Mental Health care for socially marginalised people in Europe

Results from the European Commission funded PROMO study

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Abstract

PSYCHOSOZIALE GESUNDHEITSVERSORGUNG SOZIAL MARGINALISIERTER MENSCHEN IN EUROPA – ERGEBNISSE DER VON DER EUROPÄISCHEN KOMMISSION GEFÖRDERTEN PROMO-STUDIE

Mangelnde finanzielle Ressourcen, fehlende Teilhabechancen am wirtschaftlichen und sozialen Leben sowie unzureichende Wohnsituationen – sozial marginalisierte Menschen sind einer Vielzahl von Belastungen ausgesetzt. Marginalität gilt somit als Risikofaktor für die Entstehung psychischer Störungen. Gleichzeitig sind sozial benachteiligte Menschen mit einer Vielzahl von Barrieren beim Zugang zur psychosozialen und psychiatrischen Versorgung konfrontiert, und zwar sowohl auf der strukturellen (z. B. das Fehlen von niederschwelligen Angeboten und aufsuchender Arbeit) als auch auf der individuellen Ebene (z. B. Misstrauen gegenüber den Gesundheitseinrichtungen und deren Personal; fehlende Krankenversicherung). Umso notwendiger ist es, diese Barrieren zu identifizieren und Elemente einer »Good Practice« aufzuzeigen. Deshalb wurde von der Europäischen Kommission das Forschungsprojekt »PROMO – Best Practice in Promoting Mental Health in Socially Marginalised People in Europe« gefördert. Es hatte zum Ziel, die existierende psychosoziale Versorgung von sozial marginalisierten Gruppen zu beschreiben, zu analysieren und Richtlinien einer »Good Practice« zu entwickeln. Sechs marginalisierte Gruppen wurden in die Studie einbezogen: 1. Langzeitarbeitslose Personen, 2. Obdachlose, 3. Sex-ArbeiterInnen, 4. Flüchtlinge und AsylwerberInnen, 5. irreguläre/illegal aufhältige MigrantInnen sowie 6. Roma und Sinti. Die Studie wurde in den Hauptstädten von 14 europäischen Ländern durchgeführt. Insgesamt 617 Einrichtungen im Gesundheits- und Sozialbereich wurden untersucht und 154 ExpertInnen befragt. Eine Übersicht der Ergebnisse wird im folgenden Artikel präsentiert.

Marginalisation is a multi-layered concept, which refers to exclusion of individuals or groups from meaningful participation in economic, social, political, cultural and other forms of human activities in their communities[1]. Social marginalisation is considered as a determinant of health including mental health[2], and numerous studies confirm that certain groups of socially marginalised people show a higher vulnerability to mental health problems than the rest of the population.

In homeless men Fichter et al.[3] have found a lifetime prevalence of 93,2 % for at least one psychiatric disorder and of 79,6 % for drug and alcohol addiction. Similarly, refugees and asylum seekers were found to have higher rates of posttraumatic stress disorders, anxiety and depression than regular migrants[4]. 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 mental health[5].

At the same time socially marginalised people face enormous barriers in access to health care services, some of them being structural (lack of low threshold services, lack of active outreach, discrimination, etc.), some personal (not being insured, survival needs interfering with health care needs, mistrust towards health care institutions and staff, etc.). Considering equity issues it is necessary to tackle barriers in health care provision and to identify elements of »good practice«.

The European Commission funded project PROMO (Best Practice in Promoting Mental Health in Socially Marginalized People in Europe) brought together a multidisciplinary consortium of experts from 14 EU member states (see list at the end of the article) to consolidate the knowledge in the field of mental health care for marginalised groups and identify elements of »good practice«.

Within the PROMO project medical and social services for the following six marginalised groups were explored: (1) long term unemployed people, (2) homeless people, (3) sex-workers, (4) refugees and asylum seekers, (5) irregular migrants and (6) travelling communities. These six groups were supposed to represent a broad spectrum of marginalisation, but no claim on completeness was made. A total of 617 health and social care services for these groups in the 14 participat-

ing countries were identified and assessed, and 154 experts in the respective fields were interviewed in order to identify barriers in mental health care provision and components of »good practice«. Differences between specific marginalised groups were analysed[6]. An overview on the project results is presented in the box.

MEMBERS OF THE PROMO CONSORTIUM

Austria: Heinz Katschnig, Christa Straßmayr, Michaela Amering; *Belgium:* Vincent Lorant, Pablo Nicaise, Charlotte Geerts; *Czech Republic:* Petra Holcnerová, Jiří Raboch; *France:* Tim Greacen, Hamidou Dia; *Germany:* Andreas Heinz, Ulrike Kluge; *Hungary:* Edina Gabor, Jozsef Solymosy, Barbara Koncz; *Ireland:* Margaret M. Barry, Reamonn Canavan, Maeve O'Sullivan; *Italy:* Andrea Gaddini, Valeria Fabio, Lilia Biscaglia; *Netherlands:* A.H. Schene, M.J. Kikkert; *Poland:* Marta Welbel, Jacek Moskalewicz; *Portugal:* Henrique Barros, Diogo Costa; *Spain:* Felipe Reyero Pantigoso, María Isabel Vázquez Souza; *Sweden:* Joaquim J. F. Soares, Gloria Macassa, Ulla Wihlman; *United Kingdom:* Stefan Priebe, Aleksandra Matanov, Ruth Schor, Ana Costa, Simon Tulloch, Dinah Morley (coordinating center)

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Good Practice in Mental Health Care for Socially Marginalised People in Europe Findings from the PROMO project

The PROMO project aimed to identify good practice in mental health care for socially marginalised groups in Europe. The focus was on the delivery of health and social care for people with mental health problems who belong to one of the six following groups: long-term unemployed; homeless; street sex workers; asylum seekers/refugees; undocumented migrants; travelling communities. The project was conducted within the two most deprived areas in the capital cities of the following 14 EU countries: Austria, Belgium, Czech Republic, France, Italy, Germany, Hungary, Ireland, Netherlands, Poland, Portugal, Spain, Sweden, and United Kingdom. The present document summarises the main findings concerning service provision for these groups and experts' opinions about the quality of care provided for each group.

ASSESSMENT OF SERVICES

Services providing health and social care for any of the six marginalised groups were identified in the two research areas in each capital city. A representative from each service was interviewed concerning; funding, staff, accessibility, client characteristics, programmes, coordination with other services, and evaluation.
Of the total of 617 services interviewed:

- **51 were mental health services addressing specific marginalised groups;**
- **221 were generic mental health services;**
- **84 were social care services for specific groups;**
- **187 were generic social care services;**
- **29 were health services for specific groups, and**
- **45 were generic health services.**

Group specific services existed mainly for homeless populations (111), refugees or asylum seekers (58) and the long term unemployed (45). Fewer specific services were found for street sex workers (28), undocumented migrants (13) and travelling communities (12).

EXPERT INTERVIEWS

In addition to assessing services, a total of 154 health and social care experts were interviewed using case vignettes with specific questions on pathways into mental health care, typical barriers encountered and ways to overcome

The PROMO project was funded by the General Directorate of Health and Consumer Protection (DG SANCO) of the European Union. For more information about PROMO and the findings please visit the website: www.promostudy.org

them. They were also asked general questions on the co-ordination, strengths and weaknesses of the care system as a whole for each of the six marginalised groups, and made suggestions for improvements.

BARRIERS TO MENTAL HEALTH CARE FOR SOCIALLY MARGINALISED GROUPS

The most important barriers to care for socially marginalised groups across all 14 countries were grouped into seven categories:

- Limited entitlements and administrative barriers to obtaining health care, particularly for asylum seekers and undocumented migrants, but also for the other groups who may be without health insurance.
- Complexity of needs and limited ability to engage, because marginalised people often live in poor socio-economic circumstances, inadequate housing, and social isolation, having chaotic life styles and lack information on health services.
- Language barriers and cultural differences between clients and staff in services, 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.
- Lack of flexibility in the organisation of services and administrative procedures.
- Poor co-ordination and collaboration among services in the same area.
- Negative attitudes and discrimination towards some of the marginalised groups (particularly travelling communities, street sex workers, and the homeless).
- Clients from marginalised groups often mistrust or fear staff in services, which may be associated with previous negative experiences.

COMPONENTS OF GOOD PRACTICE FOR ALL MARGINALISED GROUPS

The collected evidence suggests four 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 other services.

COMPONENTS OF GOOD PRACTICE FOR SPECIFIC MARGINALISED GROUPS

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

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.

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 the 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.

Street sex workers

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

Undocumented migrants

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

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 of unemployment agencies (e.g. job centres) with 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.

Travelling communities

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

CONCLUSIONS

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.