Provision of psychological counselling	3
<b>2. Establishing effective collaboration between specialised outreach services and mental health services to facilitate access to care</b>	
Supporting themes	Number of capital cities where themes were reported
Good collaboration between mental health, social welfare and NGOs in contact with sex workers	11
Provision of information on mental health services for other care providers	6
Ensuring access to health care coverage	5

**APPENDIX 4d: COMPONENTS OF GOOD PRACTICE IN THE PROVISION OF MENTAL HEALTH CARE FOR CLIENTS WHO ARE ASYLUM SEEKERS AND REFUGEES**

<b>PROMO Components of Good Practice: Asylum Seekers and Refugees</b>	
<b>1. Funding of and facilitating access to competent interpreting services</b>	
Supporting themes	Number of capital cities where themes were reported
Improving communication by addressing language needs	12
Provision of trained interpreters in mental health care	10
Training staff in use of interpreters in mental health care	3
Provision of bi-lingual staff/treatment in mental health care	7
<b>2. Providing culturally appropriate mental health care services</b>	
Supporting themes	Number of capital cities where themes were reported
Improving communication by addressing cultural needs	7
Training/educating staff in cultural aspects of health/mental health care	6
Training/educating staff in cultural competence/sensitivity	6
Provision of transcultural mediators	2
Providing mental health teams/professionals with relevant skills and experience for working with refugees and asylum seekers	5

<b>PROMO Components of Good Practice: Asylum Seekers and Refugees</b>	
<b>3. Developing good collaboration between mental health services and other organisations involved in care for asylum seekers/refugees such as migrant organisations, not-for-profit organisations, asylum authorities and social welfare organisations</b>	
Supporting themes	Number of capital cities where themes were reported
Addressing welfare issues linked to life in exile and immigration status	11
Good collaboration between mental health, social welfare and legal services and migrant organisations	10
Developing a network of health professionals/services	9
Exchange of expertise amongst different services working with asylum seekers and refugees	6
Provision of information on mental health issues, the health system and services available to asylum seekers and refugees	7
Provision of information in the organisations refugees/asylum seekers know and trust	5
Provision of information on mental health and services available in asylum reception centres	2

**PROMO Components of Good Practice: Asylum Seekers & Refugees**

**4. Clear information for mental health services on the entitlements of asylum seekers and refugees to care**

Supporting themes	Number of capital cities where themes were reported
Assisting clients in obtaining the health care to which they are entitled	10
Assisting clients in solving legal issues related to their immigration status	10
Educating health/mental health care professionals about health entitlements for asylum seekers	7
Educating health/mental health care professionals about asylum procedure	7

**APPENDIX 4e: COMPONENTS OF GOOD PRACTICE IN THE PROVISION OF MENTAL HEALTH CARE FOR CLIENTS WHO ARE IRREGULAR MIGRANTS**

**PROMO Components of Good Practice: Irregular Migrants**

**1. Funding of and facilitating access to competent interpreting services**

Supporting themes	Number of capital cities where themes were reported
Improving communication by addressing language needs	10
Provision of trained interpreters	9
Securing resources for interpreters in mental health budget	2
Provision of bi-lingual staff/treatment in mental health care	5

**2. Providing clear information to migrant organisations on services available and on the entitlements of irregular migrants to use them**

Supporting themes	Number of capital cities where themes were reported
Addressing legislative and health entitlement issues linked to immigration status	13
Assisting clients to obtain the health care to which they are entitled	10
Good collaboration between mental health, social welfare and legal services and migrant organisations	8
Provision of information on health care entitlement and health services to irregular migrants	6
Provision of information in the organisations undocumented migrants know and trust	3

**APPENDIX 4f: COMPONENTS OF GOOD PRACTICE IN THE PROVISION OF MENTAL HEALTH CARE FOR CLIENTS FROM TRAVELLING COMMUNITIES**

<b>PROMO Components of Good Practice: Travelling Communities</b>	
<b>1. Providing a specialised point of entry into health care either with mental health expertise (e.g. cultural mediators, specialised health care staff) or close collaboration with a mental health service</b>	
Supporting themes	Number of capital cities where themes were reported
Provision of cultural mediators	10
Involving the family and community in the decision- making process regarding the provision of care	8
Provision of mental health outreach services for travelling communities	6
Provision of specialised health professionals to liaise with and provide care to travelling communities	4
Liaising with the schools attended by children from the travelling communities	4
Developing trust with clients in individual face-to-face interaction	6
Providing specialised health care pathways for members of travelling communities	3

**PROMO Components of Good Practice: Travelling Communities**

**2. Fostering cooperation between mainstream mental health services and non-governmental organisations specialising in care for travelling communities**

Supporting themes	Number of capital cities where themes were reported
Cooperation between health and social care services and travelling communities	9
Cooperation between not-for-profit organisations specialising on travelling community with families/communities	4
Cooperation between health and social care services and specialised not-for-profit organisations providing services to travelling communities.	3
Providing information about mental health to travelling communities	4
Exchange of expertise between different types of services that provide care to travelling communities	3

<b>PROMO Components of Good Practice: Travelling Communities</b>	
<b>2. Fostering cooperation between mainstream mental health services and non-governmental organisations specialising in care for travelling communities</b>	
<b>Supporting themes</b>	<b>Number of capital cities where themes were reported</b>
Cooperation between health and social care services and travelling communities	9
Cooperation between not-for-profit organisations specialising on travelling community with families/communities	4
Cooperation between health and social care services and specialised not-for-profit organisations providing services to travelling communities.	3
Providing information about mental health to travelling communities	4
Exchange of expertise between different types of services that provide care to travelling communities	3