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# An Evaluation of The Role of The Traveller Mental Health Liaison Nurse in Carlow and Kilkenny



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive



**Trinity College Dublin**  
Coláiste na Tríonóide, Baile Átha Cliath  
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‘The story so far’ and ‘Supporting wellbeing’ images designed by Mary Byrne (Traveller Mental Health Liaison Nurse).

The SE THU Holistic Approach to Traveller Health & Wellbeing image is taken from the SE THU Traveller Health Chronic Conditions Programme Toolkit.

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## Foreword



I am delighted that this evaluation of the Traveller Mental Health Liaison Nurse in Carlow and Kilkenny is being launched. When developing the South East Traveller Health Unit (SE THU) Strategic Plan 2015 -2020, it became very evident that there was a need for a targeted approach to support Travellers to look after their mental health and wellbeing. The need to further develop supports for Travellers experiencing mental health difficulties who were not sure where to go for help, or who may not have known that any help was available, became a key priority for the South East Traveller Health Unit. The importance of addressing this within a sociodeterminants of health approach was an important principle.

It was in this context that a Mental Health Liaison Nurse for Travellers (TMHLN) was appointed. The role of the Traveller Mental Health Nurse included providing support to members of the Traveller community in understanding concepts of mental health, recognising when they experienced mental health difficulties and helping them to access primary or specialist services/supports if this became necessary. Building trust with the Mental Health Nurse was recognised as essential for successful outcomes to be achieved. The South East THU recognises that mental and physical health is closely linked and approaches Travellers' health holistically, acknowledging that one can impact / complement the other. If Travellers' mental health is not in a good space, it can be extremely hard to provide support to look at what is necessary for good physical health. Supporting Travellers' mental health is essential to enhance general health and wellbeing of members of this community.

The community development model whereby Travellers were involved at every stage of the development of the work of the TMHLN - from when this role was just an idea right through to the completion of this evaluation - is especially positive. With recognition by the SE THU that Travellers are the experts of their own lived experience, members of the Traveller community have shaped the role of the TMHLN – this was effected through the participation of Traveller Community Health Workers on the South East Traveller Mental Health Advisory Sub Group as well as via participation in the Evaluation Sub Committee where cultural appropriateness of the approach and tools used in the evaluation was assured.

The collaborative nature of the development and implementation of the TMHLN post and its associated evaluation was further underpinned with involvement of a range of key people, including the South East's Social Inclusion Department, Mental Health service and Primary Care and Traveller Health Projects.

I would like to thank The School of Nursing and Midwifery, Trinity College Dublin, for their professionalism, patience and ethical approach to undertaking this evaluation. Their ability to listen to all parties and to understand the unique issues in consideration of Traveller health offered confidence that evaluation of the role of the TMHLN would be respectful of the perspectives of all parties involved – and with ability to conduct the evaluation through the lens of members of the Traveller community.

The recommendations contained in the evaluation report are evidenced and achievable and I am committed to support all efforts of the SE THU towards their implementation.

### *Diane Nurse*

National Lead: Social Inclusion

HSE National Social Inclusion Office



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# LIST OF ABBREVIATIONS

AITHS	All-Ireland Traveller Health Study
CSO	Central Statistics Office
GP	General Practitioner
HSE	Health Service Executive
MHLN	Mental Health Liaison Nurse/Nursing
PCLN	Psychiatric Consultation Liaison Nurse
PHCTP	Primary Health Care for Traveller Projects
PHN	Public Health Nurse
TCHW	Traveller Community Health Workers
TMHLN	Traveller Mental Health Liaison Nurse
WRAP	Wellness Recovery Action Planning



# EXECUTIVE SUMMARY



# Developing the role of the Traveler Mental Health Liaison Nurse

## THE STORY SO FAR

May  
2015

Getting to know the services and structures



Traveller Culture Awareness Training



My title 'The Wellbeing Nurse'



2015  
2016

Reflections...



'Bridging the Gaps'



Wellbeing Education builds resilience



Building Trust is key to success



Fear and Stigma are key barriers

2016  
2017

Working in partnership with other services will support Travellers



Flexibility and outreach working is essential to success



Practical Support and advocacy builds engagement



Mental Health cannot be viewed in isolation



Quality Proofing Matters



Staying on Course...

2017  
2018



Formal Evaluation 2018



# INTRODUCTION

## The HSE National Social Inclusion Office

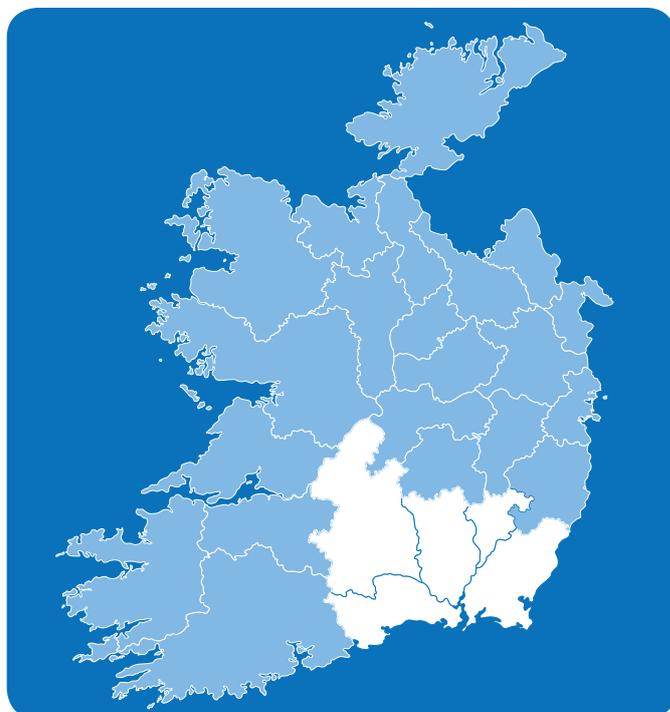
The HSE National Social Inclusion Office supports equal access to health services for people from vulnerable groups (HSE 2017). One of the groups that they support is the Traveller community. The South East Traveller Health Unit (SE THU) strategic Plan (2015-2020) has prioritised mental health as a pillar of change for this community as part of their holistic approach to health and wellbeing. Figure 1 provides a summary of the factors that affect Traveller mental health.

## The South East Traveller Health Unit

The South East Traveller Health Unit works across five counties, Carlow, Kilkenny, Tipperary, Waterford and Wexford.

The work of the HSE National Social Inclusion Office is carried out through the regional Traveller Health Units which work to:

- Improve the health of Travellers
- Help the health services to understand the needs of Travellers.
- Respond to the social factors that affect Traveller Health (Health Service Executive 2017).

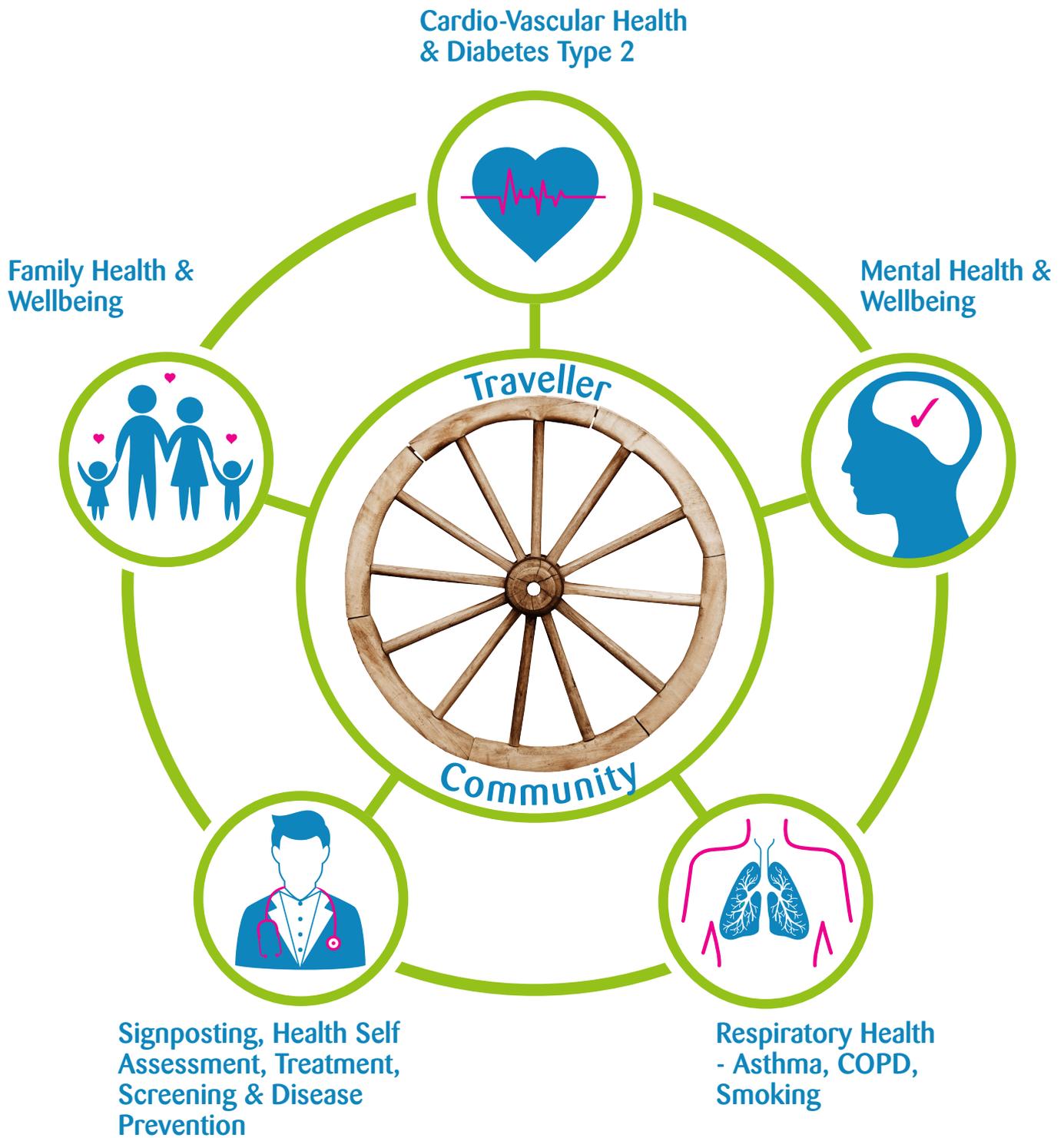


## The factors that affect Traveller mental health



Figure 1: Factors that affect Traveller mental health.

# SE THU Holistic Approach to Traveller Health and Wellbeing



## Traveller Health Projects

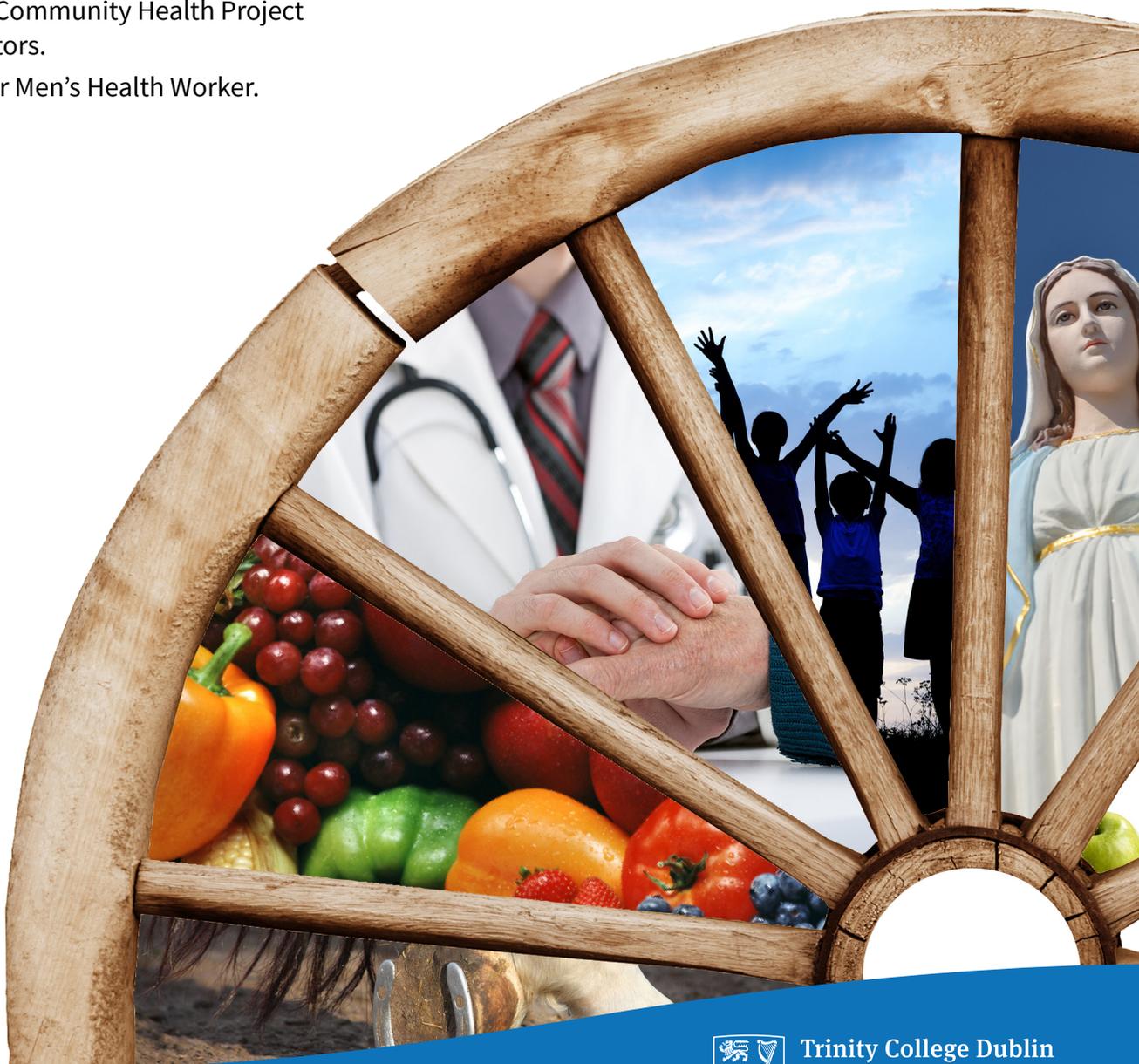
The South East Traveller Health Unit supports eight Traveller Community Health Projects and four Traveller Men's Health Projects in Carlow, Kilkenny, Tipperary, Waterford and Wexford. The Traveller Health Projects work to support Traveller health and are made up of a range of health workers including peer workers. This evaluation focuses on Traveller Health Projects in two counties; Carlow and Kilkenny.

The Traveller Health Projects in Carlow and Kilkenny are made up of Traveller Community Health Projects which employ:

- Part-time Traveller Community Health Workers.
- Traveller Community Health Project Coordinators.
- A Traveller Men's Health Worker.

## Establishing the Traveller Mental Health Liaison Nurse Role

In 2014, funding was sought from the St Stephen's Green Trust by the Carlow Kilkenny Traveller Mental Health Sub Group of the South East Traveller Health Unit to appoint a Mental Health Nurse to help address the mental health and emotional needs of Travellers in the area. In 2015, a Traveller Mental Health Liaison Nurse (TMHLN) was appointed. In November 2017 the authors of this report were commissioned by the HSE Social Inclusion Office to evaluate the role of the TMHLN.



# METHODOLOGY



## Study Aim

The aim of this study was to evaluate the role of the Traveller Mental Health Liaison Nurse and to make recommendations for future role sustainability, development, extension and expansion.

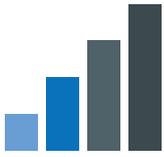


## Study Design

The evaluation used a mainly qualitative methodology. Interviews and focus groups were used to collect the data. Key stakeholders including the Traveller Mental Health Liaison Nurse, members of the Traveller Community, staff from the Traveller Health Unit, the Traveller Health Projects, Mental Health services and other health and social agencies were interviewed by the research team. Ethical approval was provided by the Health Service Executive South Eastern Research Ethics Committee.



# FINDINGS



The Traveller Mental Health Liaison Nurse became known as the 'Wellbeing Nurse' by service users. The Traveller Mental Health Liaison Nurse told us about the role and how the role helped Travellers. A summary of the activities of the TMHLN and how she supported wellbeing for the Traveller Community can be seen in figure 2.



## Roles and Responsibilities of the Traveller Mental Health Liaison Nurse

- Provision of psychosocial interventions to members of the Traveller community.
- Provision of health and wellbeing education to Travellers and their family.
- Provision of an active listening service.
- Liaison with other health and social care agencies.
- Crisis intervention.
- An appointment reminder service and follow-up for Travellers.
- Providing cultural awareness education to health and social agencies.
- Advocate on behalf of the individual Traveller and on behalf of the Traveller community.



## The Day-to-Day Work of the Traveller Mental Health Liaison Nurse

- The Traveller Mental Health Liaison Nurse used a narrative approach where she listened to the Travellers stories about their lives.
- The Traveller Mental Health Liaison Nurse worked in recovery-orientated ways and used the Wellness Recovery Action Plan when she was working with the Travellers.
- The Traveller Mental Health Liaison Nurse also used peer support to help the Travellers maintain social contacts and develop social networks.

## Supporting wellbeing

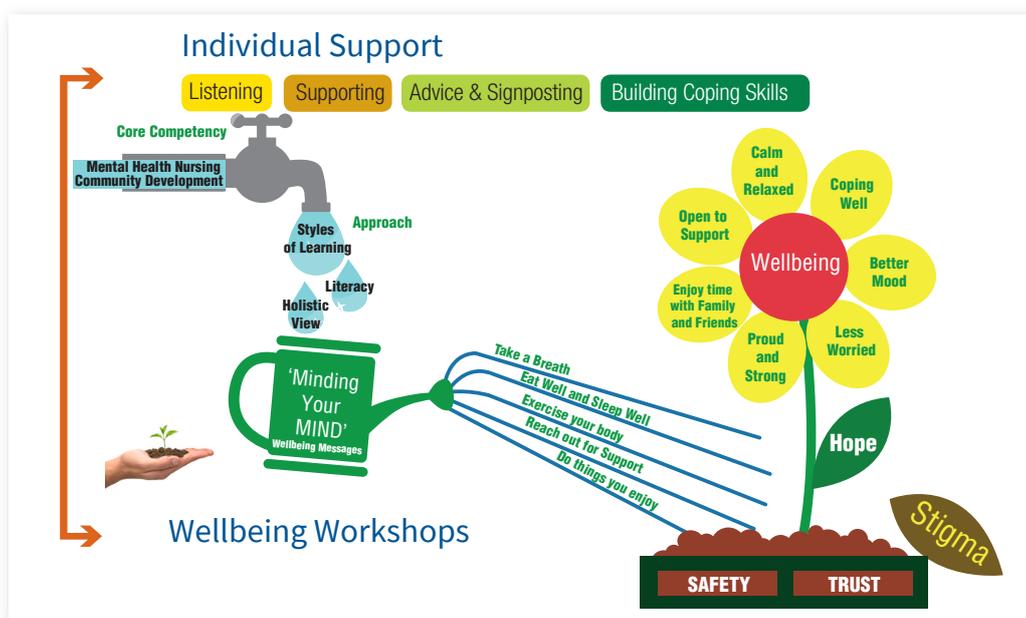


Figure 2: Supporting wellbeing





## **Governance of the Traveller Mental Health Liaison Nurse Role**

- The governance of the Traveller Mental Health Liaison Nurse is a joint venture between the Traveller Health Unit and the Mental Health Nursing Division.
- While there were positive perceptions of the governance arrangements, there was also recognition that they needed to be strengthened.
- With strengthening, the Governance structures in place for the TMHLN has the potential to provide a blueprint for shared governance arrangements in Ireland.





## Impact of the Traveller Mental Health Liaison Nurse Role

Some of the key stakeholders talked about how they were able to tell Travellers about the Traveller Mental Health Liaison Nurse. They also talked about how the Traveller Mental Health Liaison Nurse told Travellers about the different services that were available to help them.

### ***Service Users' Perceptions of the Impact of the Traveller Mental Health Liaison Nurse Role***

- The Travellers we talked to placed a high value on the work of the Traveller Mental Health Liaison Nurse and were extremely positive about the role of the Traveller Mental Health Liaison Nurse.
- They described the different ways that the Traveller Mental Health Liaison Nurse helped them, and these mainly fell into four areas: therapeutic activities, liaison interventions, educative interventions and follow-up interventions.

### ***Key Stakeholders' Perceptions of the Impact of the Traveller Mental Health Liaison Nurse Role***

The key stakeholders talked about how the Traveller Mental Health Liaison Nurse:

- Helped Travellers with their mental health needs and often helped with some of the social difficulties they were experiencing, such as accommodation.
- Told stakeholders about Traveller's cultural needs which made stakeholders more aware of the how to respond effectively to Travellers' needs.



## Facilitators and Barriers to the Development and Sustainability of the Traveller Mental Health Liaison Nurse Role

- There were a number of things without which it would not have been possible for the Traveller Mental Health Liaison Nurse to do her job; these included the Traveller Community Health Projects, the Traveller Men's Health Project the Traveller Health Unit and the Traveller Mental Health Advisory Group.
- There were also several things that may affect the role in the future, such as the amount of work that the Traveller Mental Health Liaison Nurse does, working over two counties and the risks associated with being a single-post holder.

# RECOMMENDATIONS



Based on the findings of this evaluation we make recommendations for the development, governance and sustainability of the role of the Traveller Mental Health Liaison Nurse.

## Recommendations for the Development of the Traveller Mental Health Liaison Nurse Role

- The job description of the Traveller Mental Health Liaison Nurse has changed over time and should be amended to reflect the current roles and responsibilities, with an emphasis on the role of the Traveller Mental Health Liaison Nurse as a Mental Health Liaison Nurse.
- The complexities of the interventions and the specialist nature of the work of the Traveller Mental Health Liaison Nurse should be reflected in the grade; current and future Traveller Mental Health Liaison Nurses should be employed at Clinical Nurse Specialist grade.
- The core concepts set out in the Framework for the Establishment of Clinical Nurse Specialists (2008) outline the key roles of the Clinical Nurse Specialist and these should be used to detail the Traveller Mental Health Liaison Nurses activities. The role should continue to have a strong clinical focus and should be aligned with the core values of Mental Health Nursing as described by the Department of Health and Nursing and Midwifery Board of Ireland (2016). Other core concepts of Clinical Nurse Specialist role activity include patient/client advocacy, education and training, audit and research and consultancy.

## Recommendations to Support the Current Traveller Mental Health Liaison Nurse

- The Current Traveller Mental Health Liaison Nurse should be supported to meet the criteria for Clinical Nurse Specialist as outlined by the Department of Health (2017). This should include educational support to help develop skills in audit and measurement of clinical outcomes.
- Audit and research are essential roles of the Clinical Nurse Specialist. The Traveller Mental Health Liaison Nurse should audit and evaluate nursing practice to ensure there are improvements in health and social care outcome for Travellers.
- The Traveller Mental Health Advisory Group should support the audit and evaluation activities of the Traveller Mental Health Liaison Nurse and formulate key performance indicators to ensure quality outcomes.



## Recommendations for the Traveller Mental Health Liaison Nurses' Clinical Practice

- The Traveller Mental Health Liaison Nurse should continue to advance a recovery-orientated ethos in the area of Traveller mental health and recovery-orientated approaches should continue to underpin the role.
- Consideration should be given to using a standardised recovery-orientated assessment tool (e.g. the Recovery Star), which could be adapted for use with the Traveller community.
- It is recommended that the Traveller Mental Health Liaison Nurse forge links with the Recovery College in the area with a view to increasing their knowledge of Traveller mental health and widening Traveller access to the services and courses provided.
- The Traveller Mental Health Liaison Nurse should continue to receive external clinical supervision.

## Recommendations for the Governance of the Traveller Mental Health Liaison Nurse Role

- The Traveller Mental Health Liaison Nurse should continue to be located within the primary care services.
- Governance structures need to formalise the professional relationships between the Traveller Mental Health Liaison Nurse, the Mental Health Nursing Division and the South East Traveller Health Unit in consultation with the HSE National Social Inclusion Office and the Health Service Executive.
- There needs to be clear policies in place to support the work of the Traveller Mental Health Liaison Nurse. The current policies that are in place to guide the work of the Traveller Mental Health Liaison Nurse need to be made explicit, and a plan put in place to address gaps in policy provision. Key areas within these policies must identify:
  - Risk assessment/escalation policy
  - The Traveller Mental Health Liaison Nurse's scope of practice
  - The boundaries of the Traveller Mental Health Liaison Nurse's role
  - Referral pathways and accelerated referral pathways
  - Data Protection Policy/Health Service Executive Data Protection Policy, and
  - Contingency plans for sickness and other absences.

The governance arrangements should be reviewed regularly.

## Recommendations for the Traveller Mental Health Advisory Group

- The terms of reference for the Traveller Mental Health Advisory Group should be reviewed.
- The Traveller Mental Health Liaison Nurse should be a member of the Group.
- Consideration should be given to the role of the Group in the strategic development of Traveller mental health initiatives in the area.

## Recommendations for Sustainability of the Traveller Mental Health Liaison Nurse Role

- The South East Traveller Health Unit should scope out the business case for the provision for a more comprehensive service.
- In light of the risks associated with single-postholders such as the Traveller Mental Health Liaison Nurse, it is recommended that a critical mass of Traveller Mental Health Liaison Nurses be created within each Traveller Health Unit.
- An evaluation of the professional development needs of the Traveller Mental Health Liaison Nurse should be completed. This should include access to peer networks for both professional development and supportive needs.

## Recommendations for Resources to Support the Traveller Mental Health Liaison Nurse Role

- Resources should be available to support activities used by the Traveller Mental Health Liaison Nurse to engage in shoulder-to-shoulder work with Traveller men and women.

## Recommendations for Future Research

- To support research activities, it is recommended that the Traveller Mental Health Advisory Group build a relationship with an academic environment to develop a research strategy to support the work of the Traveller Mental Health Liaison Nurse.
- Future research could explore the relationship between consistent engagement with the Traveller Mental Health Liaison Nurse and the frequency of crisis presentations among Travellers.
- Future research could explore gender differences in the mental health needs of Travellers.
- Future research could explore the work of the Traveller Mental Health Liaison Nurse using a longitudinal mixed methods approach.





# CHAPTER ONE

## INTRODUCTION

### 1.1 Background and Context

The HSE National Social Inclusion Office supports equal access to health services for people from vulnerable groups (HSE 2017a). One of the groups that they support is the Traveller community. The work of the HSE National Social Inclusion Office is carried out through the regional Traveller Health Units which work to:

- Improve the health of Travellers,
- Help the health services to understand the needs of Travellers, and
- Respond to the social factors that affect Traveller Health (HSE 2017a).

The South East Traveller Health Unit works across Carlow, Kilkenny, Wexford, Waterford and Tipperary. The Unit supports eight Traveller Community Health Projects (also known as Primary Health Projects) across the region. The Traveller Community Health Projects work to support Traveller health and are made up of a range of health workers including peer workers. In this evaluation, the focus is on two counties; Carlow and Kilkenny where there is a Traveller Health Project in each county. The Traveller Community Health Projects in Carlow and Kilkenny are based in Section 39 funded organisations; St Catherine's Community Services Centre and Kilkenny Leader Partnership and they employ Traveller Community Health Workers (TCHWs) and Traveller Community Health Project Coordinators, there are also Traveller Men's Health Projects funded by the Social Inclusion Department one of which based in the Carlow/Kilkenny area. In addition, there is a Public Health Nurse (PHN) for Travellers in the Public Health Nursing Department with links to the Traveller Health Units. There was widespread recognition that there needed to be some targeted actions in the area of mental health for Travellers and to that end, a group called the Carlow Kilkenny Traveller Mental Health Subgroup of the Traveller Health Unit came together to talk about Traveller mental health and to see what could be done. This group was made up of staff from the Regional Traveller Health Office, the Traveller PHN; Local Mental Health Service and Voluntary Mental Health Organisations and staff from the Traveller Community Health Projects. In 2012, the Regional Traveller Health Coordinator met with Travellers and asked them about the reasons Travellers didn't use the mental health services. The Travellers said that they didn't use the mental health services because:

- They was a sense of shame attached to using the mental health services.
- They had a lack of trust in the mental health services.
- They lacked the confidence to use the mental health services.
- They feared that they would lose their freedom.
- They were afraid their children would be taken into care if they had a mental health problem.



- They preferred to keep problems within the family or to tell the priest or nun.
- Travellers believed that men are supposed to be strong and don't have mental health problems and this perception stopped them getting help.
- They feared being put on medication without their problems being discussed.
- They felt that sometimes Travellers just need to talk about their problems and counselling is not always available.
- They feared that other people would know 'their business'.
- They feared becoming addicted to medication.
- They worried that medication might affect a mother's ability to care for their children.

Many of these problems stemmed from a lack of knowledge about mental health and stigma towards the mental health services. The Traveller Mental Health Subgroup felt that there needed to be a service in place to help Travellers better understand mental health and to help Travellers engage with and access services for their mental health including primary care services and the mental health services. In 2014, this group applied for and were given funding to employ a Mental Health Nurse to help Travellers with their mental health needs. The initial funding was provided by the St Stephens Green Trust which was match-funded by the Social Inclusion Department of the HSE; with a small amount of resources from the Mental Health Service to cover any shortfall. Thereafter, funding was provided by the HSE Social Inclusion Office. In tandem to the appointment of the Mental Health Nurse, the South East Traveller Health Unit published their strategic plan 2015 – 2020. It detailed proposed objectives, goals and actions to support Traveller health across eight domains:

- Cardiovascular health,
- Cancer,
- Mental health,
- Substance misuse,
- Men's health and suicide,
- Domestic violence,
- Children and family, and
- Social determinants of health.

The document laid the foundations for improving the mental health of Travellers through the provision of targeted services; increasing access to services through referral and signposting; increasing information and knowledge to help allay fears and anxieties about services; increasing the cultural capacity of services, and decreasing the stigma and shame attached to using some of the services (HSE 2015). In November 2017, the researchers were commissioned to evaluate the role of the TMHLN and this report details the findings of that evaluation. The report is divided into seven chapters including this Introductory chapter. A review of the literature is presented in Chapter Two, and the methodology including the aims and objectives of the evaluation is presented in Chapter Three. The findings of the evaluation are presented in Chapters Four, Five and Six. A discussion of the findings including recommendations across five key areas concludes the report in Chapter Seven.

# CHAPTER TWO

## LITERATURE REVIEW

### 2.1 Irish Travellers

‘Irish Travellers are a small indigenous minority group that have been part of Irish society for centuries. They have a value system, language, customs and traditions, which make them an identifiable group both to themselves and to others. Their distinctive lifestyle and culture, based on a nomadic tradition, sets them apart from the general population.’ (Abdalla et al. 2010a:9).

In 2017, Travellers were formally recognised as a distinct ethnic group within the State. The recognition of the unique heritage and cultural identity of the Traveller community within Irish society was of huge symbolic importance to Travellers. Recognition of Travellers as a distinct ethnic group is necessary to ensure that their cultural identity is respected in service provision. Furthermore, progress in achieving equality may be measured by including an ethnic identifier for Travellers in routine data collection (Watson et al. 2017).

The 2016 Irish census recorded 30,987 Irish Travellers, a 5.1% increase from the previous census in 2011, and 8,717 Traveller households, an increase of 12.3% from 2011. Traveller households are more likely to be multiple families compared to the general population (4.2% vs 1.3%). Travellers are a relatively young population with 60% aged under 25 in comparison to 33.4% of the general population. A much higher number of Travellers aged 15-29 are married compared to the general population of 15-29 years olds (31.9% vs 5.9%). Travellers are more urbanised than the general population with almost 8 in 10 (78.6%) living in cities or towns (of 1,500 or more), compared with 62.4% of the total population (Central Statistics Office [CSO] 2017).

The 2016 census shows low rates of educational attainment among Travellers relative to the general population. Among Traveller females, just 13.3% are educated to upper secondary level or above, compared to 69% of the general population. The highest level of education is primary for 57.2% of Traveller males compared to 13.6% of the general population. While there was an increase in the number of Travellers who had attained a third-level qualification between the 2011 and 2016 censuses, educational attainment was still disproportionately lower than the general population at every level (CSO 2017). Watson et al. (2017) analysed patterns of disadvantage among Travellers in a number of areas using data from the 2011 census and concluded that while levels of education have improved with time in the general population, the same could not be said for the Traveller population, with younger Travellers showing similar levels of non-completion of second-level education as older age groups within the community. It has been shown that the gap in educational attainment between Travellers and the general population emerges as early as primary school, with Traveller children academically



underperforming in comparison to their peers from the general population. Several reasons for the disparity exist which may include low levels of preschool enrolment, delayed enrolment in primary school and transgenerational educational disadvantage. Watson et al. (2017) also found that children and teenagers experience discrimination within the school environment which may precipitate early school leaving.

In terms of employment, an overwhelming majority of the Traveller population are unemployed (80.2%) (CSO 2017). Watson et al. (2017) found that employment dramatically increased among Travellers as the level of education rose. However, while education levels are extremely important for employment prospects, they did not account wholly for the disparities in the employment rate with the general population, with discrimination identified as a significant barrier. In a survey completed by O'Mahony (2017), 43% of the Travellers surveyed (n=481) reported that they experienced discrimination while accessing employment. The 2010 all-Ireland Traveller Health Study (AITHS), a census survey of all Traveller households on the island of Ireland, cited low education, a lack of role models and discrimination as significant barriers to employment for Travellers. In addition, the displacement of traditional ways of earning a living for Travellers have exacerbated poverty and has led to low self-esteem and a sense of purposelessness (Abdalla et al. 2010a). The report noted the 'fatalistic' outlook of Travellers, particularly in relation to progressing in education and employment, as Travellers did not perceive a benefit to staying in education because they would still be discriminated against in employment.

Travellers endure poor living conditions, often living in overcrowded, sub-standard accommodation which lack basic facilities and amenities (Watson et al. 2017). These conditions contribute to stress and worry, particularly among Traveller women raising children (Hodgins et al. 2006). Kelleher et al.'s (2012) analysis of data from the AITHS study found that access to sanitary facilities and a healthy and supportive environment were more influential than the type of accommodation for Travellers' ratings of their health. Furthermore, housing solutions which result in separation from family and friends may be deeply distressing for Travellers who rely on these networks for social and practical support (Abdalla et al. 2010a).

Although mortality among Irish Travellers has declined over time, it has been at a slower pace than that of the general population in Ireland; resulting in a widening gap in mortality rates, especially for men (Abdalla et al. 2010b). Life expectancy for male Travellers has not improved within the 20-year period measured in the AITHS study (1987-2008) (Abdalla et al. 2010b). Although female Travellers' life expectancy increased by 4.8 years over the same period, they can still expect to die 12.5 years before their female counterparts in the general population (Abdalla et al. 2010b). The higher mortality rates and lower life expectancies of Travellers in comparison to the general population highlight the impact of poor health over the life course. Travellers have high levels of respiratory and cardiovascular disease (Kelleher et al. 2012). Compared to the general population, they have three times the rate of disability (4.3% vs 11.3%) (CSO 2017). The disparities in health outcomes between Travellers and the general population widens with increasing age, demonstrating the effects that cumulative disadvantage in multiple domains has on health over the life course (Watson et al. 2017).



It is recognised that Travellers are more exposed to risk factors for problematic drug and alcohol use, such as inequality, marginalisation, poverty, poor mental health, unemployment and educational disadvantage (Department of Community, Rural and Gaeltacht Affairs 2009). Co-morbidity of mental ill-health and substance abuse is common in the Traveller community (Van Hout 2011). An analysis of national drug treatment data from 2007 to 2010 found that the incidence of treated problem drug and alcohol use in the Traveller population in 2010 was three times higher than the general population. It also showed that alcohol was the main problem substance reported by Travellers seeking access to treatment (42%) followed by opiate misuse (36%). This compares to general population figures of 53% and 29% for problematic alcohol and opiate use respectively (Carew et al. 2013). Although Travellers have lower prevalence rates of alcohol use compared to the general population, they exhibit heavier drinking patterns which can compound existing mental health difficulties (Abdalla et al. 2010a). A higher proportion of Travellers entering treatment reported problem use of more than one substance (polysubstance use) compared to the general population (53.2% vs 42.1%) (Carew et al. 2013). More recent figures show that the proportion of Travellers treated for problem drug use increased marginally from 1.9% in 2009 to 2.9% in 2015 (Health Research Board 2017) which may reflect greater engagement with formal services than in the past (Carew et al. 2013).

Extremely negative attitudes towards Travellers have been found in the general public in Ireland (Watson et al. 2017). It has been found that Irish Travellers have been subjected to discrimination in the areas of education, employment, housing, healthcare provision, media reporting and decision-making (Hammarberg 2008). The AITHS study found that in a sample of 1,604 Travellers in the Republic of Ireland, 61% experienced discrimination being served in a pub, restaurant or shop; 56% reported discrimination getting accommodation, and 55% reported discrimination in seeking work (Abdalla et al. 2010a). More recent data on discrimination is available from an analysis of the 2014 Quarterly National Household Survey involving 55 Travellers. The report found that, compared to White Irish, Irish Travellers were 10 times more likely to experience discrimination in seeking paid work, and over 22 times more likely to report discrimination in private services; particularly in shops, pubs and restaurants. Workplace discrimination was not examined, as the number of Travellers employed was too low (McGinnity et al. 2017).

It is widely recognised that health inequalities experienced by Travellers are inextricably linked to their economic, social, material and environmental conditions, due to lower levels of education, high unemployment, inadequate housing and barriers to accessing services (Abdalla et al. 2010a). These circumstances can often cause feelings of hopelessness and despair leading to mental distress (Pavee Point 2015). In addition, psychosocial factors related to social networks and support, community engagement and the experience of discrimination are also considered to have a major influence on Travellers' health outcomes.

Several factors have been identified as negatively affecting the mental health of Travellers and increasing their risk of mental health problems; these include changes in family structures, a decrease in religiosity, high unemployment, heavy alcohol consumption, social exclusion and discrimination, and low self-esteem. In relation to family structures, family ties are of huge cultural significance for Travellers as well as being sources of economic and social support; thus, it is thought that family



networks have a huge bearing on an individual's mental wellbeing (Watson et al. 2017). Discrimination can also have a corrosive effect on a person's sense of self-efficacy and self-esteem which in turn will likely adversely impact on their mental health (Abdalla et al. 2010a).

## 2.2 Mental Health

There doesn't appear to be any recent Irish data on the prevalence of mental health issues, such as depression and anxiety in the Traveller community. However, a recent survey by O'Mahony (2017) found that that 91% (n=481) of the Travellers surveyed believed that depression and anxiety were common among Travellers and 84% believed that mental health issues had worsened for Travellers since the recession. A Traveller Health Survey conducted with 367 respondents in Community Care Areas in North Dublin in 2002 found that a third reported depression was in their family (Traveller Health Unit 2004). UK studies on the health status of gypsies/Travellers found more self-reported difficulties with depression and anxiety compared to the general population (Van Cleemput and Parry 2001; Parry et al. 2004). A later study by Goward et al. (2006) with Travellers/Gypsies in Sheffield found the same disparity, with Travellers linking their experiences of distress and mental health problems to poor social and environmental conditions.

An analysis of data from the AITHS study found that 11.9% of Traveller respondents had frequent mental distress, defined as 14 or more days of poor mental health in the preceding month. This was two and a half times greater than that reported in a population sample of the general Irish public. It was found that, after controlling for age and gender, mental distress was impacted by impaired physical health, and experiences of bereavement and discrimination (McGorian et al. 2013). Much higher proportions of Traveller men and women in the Republic of Ireland also reported that their mental health was not good enough for one or more days in the last 30 days (59.4% & 62.7% respectively), compared to population samples of men and women in the general Irish public (21.8% & 19.9% respectively) (Abdalla et al. 2010a). A national survey conducted in 2017 found that there was a high level of concern among Travellers about mental health and drug and alcohol consumption (O'Mahony 2017).

The AITHS study found that suicide accounts for 11% of all deaths within the Traveller community which is six times the national average, with the rate being almost seven times higher for Traveller men compared to the general male population (Abdalla et al. 2010a). Walker (2008) found that 70% of completed suicides are first attempts, which suggests a community that does not seek help or engage with services at an early stage. In Connecting for Life, the national strategy for suicide prevention (Department of Health 2015), Travellers have been identified as a 'priority group' who are more vulnerable to suicide. In addition, unemployment is high among Traveller men, consequently increasing the sense of marginalisation that they experience making them even more vulnerable to suicide (O'Donnell and Richardson 2018). A national survey by O'Mahony (2017) found that 82% of the Travellers surveyed (n=481) had been affected by suicide demonstrating the impact suicide has on the community.



Several qualitative studies attest to and elucidate the experience of mental distress amongst Irish Travellers (Hodgins et al. 2006; Abdalla et al. 2010a; Pavee Point 2015). Traveller women (n=41) involved in a focus group study articulated the effect that social and environmental conditions, such as poor living conditions and discrimination, had on both their physical and mental health. Motherhood was seen by participants as an inherently stressful role, as women had primary responsibility for children, and felt that self-care was often a low priority and neglected as a result. Combined with the hardships wrought by social and environmental factors in their lives, women in the study readily identified with the experience of stress (Hodgins et al. 2006). The AITHS study found that men experienced stress as a result of low self-esteem and discrimination but did not deal with their mental health issues due to 'bravado' and the 'macho' appearance they felt compelled to portray (Abdalla et al. 2010a). Similarly, young Travellers aged 13-23 (n=88) who participated in workshops as part of a national mental health needs assessment reported that the way they dealt with mental health problems was through denial, avoidance and distraction, and they believed that suicide was a shameful topic to discuss. The authors of the report noted that Traveller children are typically considered young adults by their own community from the age of 14, which is much earlier compared to non-Traveller children (Pavee Point 2015).

### **2.3 Mental Health Service Provision and Utilisation**

Knowledge regarding access to and utilisation of mental health services among Travellers is lacking (Pavee Point 2016b). In terms of accessing health services, it is believed that Travellers tend not to utilise preventative and educational services or attend outpatient appointments but instead engage with services on an emergency basis or at the point of crisis (Hodgins et al. 2006; Abdalla et al. 2010a; Bergin et al. 2017). Primary Health Care for Traveller Projects (PHCTPs) have been found to be an important source of information and advice relating to physical and mental health for Travellers (Abdalla et al. 2010a; Tarafas et al. 2013). A lack of mental health services and Traveller-specific mental health services for young Travellers have been identified. Furthermore, many Travellers are also unaware of the services for their mental health that are available to them (Pavee Point 2015).

### **2.4 Barriers to Accessing Health Services**

Negative interactions with services or the expectation of poor treatment is identified by Travellers as one of the reasons for not availing of health services or delays in seeking treatment (Francis 2013). Travellers report poor quality healthcare interactions, including being treated unfairly, not being understood and they also report poor quality of care ratings (Abdalla et al. 2010a; Watson et al. 2017). Compared to the general population, a lower number of Travellers in the Republic of Ireland reported being treated with respect and dignity by the healthcare team (88% vs 58%) (Abdalla et al. 2010a). Traveller women in Hodgins et al.'s (2006) study recounted negative experiences with health professionals due to their tendency to criticise and scold the women which led to a reluctance to use and engage with services. Nevertheless, in terms of help for stress and depression, the women



also felt that though family and friends could offer practical support, professional support such as counselling would also be beneficial (Hodgins et al. 2006).

Stigma around health issues within the Traveller community, distrust of services and institutional racism have been identified as the main barriers to accessing health care, with stigma and shame being identified as particularly prevalent in relation to seeking help for mental health issues (Van Hout 2010; HSE 2015). As noted earlier, Traveller men and young people tended not to confront mental health issues, instead opting for strategies based on self-reliance, avoidance and denial (Abdalla et al. 2010a; Pavee Point 2015). A national survey in Ireland found that 80% (n=481) of respondents would be embarrassed to discuss mental health issues with others although 67% suggested that they would know what to do if someone close to them was experiencing mental distress (O'Mahony 2017).

Additional barriers to mental health service use highlighted by participants and health and social care providers in Goward et al.'s study (2006) include providers and Travellers having different understandings of mental health and mental health services; the stigmatisation of mental health in society; experiences of discrimination within statutory services; negative stereotypes about Travellers, and a lack of understanding of Traveller culture. For people with mental health problems belonging to a marginalised and socially excluded group in society, Travellers' knowledge of health services and how to access them is relatively lower. Furthermore, lower levels of literacy in the Traveller community negatively impacts on their ability to access and understand information and to follow healthcare instructions (Pavee Point 2016b).

The literature on treatment for substance misuse identifies multiple barriers to Travellers accessing addiction services, some of which may also be relevant to mental health service utilisation. Barriers identified included stigma and shame, poor literacy and a lack of knowledge of services, nomadism, issues adhering to treatment protocols and a tendency to deal with problems within the family rather than seek help externally. A lack of cultural competency on the part of service providers and experiences of discrimination can also negatively affect Travellers' engagement with services (Carew et al. 2013; Department of Community, Rural and Gaeltacht Affairs 2009).

## 2.5 Culturally Appropriate Services

A lack of cultural competency among health and social care providers has been found (Department of Justice and Equality 2017). Francis (2013) found that nurses' perceptions of Travellers were heavily influenced by negative media stereotypes and that they lacked understanding of Travellers' culture and health needs. Bergin et al. (2017) found that mental health service providers held negative and mistrustful attitudes towards Travellers who accessed services. Providers described Travellers as 'demanding', believing that they abused services, did not engage meaningfully with services and demonstrated high non-compliance with programmes. Furthermore, Travellers' behaviours within services are sometimes perceived as breaking the rules and not conforming to the way in which services operate (Bergin et al. 2017; Goward et al. 2006).

Culturally appropriate mental health services which foster behaviours, attitudes and policies that reflect

an awareness of and responsiveness towards the mental health needs of culturally diverse populations are required to improve services for ethnic minorities (McGorian et al. 2013). Furthermore, cultural competency training for health professionals can facilitate practitioners to reflect on their practice, its impact, and enhance their understanding of the culture and care needs of ethnic minority individuals, thus facilitating more open and respectful communication (Francis 2013). Although Irish mental health policy references the need for mental health services that are inclusive, responsive and sensitive to the needs of minority groups such as Travellers, Mental Health Reform Ireland has noted that mainstream mental health services and primary care services often do not consider the issue of cultural diversity and lack competency in this area (Mental Health Reform 2014). Furthermore, it has been noted that models of mental health treatment and promotion based on individualistic approaches may be ill-suited to working with Travellers, given the cultural importance assigned to connection to family (Goward et al. 2006).

## **2.6 Community Engagement and Relationship-Building**

Experiences of discrimination and structural and cultural barriers to accessing services can foster mistrust among Travellers in services and health professionals which can negatively impact on engagement with services (McFadden et al. 2016). In addition, psychosocial differences between the Traveller and non-Traveller communities in terms of poverty, housing, education, employment, experiences of discrimination and feelings of self-worth may make it difficult for Travellers to forge trusting relationships outside of their communities (McGorian et al. 2013). This is particularly evident in relation to Travellers' relationships with health professionals, with the AITHS study finding that the level of complete trust by Travellers in health professionals was 41% compared to a trust level of 82% among the general population (Abdalla et al. 2010a).

Targeted efforts must be made to engender trust in care among ethnic minority groups and to engage them in health care. Outreach programmes are regarded as a proactive and effective way of engaging marginalised and difficult to reach groups such as Travellers (Priebe et al. 2012b). Several Irish studies have demonstrated the positive impact of outreach work with regard to health care use among Travellers. The AITHS study reported how outreach services engendered trust and increased health care use among Travellers (Abdalla et al. 2010a). Similarly, the issue of trust was pivotal to engaging Travellers with services in a focus group study (n=16) (York & Stakem 2015). The study which ascertained the impact of TCHWs in a Primary Healthcare Programme for Travellers in County Offaly reported that Travellers had developed well-established relationships with the workers, who they felt understood their lives and offered welcome emotional support to deal with challenges they experienced. Participants reported trusting the workers which resulted in greater uptake of screening programmes and mental health services, such as counselling, and reported better health outcomes as a result of early intervention and treatment. The authors argue that community-driven interventions focused on relationship- and trust-building are fundamentally important and should not be forgotten in the national drive to achieve targets in areas identified as priorities, such as breast cancer screening, cervical cancer screening and similar programmes (York & Stakem 2015). Thus,



community engagement strategies are instrumental in breaking down barriers to health care access and facilitating the development of trust and relationship-building between Travellers and others, as well as ensuring that services respond to the specific needs of Travellers (McFadden 2016).

It is recognised, however, that it is more challenging to engage with Traveller men about health issues than Traveller women, as women are more accessible through health worker visits to the home. A number of challenges have been identified in relation to engaging men, and these include discrimination and disempowerment within health services; a lack of focus on relationship-building with mainstream service provision; cultural differences between services and Traveller men; and the concept of individualised care being unfamiliar to Traveller men (Pavee Point 2016a). Several reports and strategies reference the need to adopt a gendered approach to health (Women's Health Council 2005; Abdalla et al. 2010a; Pavee Point 2016a; HSE 2017b). A number of targeted initiatives have been established to engage men: these include the Travellers Mental Health Project, the Traveller Men's Action Plan, and the annual Traveller Men's Health Day (Pavee Point 2016a).

The authors of the AITHS report argue that health policies targeted at Travellers must acknowledge the role that social determinants play in their wellbeing in order to have any chance of positive impact and that an individualistic, disease-focused approach is inappropriate (Abdalla et al. 2010a). The Healthy Ireland Strategy - A Framework for Improved Health and Wellbeing 2013-2025 acknowledges the need to tackle the social determinants of health, such as education, employment and the physical environment so that inequitable health outcomes in Irish society may be addressed and healthy living promoted (Department of Health 2013). A focus on the broader determinants of health and wellbeing is also reflected in The National Traveller and Roma Inclusion Strategy 2017-2021 which is a cross-departmental initiative to improve the lives of the Traveller and Roma communities in Ireland in the areas of education, accommodation, health, employment and anti-discrimination (Department of Justice and Equality 2017). In relation to mental health, the strategy outlines 10 actions to respond to the high rate of suicide and mental health problems within the Traveller and Roma communities. The actions centre on the development of culturally appropriate services, the development of targeted interventions; education materials and campaign strategies to promote mental health and wellbeing; early intervention; tackling stigmatisation of mental health and addressing barriers to mental health service use. Travellers are identified within Connecting for Life - Ireland's National Strategy to reduce suicide (2015-2020) as one of the groups vulnerable to suicide in society, and so they are included under the Strategy's goals in relation to the reduction of suicidal behaviour and improvement of mental health (Department of Health 2015).

## 2.7 The Emergence and Development of Mental Health Liaison Nursing

Mental Health Liaison Nursing (MHLN) has been defined as:

‘the application of Mental Health Nursing knowledge and skills to non-psychiatric health settings’ (Roberts 1997: 103).

MHLN first emerged in the US in the 1960s. The role was characterised by liaison, consultation and education work with general hospital nurses and other disciplines, and direct intervention with patients and their families through the provision of specialised psychological care (Callaghan et al. 2003). In the UK, Government health policies aimed at suicide reduction consistently promoted liaison nursing within the emergency department (Sharrock et al. 2008). Thus, MHLN originated from crisis intervention services based in the Emergency Department in response to the growing number of suicide attempts and focused primarily on assessment and treatment of patients (Roberts 1997). A 2010 national overview of liaison psychiatry hospital-based services in Ireland found that these services were provided by teams and individuals from a range of disciplines, including liaison nurses (Mental Health Commission 2010). The role of a MHLN in Ireland exists to provide short-term interventions to patients with mental health issues within the general hospital setting and to enhance the knowledge and skills of non-mental health colleagues (Johnston & Cowman 2008). According to Sharrock et al. (2008), mental health consultation-liaison nursing has evolved rapidly in Australia with the mainstreaming of mental health services within the general health-care system and a shift away from institutional models of mental health care.

Since its emergence, the MHLN role has become firmly embedded in Emergency Departments in numerous hospitals with the aim of improving patient-focused outcomes in terms of access to care, coordination of care, therapeutic intervention and follow-up care. Its remit has also expanded into other areas of care including cancer, stroke, heart disease, HIV, recovery from burns and mutilating surgery, alcohol addiction and care of older people, with a focus on recovery-orientated care (Roberts 1997; Baldwin et al. 2004; Wand and White 2007; Hughes 2008; Wand et al. 2015).

MHLN is regarded as an advanced and specialist area of Mental Health Nursing in the US, the UK, Ireland and Australia (Roberts 1997; Callaghan et al. 2003; Brinkman et al. 2009; Johnston & Cowman 2008). Several studies have shown that nurses working in this role are highly experienced (Roberts & Whitehead 2002; Callaghan et al. 2003; Sharrock et al. 2008). However, a lack of formalised training in the role, as well as formalised support, has been noted in both Australia and the UK (Sharrock et al. 2008; Hepworth and McGowan 2015).

A lack of role definition has also been found in relation to MHLN roles (Roberts 1997; Brinkman et al. 2009). It is thought that the role has developed in an ad hoc manner (Roberts 1997), highlighted by the inconsistencies in the titles given to the role (Sharrock et al. 2008; Brinkman et al. 2009). For example, a variety of terms are applied to the MHLN role and these include ‘Mental Health Consultation-Liaison Nurse’, ‘Psychiatric Consultation-Liaison Nursing’, ‘Liaison Psychiatric Nursing’, ‘Psychiatric Liaison Nursing’, ‘Mental Health Liaison Nursing’ and ‘Liaison Mental Health Nursing’ (Merrit & Proctor 2010). Wand et al. (2015) contend that although MHLN services are well established within emergency departments in many countries, no standardised model of care is applied.



Several studies have outlined the activities which MHLNs perform. Reet & Brendon (2001) found that liaison nurses engaged mostly in clinical work but also administration, supervision, audit, research and education (cited in Callaghan et al. 2003). A study by Sharrock et al. (2001) examining the role and functions of a Psychiatric Consultation Liaison Nurse (PCLN) within a general hospital setting found that the PCLN mainly provided a range of interventions to patients experiencing mental health problems but also performed a consultative service by inputting into broader hospital issues, and provided education and support to colleagues, including guidance on support services to refer patients to. In a later study, Sharrock et al. (2008) again found that PCLNs provided consultation and education to colleagues, a finding that was echoed elsewhere (Roberts and Whitehead 2002). Johnston & Cowman's (2008) exploration of the role and services provided by the PCLN at a rural general hospital in Ireland found that while the PCLN engaged in clinical work, providing mental health interventions to patients and coordinating referrals to other services, the education and de-stigmatization roles alluded to in the literature did not emerge in any distinctive way. Brinkman et al. (2009) described and evaluated a MHLN service based in a rural health centre in Canada. Similar to the other MHLN roles described, the role comprised education, indirect and direct client intervention, and follow up. However other core functions of the role identified included advocacy and building a collaborative culture between the local hospital, medical and mental health clinics, and local community agencies, a form of relationship-building and bridging, referred to as culture brokering. The aforementioned studies and other studies highlighted that patients who self-harmed, attempted suicide, were at risk of self-harm or suicide, or had mood disorders, such as depression, accounted for most of the MHLN's caseload (Tunmore 1994; Sharrock et al. 2001; Roberts and Whitehead 2002; Callaghan et al. 2003; Sharrock et al. 2008; Johnston & Cowman 2008).

Roberts (1997) asserts that MHLN practice is underpinned by a combination of biological, psychological and sociological theories while Merritt and Proctor (2010: p.162) state that the role of the mental health consultation-liaison nurse in Australia encompasses:

‘the bio-psycho-socio-spiritual, cognitive, behavioural, and emotional responses of patients and families’.

It is thought that the value of nurses in a liaison role is that they focus less on the pathology of illness and more on using the interpersonal relationship with patients to provide them with emotional support and experiential learning (Roberts 1997) and to reduce distress and stigma related to mental ill health (Merritt & Proctor 2010). Gaps in the care of patients with chronic illness and neglect of their psychological and emotional needs reinforce the importance of the therapeutic relationship between patients and nurses and its role in the promotion of recovery. This approach is also consistent with a person-centred, partnership and recovery-orientated approach to mental health care which is advocated nationally and internationally (Merit & Proctor 2010; HSE 2012; Mental Health Reform 2013). Several studies indicated that MHLNs utilise therapeutic skill and interpersonal skills when engaging with patients (Hepworth and McGowan 2015), and user evaluations of liaison nurses identify these skills as valuable and important to them (Wand & Schaecken 2006; Eales et al. 2006).

Only one study of a liaison nurse for vulnerable minority groups was identified in this rapid literature review (McBride et al. 2016). It was a pilot initiative at an Australian Hospital which aimed to build capacity within the health sector to more effectively respond to the needs of asylum seekers and refugees by improving cultural competency and access to care. The nurses conducted assessments of the physical, mental and social health of referred individuals and provided clinical support, advocacy, education, referrals, and both formal and informal capacity building. According to the authors the initiative:

‘emphasised that nurses are in a unique and influential position within the acute environment and can support patients through the development of trusting therapeutic relationships, and applying a social determinants framework.’ (McBride et al. 2016: 720).

While the MHLN role doesn’t appear to be well established with ethnic minority groups, the potential for expanding into mental health service provision for populations who are currently underserved is recognised. It is thought that MHLNs could provide improved access to care and specialist care which responds to the specific needs of vulnerable cohorts (Wand & White 2007). In Ireland, the first Traveller Mental Health Liaison Nursing (TMHLN) post was established in Carlow/Kilkenny in 2015 as part of a strategic plan to improve Traveller mental health across a number of key areas, including increasing awareness of mental health; improving access to services; reducing stigma and improving outcomes related to men’s health and suicide (HSE 2015).



# CHAPTER THREE

## METHODOLOGY

### 3.1 Introduction

The aim of this chapter is to present the aims and objectives of the evaluation and the evaluation methodology. It provides an overview of the sample and how they were accessed and recruited. It sets out the procedures for collecting and analysing the data and the ethical issues that emerged as part of the evaluation.

### 3.2 Aim

The aim of this study was to evaluate the role of the Traveller Mental Health Liaison Nurse (TMHLN) and to make recommendations for future role sustainability, development, extension and expansion.

### 3.3 Objectives

- i. To review the original aims of the TMHLN role and to explore how the role has evolved since inception.
- ii. To provide a descriptive account of the role and activities of the TMHLN using qualitative and quantitative data.
- iii. To review the governance structures for managing the work of the TMHLN.
- iv. To explore the mechanisms that the TMHLN has used to engage with the Traveller community and the barriers/facilitators to establish trust with this population.
- v. To explore the role and extent of the TMHLN's engagement with other key stakeholders (including the Traveller Community Health Projects, Traveller Wellbeing Groups, primary, specialist, and voluntary services etc.).
- vi. To explore key stakeholder's (including members of the Traveller community and service users) experiences of and perceptions of the role of the TMHLN.
- vii. To explore the psychosocial stressors and social factors that impact on members of the Traveller community and their role in influencing Traveller engagement with the TMHLN.
- viii. To make recommendations based on the findings from I – VII.

### 3.4 Research Approach

This evaluation used a descriptive qualitative methodology to meet the aims and objectives of the study. While a mixed methods evaluation was originally conceived, as the study progressed it was decided in consultation with the steering group that a purely qualitative methodology was appropriate given the role under review. In addition to the qualitative data, some documentary analysis was also undertaken.

There were multiple stakeholders involved in this research, and some of those stakeholders were considered a vulnerable and hard to reach group. There were ethical and methodological considerations to conducting research with members of the Traveller community. Therefore, the study used a participatory approach which has been advocated in conducting research with minority groups (Brown & Scullion 2009; Wallestein & Duran 2009). The research design was discussed with the steering committee and adapted as per the requirements of the Traveller community in order to achieve the agreed objectives. A peer researcher from the Traveller community was engaged to assist with the data recruitment and collection processes to ensure the cultural congruency of the study, and the study materials and processes.

### 3.5 Access to and Recruitment of Participants

All stakeholders, including, the TMHLN, TCHWs, managers, members of the Traveller community and service users were invited to take part in the evaluation. A list of all key stakeholders was compiled by the TMHLN and agreed with the steering committee. An email was sent to all of the key stakeholders by a gatekeeper informing them of the evaluation and inviting them to take part. Written information about the nature, aims and objectives of the study was given at this point in order for them to make an informed decision about whether to participate or not. They were advised to contact the researchers if they wanted to take part. Depending on the availability of stakeholders, a face-to-face or telephone interview or focus group was conducted.

Travellers who had accessed the TMHLN either through her work with the Traveller Wellbeing Groups or who had met her on a one-to-one basis were also invited to take part. As these can be considered a vulnerable group care was taken to ensure that they understood the purpose of the study and were able to provide informed consent. Gatekeepers were used to access the Traveller participants, and these were the Coordinators of the Traveller Health Project in Carlow and Kilkenny. For those Travellers who attended the Traveller Wellbeing Groups that the TMHLN co-facilitated, focus groups were conducted. For those Travellers who met the TMHLN on a one-to-one basis, individual interviews were conducted. Information sheets were designed to meet the needs of Travellers. To ensure that they were culturally congruent, a peer Traveller researcher reviewed the language and wording of the information and consent forms to ensure cultural appropriateness. In addition, members of the steering committee also reviewed the information and consent sheets to ensure that they were appropriate. The Coordinators of the Traveller Health Projects were asked to go through the information sheets with the potential participants and answer any questions that they had. When the Travellers agreed to take part, information was reiterated at the beginning of the data collection process, and the voluntary nature of involvement was stressed.



### 3.6 Data Collection

Qualitative data were collected using one-to-one interviews and focus groups. The TMHLN was a key informant and was essential in shaping the qualitative data collection processes. Initially, a one-to-one interview was held with the TMHLN to ascertain the key stakeholders who influence the role of the TMHLN. From this, a conceptual map of the key stakeholders was drawn, and plans for further interviews and focus groups were established. The researchers were keen to understand the TMHLN's role early in the process, so they could develop interview guides that corresponded to her role. Topic guides for the one-to-one interviews and focus groups were developed after the interview with the TMHLN and in partnership with the steering committee. A number of guides were developed depending on the stakeholder being interviewed. In total, five interviews were conducted with the TMHLN and there were numerous email correspondence and telephone calls throughout the evaluation.

A total of three focus group interviews were conducted with the Travellers (n=14) who attended the Traveller Wellbeing Groups. These were conducted by members of the research team and were audio-recorded. They lasted from about 30 minutes to one hour in length. Ten participants who attended one-to-one sessions with the TMHLN took part in individual interviews across Carlow and Kilkenny. These interviews also lasted between 30 minutes and one hour. Interviews with members of the Traveller community were conducted at either St Catherine's Community Services Centre, Carlow or O'Loughin Court Community Centre, Kilkenny where the Traveller Health Projects are based. Thirty-seven key stakeholders were identified and were interviewed individually over the telephone or face-to-face, or as part of a focus group.

### 3.7 Data Analysis

Qualitative data were analysed using thematic analysis guided by Braun and Clarke's Analytical Framework (Braun and Clarke, 2006). This involved verbatim transcription of the interviews and focus groups, coding the data, identifying themes and relationships, and identifying differences between various participants. The computer software package NVivo (NVivo 2012) was used to assist in the management and analysis of the qualitative data.

### 3.8 Documentary Review

A documentary review was also conducted to examine the tools, methods and approaches used by the TMHLN, to comment on the appropriateness of their use with the Traveller community.

### 3.9 Ethical Considerations

Ethical approval was sought from the HSE South Eastern Research Ethics Committee. All involved with the study were bound by national and international codes of good practice in research, and by professional standards within their disciplines. The rights and dignity of participants were respected throughout by adherence to models of good practice relating to recruitment, voluntary inclusion, informed consent, privacy, confidentiality and withdrawal without prejudice. The researchers were aware that Travellers are a vulnerable group and as such, need to have mechanisms in place to enable them to fully participate in the research process. The rights of the participants and their wellbeing were given precedence over data collection. Consent was viewed as an ongoing process, which required negotiation throughout all aspects of the study. An information sheet outlining the aims and objectives of the study was given to all potential participants. Both written and verbal consent was obtained before the interviews. The voluntary nature of participation was emphasised throughout the data collection process and participants were free to withdraw from the study at any time without fear of penalty. Similarly, all identifying information was removed from the qualitative data and participants were assigned a code number. In the final report, no reference is made to individual names or locations that could identify the participant. Any information sheets and consent forms etc. developed for use in the project were reviewed by the steering committee prior to their use. In addition, a Traveller peer researcher reviewed the information for Travellers to ensure that it was at a suitable level and culturally congruent. Gatekeepers were used to select potential service users to ensure that only those individuals who were well enough to take part were approached. If service users became upset during the interview, a support mechanism was put in place to ensure that their mental health was not unduly affected. The researchers are experienced clinicians and researchers and were able to provide support in the first instance if the participants became distressed or upset. Additional supports for the Travellers or other participants was not required in this instance. Data was password-protected and stored in accordance with the Data Protection legislation.



# CHAPTER FOUR

## THE ROLE OF THE TRAVELLER MENTAL HEALTH LIAISON NURSE (TMHLN)

### 4.1 Introduction

The aim of this chapter is to present the findings of the evaluation which relate to the role of the TMHLN and this will be described under a number of headings. Where appropriate, quotations from the interviews will be used to illustrate the points being made. In doing so, identifying information has been removed to maintain the confidentiality of the participants. A discussion of the findings will be presented in Chapter Seven which will also include the recommendations that have emerged in response to the findings.

### 4.2 Profile of the Traveller Community in County Carlow and County Kilkenny

According to the CSO (2017), there were 507 Travellers living in County Carlow and 554 Travellers living in County Kilkenny (total n=1061). This was an increase of 22.7% from the 2011 census report when there were 413 Travellers living in County Carlow. There was a 14.6% (n=483) increase in the number of Travellers living in County Kilkenny from 2011 to 2016. The number of male and female Travellers living in Carlow and Kilkenny is shown in Table 4.1.

	Carlow	Kilkenny
Male	253	284
Female	254	270

Table 4.1: Male and Female Travellers in Carlow/Kilkenny (CSO 2017)

The total number of Travellers can be further divided into the number of Traveller families which is calculated by the Department of the Environment. The last report that could be located on the Department's website was from November 2016. There were 90 families altogether in County Carlow and 120 in County Kilkenny. The vast majority of the Traveller families were living in local authority supported housing in both Carlow and Kilkenny. Both counties have a Traveller Health Project which is made up of a team of TCHWs who are overseen by project coordinators. Both Traveller Health Projects are governed by voluntary organisations but receive funding from the HSE (St Catherine's Community Services Centre, Carlow and The Kilkenny Leader Partnership, Kilkenny). The area is managed by the Social Inclusion Officer (Regional Traveller Health Coordinator HSE South East Community Healthcare). In addition to the TMHLN, there is a PHN for Travellers and a Traveller Men's Health Worker all of whom provide services across both counties. There is also The Kilkenny Traveller Community Movement and the Carlow Traveller Network both of which are Traveller-led community development fora.

### 4.3 Description of the Sample

The main source of data for this evaluation were key stakeholders including members of the Traveller community. A description of interview and focus group participants are displayed in Table 4.2 and Table 4.3 respectively. In total, we interviewed 10 service users who had accessed the TMHLN on a one-to-one basis across Carlow and Kilkenny. In addition, we conducted three focus groups with Travellers who attended the Traveller Wellbeing Groups facilitated by the Traveller Health Project (Carlow, n=2; Kilkenny, n=1) all of whom were women.

	Carlow	Kilkenny
Male	1	3
Female	5	1

Table 4.2: Number of Participants in Individual Interviews Conducted in Carlow and Kilkenny

	Carlow	Kilkenny
Wellbeing Focus Group 1	4	5
Wellbeing Focus Group 2	5	

Table 4.3: Number of Participants in each Focus Group Conducted in Carlow and Kilkenny

In addition to the individual interviews and focus groups, the evaluation team spoke to key stakeholders who were identified by the steering group as key informants for the evaluation. An overview of the key informants is presented in Table 4.4. To protect the confidentiality of the informants, limited information is provided about their roles and locations. In addition to the stakeholders listed, numerous consultations were held with the TMHLN.

Key Stakeholder	Individual Interviews	Focus Groups
Traveller Health Project	7	2 (n=4x2)
Social Inclusion	3	
Mental Health Nursing	3	2 (n=2x2)
Family Support	3	
County Council	3	
Substance Misuse		1 (n=2)
Youth Service	1	
Suicide Prevention	1	
Women's Aid	1	
Voluntary Organisation	1	
Total	23	3 (n=14)

Table 4.4: Number of Key Stakeholders who Participated in Individual Interviews and Focus Groups



## 4.4 Working with the Traveller Community in the Carlow/Kilkenny Area

Working with the Traveller community was described by the stakeholders as complex; many Travellers presented with multiple problems, and this meant that working with the community could be challenging in terms of the range of problems that could be presented. Throughout the interviews with the TMHLN and the key stakeholders were descriptions of the difficulties that the Traveller community had from socioeconomic and mental health perspectives. Housing and finances were the two main problems that existed from a socioeconomic perspective and many of the problems that existed emerged from these. While many of the Travellers were living in houses, some had difficulties with their landlords or had problems that needed attention within the houses. Unemployment was perceived as a huge problem and this not only caused difficulties from a financial point of view, it also meant that Travellers were less socially integrated with the wider community. Some Travellers were living on halting sites, and these had very poor conditions in terms of location and the essential services provided to them, as opposed to conditions within the caravans themselves. However, large families were housed within these caravans which meant that there was a lack of living space and privacy. Drug and alcohol problems were frequently mentioned; while alcohol misuse was more prevalent, there was a perceived emergence of drug misuse within the Traveller community, especially in Carlow. The challenges of stigma and discrimination faced by the Traveller community were also mentioned by the TMHLN and key stakeholders. Lower levels of literacy was also frequently mentioned as an issue affecting Travellers' mental health and affected them from help-seeking and self-care perspectives. Fear and mistrust of the health services, particularly the mental health services, was frequently mentioned throughout the interviews with key stakeholders, and these affected Travellers' level of engagement with health and mental health services.

There were a number of Traveller community-related characteristics described by the stakeholders, and these sometimes made it difficult to engage Travellers from a mental health perspective. The TMHLN described how Travellers often lived 'chaotic lives', filled with stress, especially women. Many of these stresses emerged in response to some of the socioeconomic factors that have been mentioned earlier. The Travellers that the TMHLN and other key stakeholders encountered often had difficulty describing their needs or had poor mental health literacy. This meant that even when they visited the general practitioner (GP), they were unable to articulate their concerns. For example, if Travellers received a prescription, they often had difficulty understanding what the medication was for or how it worked. Adherence to health instructions and medications was also hampered by poorer literacy levels for example, medications were sometimes stopped after a short period because they were perceived as not working. The TMHLN and key stakeholders, including the Travellers themselves talked about suicide and self-harm, and there was an acute awareness among the stakeholders how this disproportionately affected the Traveller community, especially men. There was also discussion about how suicides were felt throughout the community and how they impacted on Travellers and often resulted in complex grieving reactions for the relatives and friends of the deceased.

Although a job description existed, the TMHLN described her role as evolving. The TMHLN was given considerable scope at the start to develop the role in a flexible and responsive way. This flexibility was seen as important as it allowed the TMHLN to forge relationships with the Traveller community and key

stakeholders within the area. The TMHLN's prior experiences working in the community, specifically with families and disadvantaged groups, provided her with a knowledge and understanding to base her work from. There was a sense that the TMHLN felt that she was on a journey and that the role that was emerging was being co-created with the Travellers who were using the service.

In the area of mental health, Travellers are on a journey, and I am on this journey with them. I am pioneering something completely new to the Traveller community. I am learning as I go and have learned so much. I am doing clinical work and also education and mental health promotion. [TMHLN]

From the outset, in practice there was a move away from describing the nurse as a mental health or psychiatric nurse because it was perceived that these terms had negative connotations and were stigmatised among Travellers. This happened early in the initial development of the role when the TMHLN was orientating herself to her work. The title 'Wellbeing Nurse' emerged as an alternative title and was deemed more suitable given the nature of the role, as it was felt that Travellers would relate more to it. In addition, the title adequately reflected her role, given the strong emphasis on wellness, recovery-orientated interventions, and the relationship between physical and mental health. While the TMHLN could have just referred to herself as a 'nurse', she was keen to differentiate herself from the PHN for Travellers in terms of role function and to minimise confusion.

Travellers know me as the Wellbeing Nurse, and it is important that they are not confused between my role and the PHN, which can happen at times. [TMHLN]

Mental health and mental illness were also poorly understood, and in discussion, these terms were often used interchangeably by Travellers. There was a perception by the TMHLN and other stakeholders that engagement with the community might be made more difficult were they to use these terms. There was also a view that Travellers were suspicious of services delivered by the settled community, and in some cases were particularly fearful of the mental health services and lacked understanding of the role of the mental health services.

#### **4.5 Building Trust and Creating Relationships with the Traveller Community**

There was an awareness that building trust and developing relationships was key to engagement with the Traveller community. The experience and skills that the TMHLN brought with her to the role were central to developing relationships and being able to work effectively with Travellers. This was mainly put down to her experience of interagency working which supported work with Travellers. In addition, the TMHLN's experience of working with families was also perceived as an asset. Years of experience as a Mental Health Nurse employed in acute psychiatry was also described as important preparatory work for the role. However, there was a sense that while these experiences provided some preparation and groundwork for the role, one had to 'go through it' in order to understand what the role involved and how to do it. This is exemplified in the following quotation:

I think for me; my professional background was very helpful in developing this post. The post was created, and without a template to work from, so it was learn as you go. In that way, it was a different experience. [TMHLN]



While the job description offered some guidance as to the role of the TMHLN and the activities she was to engage in, the reality was different and was very much based on the context and situation that she found herself in. This was perceived as being of particular importance if the role is to be rolled out in other parts of the country and how the success of the role is contingent on building relationships with the Traveller community as a solid foundation for engagement.

But I suppose the way the post is set up, and again like, when I started there was no template there was no nothing. It was very much, there is your job description. [TMHLN]

There was also an awareness that the role might develop over time and that it was important to view the role through a wide lens:

Following my own experience of setting up this post, I am now in a position to support the development of other posts. However, while a template is now there, any other posts will need to be built on trust as the key ingredient and foundation. [TMHLN]

The Traveller Health Projects, in particular, the TCHWs and the Men's Health Worker were key to helping the TMHLN forge links with the community through their outreach work. They were able to tell Travellers about the work the TMHLN was doing and encourage attendance at the Traveller Wellbeing Groups in Carlow or Kilkenny, or advise Travellers to meet with the TMHLN on a one-to-one basis.

#### 4.6 Creating a Comfortable Space

Creating a space where Travellers felt comfortable was discussed throughout the interviews with the TMHLN, and once relationships and trust were established, they were not taken for granted and needed to be considered continually. This was made easier in St Catherine's, Carlow, where a number of Traveller Wellbeing Groups established by the Traveller Health Project had been up and running for a number of years and were generally well attended by Traveller women. In Kilkenny, the Traveller Wellbeing Groups were not as well established, and attendance was not as reliable as in Carlow. However, they offered the TMHLN an opportunity to engage with Travellers and deliver health and wellbeing messages within a comfortable environment. Within the Traveller Wellbeing Groups, a creative activity was often used as a medium to facilitate comfort, as is described in the following quotation.

I introduce creative activities to help engage Travellers, which supports shoulder-to-shoulder working. This helps people to sit and relax, and they are more open and can listen and engage well. [TMHLN]

However, this comfort was not limited to the Travellers. It was important that the TMHLN felt comfortable herself and this was also important in creating a comfortable space.

When I am comfortable in the space I work from that really helps to create a relaxed atmosphere. One of the workers made a comment that when I am relaxed, they all relax too. [TMHLN]

The TMHLN's prior experience in community development and being used to going into family homes contributed to this feeling of comfort. There was a sense that over time and with experience, the TMHLN

was able to build up a set of skills that were transferable to working with the Traveller community. Central to this was the ability to work in a non-threatening and respectful way. In addition, the TMHLN had also worked with Traveller families in Carlow within a family support context. When she started the position, she had already worked with some of the families, and this went a long way in terms of her ability to engage with the community and facilitate trusting relationships.

My years of experience of working out in the community has supported me to feel comfortable in that space and outreach work is an important part of the job to support engagement. [TMHLN]

When discussing her role, the word ‘complex’ was used frequently and consistently throughout the description of her experiences. The complexities emerged from the range of social factors that impact on the Traveller community and is highlighted in the following quotation from the interviews:

Travellers lives are often very stressful with so many issues to deal with, and they score poorly under the overall social determinants of health. They deal with many issues day-to-day; e.g. housing, parenting, health worries, and all these impact on mental health. [TMHLN]

While on the surface the interventions and approaches appear simple, this was not the case, and the TMHLN needed to view everything through a Traveller lens. This meant every intervention needed to be considered from a number of perspectives as is highlighted in the following quotation:

Travellers often present in crisis and need practical help and support, e.g. suggesting that they go to the doctor. That can be simple enough for me or you, but sometimes it can be a challenge for Travellers. They may not have a medical card or a GP. They may not feel comfortable to arrange an appointment or know what to tell the GP when they get there. [TMHLN]



## 4.7 The Work of the Traveller Mental Health Liaison Nurse (TMHLN)

### 4.7.1 Demographic Characteristics of Service-Users Accessing the Traveller Mental Health Liaison Nurse (TMHLN) Service

The TMHLN worked across counties Carlow and Kilkenny, rotating between the two. The TMHLN had access to office space at St Dymphna’s Hospital in Carlow, but rooms were made available in other centres as required. The main areas where the TMHLN practised are listed below in Table 4.5 and are highlighted in the map of the two counties (Figure 4.1).

County Carlow	County Kilkenny
St Catherine’s Community Services Centre, Carlow	Kilkenny
Tullow/Ardristian	O’Loughlin Court/Hebron
Bestfield	St Catherine’s Avenue (Wetlands Halting Site)
	Callan
	Rosbercon

Table 4.5: List of Areas where the Traveller Mental Health Liaison Nurse (TMHLN) Practiced in Carlow and Kilkenny



Figure 4.1: Map of Carlow and Kilkenny Identifying the Geographical Areas Where the Traveller Mental Health Liaison Nurse (TMHLN) Practiced

The number of Travellers who accessed the TMHLN in Carlow and Kilkenny in years one and two are presented in Table 4.6. Between year 1 and year 2 the number of referrals to the TMHLN increased by more than two-fold. Twenty Travellers accessed the TMHLN in year one and 58 accessed the services in year 2.

	Carlow	Kilkenny
Year 1	12	8
Year 2	40	18
Percentage Increase	233%	125%

Table 4.6: The Frequency and Percentage Increase In Referrals to the Traveller Mental Health Liaison Nurse (TMHLN) in Years 1 and 2

The gender breakdown of Travellers who accessed the TMHLN is presented in Table 4.7. Overall, the TMHLN saw more women than men in years 1 and 2.

	Male	Female
Year 1	9	11
Year 2	14	44
Total	23	55

Table 4.7: Number of Referrals to the Traveller Mental Health Liaison Nurse (TMHLN) by Gender in Years 1 and 2

The age profile of the Travellers who accessed the services is presented in Table 4.8.

	Year 1	Year 2
18-20 years	0	2
20-30 years	5	20
30-40 years	4	18
40-50 years	8	14
50-60 years	3	4

Table 4.8: Age Profile of Travellers Accessing the Traveller Mental Health Liaison Nurse (TMHLN) in Years 1 and 2

#### 4.7.2 In-Reach and Outreach Activities

The TMHLN's role could be broadly classified into in-reach and outreach roles, with a liaison role transcending both components. The TMHLN's in-reach work centred on maintaining links and providing mental health and wellbeing support to Travellers who were already attending or involved with the Traveller Health Projects. Outreach work involved establishing links with Travellers who were



outside the health projects and encouraging them to access support. In the TMHLN's in-reach and outreach work, encouraging access to and use of mainstream primary care or mental health services were primary objectives. In both cases, the work was supported by the Traveller Health Projects in Carlow and Kilkenny. While the TMHLN was not attached to any one mental health or primary care service, her role crossed the two counties. For some Travellers, she offered advice and support to manage current stressors to prevent further deteriorations in mental health. For other Travellers, where necessary, referrals were made to the mental health services through primary care, or links were re-established if the individual had previous contact with the mental health services.

### 4.7.3 Traveller Wellbeing Groups

The TMHLN worked with groups of Travellers in the Traveller Wellbeing Groups, and also with individual Travellers in one-to-one sessions. As mentioned, Traveller Wellbeing Groups were already in place in Carlow, and they were also being set up in Kilkenny although they were not as firmly established there. The TMHLN ran wellbeing-themed workshops as part of the Traveller Wellbeing Groups. The workshops were tailored to meet the needs of the Travellers attending and often centred around upcoming events that were known to be stressful. For example, the data for this evaluation were collected in November and December, and consequently, the workshops were about getting through the Christmas period which the Travellers found extremely stressful.

I run wellbeing themed workshops at the project and on the sites. I try to pick a relevant topic, e.g. 'surviving the Christmas season' or 'managing stress over the school holidays'. It is focused on a few simple messages and practising a little bit of mindfulness during the workshop. [TMHLN]

The Traveller Wellbeing Groups were run in a very informal way and were flexible and responsive to the needs of the individuals attending. There was recognition that many of the Travellers 'had a lot going on' and this had to be considered when facilitating the groups. The Traveller Wellbeing Groups were mainly attended by Traveller women, and the TMHLN was acutely aware that they had little, if any time to themselves during their day-to-day lives. Consequently, the workshops offered an oasis of calm and a break from the stresses and strains associated with Traveller life. As mentioned the Traveller Wellbeing Groups usually included an activity such as a craft of some sort and this helped the women relax and facilitated engagement. Wellbeing messages were then delivered, and these were generally simple strategies to promote mental health and were inspired by the HSE's 'Little Things' campaign or other wellness strategies.

Within the Traveller Wellbeing Groups, Travellers were also given the opportunity to practice wellbeing strategies such as relaxation techniques, and they were encouraged to practice these when they went home. The wellbeing messages were consistently repeated, and their importance was reinforced. The Travellers were repeatedly told the importance of taking some time out for themselves and recognising when they were under pressure. The TMHLN stressed the importance of repeating the wellbeing messages, as issues such as poor concentration and problems with literacy adversely affected the comprehension and retention of information by the Travellers who attended.



In addition to wellbeing messages, there was an additional mental health education piece that focused on helping Travellers to understand the nature of mental health and the factors that positively and negatively affected it. This was linked to the wellness strategies that were discussed in the Traveller Wellbeing Groups and emphasised the holistic nature of wellbeing which incorporates physical and mental health. These sessions were often based on a presentation of visual images that used pictures to help Travellers to make connections between the stresses in their lives and how they were feeling. These sessions were kept short and minimised the use of text to encourage discussion about the things that might cause stress in a person's life, with a particular emphasis on the things that most affected Travellers. For example, a picture of a woman who appeared deep in thought would be displayed, and the group were asked to think about what she might be thinking about or what might be bothering her. Questions were framed using references to stressful life events and strategies that could be used to help manage or reduce the impact of stress. As before, the messages were repeated and were often related to specific time points that were known to be stressful such as Christmas or when children were returning to school.

#### 4.7.4 One-to-One Services

Travellers were typically referred from a variety of sources for one-to-one sessions with the TMHLN, and these are presented in Table 4.9. Many who attended the Traveller Wellbeing Groups got to know the TMHLN and requested to see her on a one-to-one basis themselves. Others were referred by the TCHWs or the Traveller Health Project Coordinators with the Travellers permission. They were also referred by the PHN for Travellers or one of the other agencies that the TMHLN worked closely with. Once referred to the TMHLN, the person was usually contacted within a week, or an appointment was made via the referral agent to meet the Traveller at the drop-in centre at the Traveller Health Projects. At the time of report, there was nobody on the waiting list to see the TMHLN.

Source of Referral	Year 1	Year 2
Self-Referral	5	15
Family Member	8	5
GP/Community Services	2	8
PHN for Travellers	1	1
Traveller Health Projects	4	29
<b>Total</b>	<b>20</b>	<b>58</b>

Table 4.9: Sources of Referral for One-to-One Consultations with the Traveller Mental Health Liaison Nurse (TMHLN)

The Travellers presented to the TMHLN with a range of needs following referral. Relationship issues and previous history of mental health problems were the most common needs at referral. An overview of the primary presenting needs at the point of referral is presented in Table 4.10.



<i>Primary Presenting Need</i>	<b>Year 1</b>	<b>Year 2</b>
<i>Housing</i>	1	9
<i>Complex Relationship Issues</i>	6	10
<i>Addiction</i>	3	4
<i>Bereavement and Loss</i>	4	19
<i>History of Mental Health Problems</i>	6	16
<b>Total</b>	<b>20</b>	<b>58</b>

Table 4.10: The Primary Needs of Travellers Presenting to the Traveller Mental Health Liaison Nurse (TMHLN) at the Point of Referral in Years 1 and 2

In one-to-one sessions, the TMHLN used an approach similar to that in the Traveller Wellbeing Groups, but the interventions were more complex. An overview of the various interventions used by the TMHLN are contained in Table 4.11.

<i>Type of Intervention Offered</i>	<b>Year 1</b>	<b>Year 2</b>
<i>Listening and Support</i>	20	58
<i>WRAP/Self-Care Support/ Brief Intervention</i>	20	58
<i>Link Person Back to the Mental Health Services</i>	4	14
<i>Referred/Advised to See GP</i>	12	13
<i>Advocacy</i>	5	9
<i>Referred/Linked to Commu- nity Support</i>	4	5

Table 4.11: Type and Frequency of Interventions Offered to Travellers Presenting to the Traveller Mental Health Liaison Nurse (TMHLN) in Years 1 and 2

For the most part, the TMHLN met with the individuals in either St Catherine’s Community Services Centre or O’Loughlin Court where the Traveller Health Projects were based. However, she did see some people in their own homes. The sessions began with the creation of a comfortable environment and reassurances about confidentiality. Explanations were provided to the individuals about the TMHLN’s role and what they might talk about. Consent was negotiated and was either signed or verbally agreed, and this consent provided the TMHLN with permission to keep some records about the person. In addition, the limitations of the confidentiality were explained for issues such as child protection. Negotiating consent and introducing any official forms were a huge concern for the TMHLN, as it was suggested that Travellers were suspicious of forms. This was partly to do with Travellers’ poorer literacy levels, and this meant that any forms or work had to be adapted to meet their needs. In addition, any forms or paperwork had to be introduced slowly and carefully. This was described by the TMHLN as ‘pacing’ which was a term also used to describe how the TMHLN worked with the Travellers more

generally. This approach was considered essential; the TMHLN was careful that she introduced things slowly, building up trust before introducing more complex interventions or additional professionals, and not acting too quickly or compromising the trust that she had developed. While the TMHLN felt that this was a suitable approach, it meant that working with Travellers was very time-consuming.

While an assessment was completed, it was conducted in a less formal way to maintain a comfortable and non-clinical atmosphere. At this point, one of the most important activities was allowing the person to talk about the issues that affected them and actively listening to their concerns. Many of the Travellers just needed to 'off-load' and didn't require additional interventions beyond this. For others, active listening helped the person to prioritise the issues that were affecting them; it also helped them to put things in perspective and explore the options that were available to them. At this point, advice, guidance and support were offered and the person was either signposted to a service that might be able to help or referred to primary care.

When a woman comes to meet me, I will listen to her worries and provide support. Sometimes I am limited as to what I can do. I aim to help this woman to problem-solve and identify what she needs at that moment in time. I can signpost on when that is required also. [TMHLN]

Practical support was also provided, making appointments with a third party for the Traveller and supporting them to attend. Many of the Travellers who attended the TMHLN on a one-to-one basis presented in crisis, so some of them were overwhelmed by the time they came into contact with her. Therefore, the TMHLN described techniques to help de-escalate the situation. In these situations, where multiple problems often co-exist, attempts were made to identify the most urgent need at that point and to provide assistance to address needs via liaison and signposting. In addition, opportunities were explored for self-care and strategies that the person might be able to use to promote wellbeing. Where necessary, more urgent referrals were also made.

I listen to the issues and provide empathy and acknowledge the stress levels when I meet Travellers. Sometimes I suggest self-care while Travellers are managing issues that are long-term and not easily fixed. My response depends on the needs presented, and when a person presents in crisis I respond appropriately by linking with the GP and supporting a more urgent response. [TMHLN]

Within the one-to-one sessions, health and wellness messages were also reiterated, and relaxation techniques were also practised. The approach that was described within the one-to-one sessions was referred to as a 'wrap-around approach'. The wrap-around approach drew inspiration from solution-focused brief interventions, family work, recovery-orientated approaches with an emphasis on Wellness Recovery Action Planning (WRAP) and crisis intervention work where necessary. The approaches that were used were mainly influenced by the TMHLN's prior experiences of working with people in the community including members of the Traveller community. Solution-focused brief interventions were considered suitable as they were goal-directed, focused on the present and the future and were person-centred. This approach offered an opportunity for the Traveller to prioritise presenting issues and was useful to help engagement in the short term.



A brief intervention can work well for some and can de-escalate issues and help to problem-solve, which can often be sufficient. [TMHLN]

Family work was central to the ‘wrap-around approach’ where the TMHLN was not only able to work with the individual but their family as well. While families and children were important to Travellers, and often central to their support network, they were also sources of stress, particularly if there were problems with alcohol or drug misuse, or intimate partner violence. While not described as ‘family therapy’ this work used some of the core skills associated with family therapy and focused on exploring the relationships between family members and signposting them to appropriate services where necessary.

Wellness Recovery Action Plan (WRAP) was also heavily drawn from in one-to-one sessions and Traveller Wellbeing Groups, and the TMHLN had undergone training to facilitate WRAP. The TMHLN believed WRAP was a useful toolbox, as it was easy to use and many of the concepts and approaches within the plan were strengths-based. In addition, many of the approaches were easily adaptable to meet the needs of Travellers where necessary. However, WRAP was used in an eclectic fashion where strategies were used to meet the needs of the individuals, rather than the plan being implemented in its entirety. Nevertheless, some of the Travellers did attend the 2-day course for completing their own WRAP. For some of the service users, one session with the TMHLN was enough to get the support they required or to prompt contact with the health or social agency that they needed. The holistic nature of the interventions is demonstrated in the following quotation.

Travellers present with many different issues and require an assessment of their needs to identify the best approach. If the need is a housing or social welfare issue, I can refer to the projects to provide supports. Mental health is greatly impacted on by many issues, leading to chronic stress and anxiety for Travellers, so a wrap-around service is most helpful to make a positive impact. [TMHLN]

For others, a more intensive intervention was required, and the TMHLN described instances where she continues to see people even after two years.

Some people require more intensive longer-term supports and will access my service regularly. I am limited to what I can provide at times due to the geographical area I cover as a lone worker. Many Travellers juggle many complex issues and can be reluctant to engage with services. [TMHLN]

There was a sense that this level of engagement emerged in response to the trust that the service user placed in the TMHLN, where they began to ‘trust in the process’, and the opportunity to engage in therapeutic activity. Many of the Travellers who met with the TMHLN, never had the chance to talk about their experiences and the difficult circumstances that they had sometimes encountered as they grew up.

Travellers have related that they never speak about their problems or it can often be the first time that they have spoken to anyone before now. They can disclose many issues from their troubles growing up and their current journey where life got more difficult. It is



important to support Travellers who disclose issues to be able to manage and cope with many complex feelings that disclosure can trigger. [TMHLN]

Outreach happened in a similar fashion where individuals were referred to the TMHLN in a similar way. In this instance, arrangements would be made to visit the person in their own home if they were unwell or unable to come into one of the community centres. The TMHLN would visit the individual accompanied by either the PHN for Travellers or the Men's Health Worker. In the Traveller's home, similar interventions to those used in one-to-one sessions took place. However, within the home, the TMHLN could assess living conditions and liaise with appropriate services where necessary. In addition, the TMHLN could provide assistance to other family members who were experiencing distress. In many cases, family members were also contributing to the stress experienced by the individual. As well as outreach work with individuals, the TMHLN also conducted Traveller Wellbeing Groups in some of the areas where Travellers were located. For example, a Traveller Wellbeing Group was organised and delivered in St Catherine's (also known as Wetlands), Callan and Rosbercon.

#### **4.8 Governance of the Traveller Mental Health Liaison Nurse (TMHLN) Role**

There is a Joint Management Structure between the Social Inclusion Office and the Mental Health Division which oversees the work of the TMHLN. In practice, this means that from a human resources perspective the TMHLN directly reports to the Regional Traveller Health Coordinator (Social Inclusion Office) for the HSE South East Community Healthcare area. From a clinical nursing perspective, the Social Inclusion Office is supported by an Assistant Director of Mental Health Nursing who is located within the Carlow/Kilkenny area. The TMHLN meets with both the Social Inclusion Office Traveller Health Lead and the Clinical Lead regularly. Funding for the TMHLN comes through the Social Inclusion Office which locates the TMHLN within the primary care services. When the post was originally conceptualised, and funding sought, there was an awareness that although this position was not located within the mental health division, it was a nursing position and required governance from a nursing perspective. Therefore, the Mental Health Nursing team were involved from an early stage, supporting the writing of the job description and the recruitment process. In addition to this arrangement, the TMHLN has an external clinical supervisor who she sees every four to six weeks; however, this person has no governance function. There is recognition that this is a non-traditional governance arrangement where the TMHLN does not fit within a community mental health team and the governance arrangements that emerge from that. It was suggested that this was not a common governance arrangement in Ireland presently. The Governance arrangements are explained in the following quotation from one of the key stakeholders.

So, I suppose, from a governance point of view, [TMHLN] comes to me with clinical issues and reports clinical issues and clinical difficulties, challenges and clinical priorities, which she plans for the upcoming quarter. [Key Stakeholder 22]

While there were some mixed feelings about the governance arrangements expressed by the key stakeholders, it was generally perceived as a successful arrangement from those who were aware of



and involved in the governance structures. On one hand, the Social Inclusion governance structure provided support and expertise in the area of community development. In addition, it allowed direct access to the Traveller community through the Traveller Health Projects which were linked to the Social Inclusion Office via the regional Traveller Health Lead. This also meant the TMHLN had access to a wealth of expertise in the area of Traveller health and direct links with key personnel in the area. The responsible person from the Social Inclusion Office had a wealth of experience working with Travellers and a particular interest in mental health; this combination was advantageous to the role of the TMHLN.

So, while we had them [Mental Health Nurses] around the table that wasn't enough, in terms of governance. So, we contacted [Director of Nursing], [General Manager for Mental Health]. [The Director of Nursing] and we said, look we sought the clinical nursing governance. Because without it we couldn't employ a nurse. So, therein became that structure. I was the operational day-to-day line manager. I give direct support and supervision regarding the whole community development area, and my experience of working with and learning from Travellers; I ensure that time sheets and day-to-day management and policies and procedures and everything is followed. In terms of the operational bit it is the ADON [Assistant Director of Nursing], who is the clinical nursing governance. [Key Stakeholder 6]

On the other hand, there was also clinical nursing governance from a senior nurse manager who provided support from a clinical and operational perspective. In addition to formal meetings with the nurse manager, he was available for informal conversations on the telephone as issues emerged. There was a sense that a traditional Mental Health Nursing governance framework would not be suitable given the role of the TMHLN and the emphasis on the promotion of mental health within the Traveller community. Coupled with this was a desire to keep the role of the TMHLN separate from the role of Community Mental Health Nurses who already had members of the Traveller community as part of their caseloads. In addition, the original conceptualisation of the role firmly situated the TMHLN within primary care. Therefore, one of the central aims of the TMHLN role was to keep Travellers within primary care, and only refer them to the mental health services and facilitate access when required. While the TMHLN worked exclusively with Travellers, her role was partly to facilitate access to the mainstream services which is part of the role of the National Office for Social Inclusion. There was a fear that a traditional nursing governance structure might impinge on the role of the TMHLN where she might become the Community Mental Health Nurse for Travellers who were already known to the mental health services. It was clear from the interviews with the stakeholders who led the initiative that this was not what was wanted or needed.

While the TMHLN is separate to the mental health multidisciplinary team based in Carlow and Kilkenny, it was suggested that there was close contact between the two. In addition, as there were a number of multidisciplinary teams working in the area, membership of one or more may have either stifled the role of the TMHLN or might have created an administrative burden. The TMHLN has a desk in St Dymphna's Hospital where it was perceived that cross-over activities occurred. In addition, there was awareness of the role of the TMHLN and the boundaries of the role, including the interface between the multidisciplinary team and the TMHLN. As mentioned, there were some concerns

about the governance arrangements expressed by some of the stakeholders, but overall there were good working relationships between the TMHLN, the Social Inclusion Office and the Mental Health Nursing Division. The inclusion of an external clinical supervisor who the TMHLN met regularly was also positively received and was necessary; given the role of the TMHLN and the complexity of the community that she catered for. It was also recognised that working with the Traveller community could be very stressful and that staff retention and burnout was an issue that could potentially affect the sustainability of the role if not carefully managed. While the external clinical supervisor did not provide a direct governance role, he did form part of a tripartite arrangement of supports; providing a restorative piece for the TMHLN which complemented the educational and managerial functions that the others fulfilled.

There were some challenges associated with the current governance structure identified by the TMHLN, the Mental Health Division and the Social Inclusion Unit. It was recognised that the current structures work most of the time, but there were times when the TMHLN felt that there needed to be clearer protocols to support the current governance structure. From conversations with the TMHLN, these concerns emerged in response to incidents that had occurred; there was a sense that she felt a vulnerability in terms of the boundaries of her role, and what she believed she could and could not do. This caused her to question the governance arrangements and to ask herself were these enough? Central to these concerns was the safety of Traveller service users, the boundaries of her role and her professional responsibilities as a registered nurse. These concerns are perhaps made clearer in the following quotations:

I have a clear understanding of my role and manage the work within the role most of the time with a level of ease. When Travellers present in crisis, I respond and can de-escalate many situations. However, when a Traveller requires an urgent assessment by the Mental Health Service and is not a current service user of the services it can be a challenge. I have no direct links with the service so will signpost to the GP. Should the person not follow up with the GP it can be a concern. I am often the first port of call for concerned family members. [TMHLN]

In some families, there may be no protective factors to support a Traveller who becomes very unwell. This, coupled with a reluctance to seek help, is a concern and increases risk. [TMHLN]

These concerns appeared to reinforce a sense of isolation that the TMHLN felt as she was not part of a multidisciplinary team and spent considerable time working alone. While it was recognised that the TMHLN has supports in her day-to-day practice, there was a perception that these professionals were not Mental Health Nurses and she didn't have the scope to sound out ideas or concerns within a mental health nursing context. From the interviews, it appeared that a closer connection with other Mental Health Nurses was required but how this could be achieved was not clear.

As a lone Mental Health Nursing post worker, I have very limited peer support on a day-to-day basis. The clinical governance is provided by a senior management post. I work with many different professionals who are very supportive but are not Mental Health Nurses, so the space to reflect on specific issues or challenges that support best practice is missing.



I can access my clinical governance as required, when available; but may not discuss day-to-day issues as they arise, leading to a sense of isolation at times. [TMHLN]

As mentioned, there was recognition that the current governance arrangements needed to be strengthened, and at the time of writing these were under review.

I am the Traveller Mental Health Nurse; I am a nursing post, a clinical responsibility for people and if they are not willing to go on my kind of advice and they don't follow through, and if something untoward happened to that person, they decided they have had enough, and they die by suicide. The ultimate where would I be, standing on that; I would keep notes and I would do my records, and I do everything, but I mean at the end of the day is it enough? [TMHLN]

#### **4.9 The Role of the Carlow/Kilkenny Traveller Mental Health Advisory Group**

The Mental Health Advisory Group was established in 2012, and they are a group of stakeholders who have an interest in the promotion of mental health among Travellers. While personnel have changed over time, it was the original advisory group that applied for funds to initiate the TMHLN role from the St Stephens Green Trust in 2014. Terms of reference for the group are detailed below:

1. To appropriately raise awareness and break down barriers within the Traveller community of existing supports available to those with mental health issues.
2. To improve access for Travellers to existing mental health services
3. To educate existing support groups on Traveller mental health issues, e.g. provide Traveller Cultural Awareness Programme.
4. To identify gaps that may exist in the existing service provision.
5. Meet four times a year on task-orientated mental health projects/initiatives for Travellers.

We interviewed all members of the Traveller Mental Health Advisory Group; they talked about the meetings that they had and the structure of the group. The original advisory group came together to look at how Travellers could be better supported to access the mental health services. It was decided early that a mental health outreach worker would be employed if the advisory group were able to access funds to support it. The Regional Traveller Health Coordinator facilitated a focus group with Travellers from the region (the Regional Traveller Health Network) to ascertain their needs and issues when it came to accessing services for their mental health on behalf of the advisory group and this made up part of the original application to the St Stephen Greens Trust. The advisory group has remained in place since, and the terms of reference have not changed. Regular meetings occur and provide a forum to share information and provide support for the TMHLN. The role of the advisory group is described in the following quotation:



Well, it was to, as I understood it, was to support Travellers in whatever way we could around mental health and to look at that as a group as to what can we all pull together on this, you know because everybody was off doing a little bit here and there. But to sit down together and see what is the most effective way of using our time, as well as everything else because resources are so limited and with the Travellers, asking what do you need like? What? And that is where the role came from was what is the need and what how can we go about, do you know, bridging that gap. [Key Stakeholder 7]

However, since the TMHLN was appointed, there is recognition that the role of the Mental Health Advisory Group could be strengthened which is highlighted in the following quotation:

The Mental Health Advisory Group, it was Carlow Kilkenny Mental Health Subgroup of the Traveller Health Unit. Then when the [TMHLN] came on board, I think it ended up being called the Advisory Committee. It's a reporting structure really. [TMHLN] comes in and she gives her updates, and we discuss issues and look at potential solutions. I do think it could be strengthened. [Key Stakeholder 6]



# SERVICE USER'S PERCEPTIONS OF THE TRAVELLER MENTAL HEALTH LIAISON NURSE (TMHLN)

## 5.1 Introduction

As part of the evaluation, we spoke to ten Travellers who met with the TMHLN on a one-to-one basis. In addition, we completed three focus groups with Traveller women who had worked with the TMHLN through their attendance at the Traveller Wellbeing Groups that were run by the Traveller Health Projects. The aim of this chapter is to present the findings from those interviews with service users.

## 5.2 Factors affecting Traveller Mental Health

In the individual interviews, the service users described the issues that affected them and the reasons that they had consulted with the TMHLN. Some of the service users had pre-existing mental health problems that were being treated by the mental health services. While the issues affecting the service users were similar to those of the settled community, they were exacerbated by a range of social issues that magnified and prolonged their experiences of mental distress. One of the key issues affecting the service users was accommodation, and this was a persistent worry for many of the Travellers in this evaluation. Some of the service users were living in caravans on halting sites, and others were in private or local authority rented accommodation where they described unsuitable conditions such as having no heating or the presence of mildew. While many of the other social issues that affected the service users are present in the settled community, they were more prevalent in the Traveller community. For example, unemployment and financial worries were widespread, and alcohol misuse was frequently mentioned as an issue throughout the interviews. In some of the interviews, the service users talked about illicit drug misuse, and this appeared to be an emerging issue either for the service users themselves or within their immediate families.

The service users described a patriarchal community where gender roles were clearly defined. Most of the Travellers we interviewed were women, and they talked about their role as homemakers and mothers. Their day-to-day lives were ones where they had to juggle many different responsibilities and for the most part, they had little if any time for themselves. Traveller Men, on the other hand, were perceived as the breadwinners who worked outside the home. While there were some exceptions, Traveller men did not engage in housework or related activities for the most part. The service users talked about Traveller men and how they were particularly vulnerable to mental distress as they had a tendency to hold in their emotions and not discuss them with others, even their families. This appeared to stem from traditional conceptualisations of gender roles where men were to appear tough and did not give themselves permission to talk about their feelings. In addition, this perception was perpetuated by other Traveller men who made fun of or belittled men who talked about their

feelings in this way. One of the service users referred to this as having to ‘put up the man’ and this meant that men had to appear tough; this meant that Traveller men did not talk about how they were feeling to other men and associated this with weakness which went against their perception of Traveller masculinity. This is exemplified in the following quotation from one of the interviews:

But when you get outside that door, you’ll come down the hard way. Because you’re not the man, you’ve to put on a brave face; you can have the wall inside. But the wall, you have the black wall inside. But when you’re out there talking to other Travellers you have to put up the man. You have to talk about horses, you have to talk about cars, talk about drinking, talk about a drug. They’ll listen to all that. [Participant 5]

In one of the focus groups with the TCHWs, they talked about the erosion of Traveller culture and this having a particular impact on Traveller men. For example, the traditional outdoor life, rearing and tending horses were skills that offered protection against mental distress but were not considered as commonplace as in the past. In addition, the connection between mental health and engaging in meaningful occupation was not always clear for the Traveller men. This is explained in the following quotation:

But one time ago like, a Traveller man would, even now. If you see a Traveller man with horses and things like that. Or out in the field with horses, trotting, whatever he’s doing, with sulkies and things like that. Well that man’s not on drugs, or anything else. And he’s dealing with his wellbeing. And he’s trying to keep himself well. Because that’s his hobby. That’s his craft. He’s good at it; he’s making money out of it. It’s his skill. And they don’t see that, do you know? They don’t see the wellness that comes with all of that, you know what I mean. But they’re trying to take it from them. [Focus group 1]

While women were also vulnerable to mental distress, they were perceived as more socially connected with other Traveller women, and therefore were more likely to talk about the issues that affected them, although this was not always supported by the findings. In addition, their ‘craft’ which revolved around activities such as cooking, cleaning and childrearing provided meaningful occupation and routine that many Traveller men lacked. However, this meant that Traveller women had to carry most of the responsibilities within the household:

We have a craft and we have stuff and routine at home that we don’t bring in. Like, when we go home there’s loads of children. There’s cooking, there’s cleaning, there’s the norm. And then there’s the practical stuff that you’d be doing. You’d be catching up with cousins, or friends, or whatever you’d be doing. More so on the phone now than the community. We’re better talkers. And we’re very communicative. [Focus group 1]

The traditional patriarchal community was also reflected in attitudes towards marriage and divorce. Separation and divorce were stigmatised and Travellers who do end their marriages could find themselves isolated and, in some cases, ostracised from the community. There was a sense that the public perception of the family was more important, and the projection of an outward image of contentment and satisfaction with life was paramount which added to the marked stresses that



already existed. While there was some mention by the key stakeholders of LGBT issues and the lack of tolerance towards same-sex relationships, this was not really discussed by the Travellers in this evaluation.

A major issue affecting many of the service users in this study was suicide, and most of the service users who met with the TMHLN on a one-to-one basis had a close family member who died by suicide. In addition, two service users had made serious attempts to end their lives, and another participant described themselves as being suicidal in the past. The service users described a close-knit community where everyone knew each other; most were married and either had a large family of their own or came from large families. While this was perceived as a supportive environment in some ways, there was a sense that they still felt that they had no one to talk to about the issues that affected them. The service users described themselves as very private people, and there was a reluctance to talk about their feelings or things that were worrying them to other people. The issue of mental distress was not something that was openly discussed generally and was highly stigmatised. While this was perceived as something that was changing and had changed over time, there was an unwillingness to talk about mental health or mental distress, and this resulted in both men and women projecting a tough exterior layer. In addition, there was a lack of awareness of the concepts of mental health and wellbeing and of the relationship between the two. This resulted in poor coping responses to stress and a lack of knowledge about how to look after themselves from a mental health perspective. In addition, factors that might be perceived as protective to mental health among the settled community were sometimes risk factors for the Traveller community. For example, because families were close-knit and often intertwined with other families, issues that happened within the community, like a suicide, had a wide reach.

While the issue of prejudice and discrimination was not discussed by all the service users, it was raised as an issue by the TCHWs and many of the key stakeholders who were also interviewed. Some of those that discussed discrimination felt that while it had always existed, it was getting worse. The main areas of discrimination that were mentioned were in the areas of accommodation, access to leisure activities and employment. Some of the key stakeholders mentioned that it was sometimes difficult to access local gyms or leisure centres, although this discrimination was not overt. Within housing, it was also suggested that the majority of Travellers were housed in private rental accommodation which suggested that prejudice and discrimination was a perception in this case. One of the Traveller women recounted a story where following the death of a relative by suicide, the hotels and pubs in the town closed on the day of the funeral as a means to avoid accommodating the mourners. This is highlighted in the following quotation:

Like, whereas you're born and reared like in a town, like here last year, I was saying here to some of them last week. My [relative] committed suicide [month] last year. And like, he was [age], I think when he died. And every pub in [name] town closed down the week of his funeral. Because it was a Traveller funeral. [Focus Group 1]

### 5.3 Accessing the Traveller Mental Health Liaison Nurse (TMHLN)

Service users who were interviewed accessed the TMHLN in a variety of ways. In Carlow, most attended the Traveller Health Project based at St Catherine's Community Services Centres and heard about the TMHLN there from the TCHWs, the Health Project Coordinators or the PHN for Travellers. Similarly, in Kilkenny the service users heard about the TMHLN through their attendance at the Traveller Health Projects based in O'Loughlin Court. In both centres, staff were very familiar with the people who attended and recognised when they might benefit from an appointment with the TMHLN. Typically, staff would suggest to the participant that the TMHLN was available and would be able to help them with any issues that were affecting them at the time. Sometimes the TCHWs, the Health Project Coordinators, the PHN for Travellers, or other stakeholders asked the Travellers if they could tell the TMHLN about the Traveller who was experiencing distress and if they would like the TMHLN to visit them in their home or a place where they would feel comfortable. As many of the service users attended the Traveller Wellbeing Groups at the centres, they got to know the TMHLN through the Traveller Wellbeing Group sessions and made an appointment to see her on a one-to-one basis themselves. For the most part, there was no waiting time and the service users were able to see her almost straight away. Once the service users met with the TMHLN, they were able to contact her themselves if they wished following the initial consultation. Some of the service users that met with the TMHLN on a one-to-one basis had heard about her from other Travellers when they were attending the Traveller Wellbeing Groups that the TCHWs facilitated. This is highlighted in the following quotation:

I think we might've, in the start we might've just come in here and might've met up with her. I know I met her here one day, this was the first time I met her. And I was after hearing people talking about her, do you know a few people saying that, oh I'm going to [TMHLN]. I used to never, at the time I didn't know who [TMHLN] was. And then when I came in and got to know [TMHLN] I said to meself, god bless us, you know. She's definitely a person that you'd want to be meeting like, do you know what I mean? [Participant 8]

### 5.4 Reasons for Seeing the Traveller Mental Health Liaison Nurse (TMHLN)

The service users came to see or were referred to the TMHLN for a variety of reasons. The main reasons that they came were for depression, anxiety, stress and resultant panic attacks which, for the most part emerged in response to an external event or situation. Accommodation issues were cited as the most stressful situation for Travellers, although other issues were mentioned. Situations emerging from within the Traveller's family were also cited as causing stress. For example, alcohol or drug misuse, marital problems and problems with children, such as poor school performance, were also sources of distress. Some of the service users also said that they were suicidal when they first met the TMHLN. As mentioned, some of the service users had also been bereaved by suicide and were affected by adverse grieving reactions. Many talked about their experiences using lay terms to describe their symptoms or feelings. They talked about 'being under stress', 'being in a dark place', 'being down and out', 'having bad thoughts' and 'suffering with nerves'. Some of them also mentioned that they had



mood swings and described difficulty sleeping, having a ‘racing brain’ and ‘having low self-esteem’.

While the issues that were discussed by the service users may appear relatively straightforward and similar to those of the settled community, interviews with the key stakeholders highlighted the complexity of the Travellers’ needs when they met the TMHLN initially. Issues such as anxiety and depression were often set against a backdrop of immensely ‘complex’ and ‘chaotic lives’ where the service users had multiple stressors that affected their mental health. This meant that approaches to the participant’s needs were often not just person-centred but also relationship-centred and focused on providing assistance to other family members as well where necessary. In addition, there was a marked social dimension to the interventions where assistance was also provided for social issues that affected the participant.

## **5.5 Travellers’ Experiences and Perceptions of the Traveller Mental Health Liaison Nurse (TMHLN)**

The service users in this evaluation were extremely positive about the TMHLN and heaped praise on her and the work she did with them. Throughout the interviews, there were no negative or neutral comments about the TMHLN, and the service users placed a high value on the relationship they had with her and the help that she had given them. As soon as the service users met with the TMHLN, they liked her, trusted her and placed great faith in her ability to help them. As they got to know her, this relationship strengthened and there appeared to be a great bond between the service users and the TMHLN. Some of the adjectives that were used to describe the TMHLN was that she was ‘warm’, ‘very kind’, ‘very understanding’, ‘trustworthy’, ‘reliable’, ‘positive’, ‘genuine’, ‘non-judgemental’, ‘supportive’ and ‘caring’. In the next quotations, the participant suggests that the TMHLN was able to transform her mood and that the TMHLN is ‘very good’ and ‘doing a great job’. These sentiments were repeated throughout the interviews, and the service users described positive experiences and perceptions of the TMHLN throughout the interviews.

Yea, the others come their self like. If I was in here, or [TMHLN] came in, and she’d say we’re doing to relaxation now today. That’s what we all love and go home then. [We] might come in with a heart full of god knows what, and then you go home, and everything is just like, something just happened, a big smile on your face when you go home. That’s it, and this is what life is all about. So that’s my story anyway about [TMHLN], she’s very good now, and sure I find here [community centre] great. She’s doing a great job, and we have her health and her strength, says you. So that’s it. [Participant 3]

So [TMHLN] started putting things together for me. And every time I used to see her, I used to be delighted to see her. But I’d never talk, I think [TMHLN], and [Traveller Men’s Health Worker] were the only ones I could ever relate to. But I wished I had to meet [TMHLN] sooner. That’s my, that was my big dream because [TMHLN] and [Travellers Men’s Health Worker] both, the two like, they were brilliant. Because everything, I’d lay my whole heart on [TMHLN] and [Travellers Men’s Health Worker]. [Participant 4]

Trust, confidentiality and privacy were repeatedly talked about by the service users as being essential to any relationship that they had with health professionals and from the onset the service users talked about how they almost instantly developed these with the TMHLN. This was strengthened by the fact that the TMHLN was a registered nurse, as these values were seen as synonymous with the role of a nurse. Nurses were also perceived as qualified and knowledgeable by the service users which also influenced their decision to engage with the TMHLN. This is exemplified in the following quotation.

God, I don't know really where they would go, there was nowhere to go because all you could go to was your doctor; and it's not the same because you can speak to [TMHLN]. And you don't have to be a woman to speak to a lady. Ah she could speak to a man as well. She has got that, what would you call it? Education, that the brain; she can draw it out, if you say I am closed in and things like that [TMHLN] will kind of draw it out and ease it out of you to relax. [Participant 7]

The service users also knew the PHN for Travellers and associated the TMHLN with her. In addition, the TMHLN worked within an established infrastructure where there were many individuals who already worked with the Traveller community who were known and trusted. For instance, the TCHWs, and the Coordinators of the Traveller Health Project based at St Catherine's Community Services Centre were part of this infrastructure and the TMHLN was associated with them and the trust that many of the service users had with those. This sense of confidentiality and privacy allowed the service users to feel comfortable with the TMHLN and meant that they were able to talk about the issues that affected them in an open manner. For the service users, this meant that they could tell the TMHLN anything without fear of it being repeated to others. However, the service users were aware of the limitations of this confidentiality and knew that the TMHLN could breach this confidentiality in certain situations, such as child protection issues. The value of talking about problems within a safe, private environment is exemplified in the following quotation:

Talk about it, talk about it, do you know what I mean? If there's anything there on your mind like or anything there that you feel that you need to get off your chest like. And you don't want to talk to a family member do you know, talk to someone like [TMHLN]. Because it's never going to be ever repeated, and at least you're after sharing it with somebody else, and it's that less of a load for you to carry. You know, because it's only going to fester and fester. And that's what makes your mental health, you know; ten times worse, do you know, so. [Participant 8]

Another participant shared a similar experience, and in this example, the participant describes how he felt comfortable talking to the TMHLN, something that he didn't feel when he was at the doctor's. In addition, this participant described his relationship with the TMHLN as being like the relationship he had with friends or family.

And it was just; being a Traveller, it was just nice to be able to talk to her about it. Do you know I didn't feel judged, do you know? Because I had kind of talked to a doctor, do you know. But I felt, it's not really that I was judged, it just, I didn't feel at home, do you know? I know he's being professional and stuff and I know [TMHLN] was as well. But she was more



like a friend, a family member. Do you know, I just felt at ease. I can't really explain it to an extent. It's just, I just felt at ease with her, do you know? So that's what we talked about, when we first met like, do you know. [Participant 9]

During the interviews the service users talked about how the TMHLN helped and the type of help that she gave them. Any of the help that was provided was embedded within an interpersonal communication process that was tailored to meet the communication needs of the service users. The service users recognised this and talked about how the TMHLN talked to them and how they were able to understand and respond to her. They also talked about how the TMHLN understood their needs. They mentioned that the TMHLN was easy to talk to and that they knew they could have a private conversation with her. One of the service users said that once you met the TMHLN you felt like you knew her for ages. Important components of this interpersonal relationship were time and being listened to; the service users valued these and there was a sense that this didn't happen in other interactions with the health professionals they encountered. This is highlighted in the following quotation where the participant talks about the difference between going to see the doctor and the TMHLN in terms of how she provides time for exploration of issues and listens to the person:

[TMHLN]'s approach is she listens to you. She'll listen to your problem. She'll try and tell you what to, like what would be the best way to come around to it. [TMHLN] not now, when you go in and you try and explain what. Those head doctor's that's getting well paid, that's the way I look at them like. So, don't say that to your own doctors. They're here with a pencil. And yea right so, right, do you know now we're very busy today, we've a lot coming into today. Did you know you should've made an appointment. And probably being honest with you, you could be struggling with your brain and I tell a doctor, even I think that's how I came down with depression. That's how I came down with everything. Because every time I go to a doctor, do you know their attitude, it put me off. [Participant 4]

The provision of time and being listened to within a private and confidential setting established a safe and secure environment for the service users to open up and tell the TMHLN about their problems. Within this relationship, a number of activities occurred. While the service users did not talk about a formal assessment, they did mention that the TMHLN knew them and knew how to help them. The service users found it hard to describe how the TMHLN helped them and mostly spoke about the practical things that she did. For example, helping them get an appointment with the doctor and helping them to address some of the social issues that were at the root of their distress were frequently mentioned. The inability to describe what the TMHLN did during the one-to-one sessions is summed up in the following quotation:

I don't know; it was the way she'd talk to you. Like, it's hard for us to describe that to you. Because the way [TMHLN] would talk to you; she, you have to have the problem; you have to have a one-to-one basis with [TMHLN]. The way, you see the way [TMHLN] does things you can't describe it. Because there's so many at once. [Participant 5]

However, through gentle questioning and probing the service users were able to recount some of

the interventions that occurred during the one-to-one sessions. From the service users' descriptions, these can be divided into a number of interventions:

- Therapeutic interventions,
- Liaison interventions,
- Educative interventions, and
- Follow-up interventions.

### 5.5.1 Therapeutic Interventions

The TMHLN's used a range of interpersonal skills to develop therapeutic relationships with service users and to work actively within this relationship. Service users talked about how the TMHLN spoke to them about their problems and how she helped them to relax using relaxation techniques such as listening to music or deep breathing. The TMHLN also helped the service users to examine the issues that affected them and see them in a different light. This involved the use of humour which was also perceived as helpful.

Yes, she like, she made me relax better and see a different light on the matter kind of thing. She was, she put a different light on the matter now you know; she, you would be happier, you might be sad coming in to her, things just not going right maybe with one thing or another, families or whatever. And then you feel happy. [TMHLN] would make you laugh and you would have a, you know...We talked about health and past things and done a bit of writing things, you know; life, we talked about life. [Participant 7]

Talking to the TMHLN and getting things off your chest are also described in the next two quotations from the interviews:

But that's what I'm saying to you now. If I hadn't have talked to [TMHLN] and [Traveller Men's Health Worker}], I don't know where I'd be, because I'd get all panicky, and because a thing like this [panic attack] never happened, thank god, and I hope it will never happen again. But [TMHLN] brought me along that road you know. Me and [TMHLN] have our own chats now. And I feel confident with [TMHLN] and [Traveller Men's Health Worker] now. [Participant 4]

And like, at one stage there I came down to [TMHLN] and I was after been giving a letter for the psychiatric unit and everything. And coming down to [TMHLN], I said I'd talk to [TMHLN], and [TMHLN] was able to make me feel comfortable. I do you know, it's just I felt that it was someone to go to. You knew it was private and confidential. I'd no fear of talking to her. I was never worried about ever saying anything to her. And the answers that she gives me just made me feel completely different going out. I'd be crying coming in, but I wouldn't be crying go out like. I'd feel so good in meself going out. [Participant 8]

These interventions were considered hugely supportive and communicated to the service users that they were valued, that they were not alone, and that the TMHLN cared for them and for their welfare.



In this sense they facilitated hope and provided a more positive outlook for the service users. The TMHLN told the service users not to be too hard on themselves and that they needed to look after themselves as well. This was verbalised by one of the service users as ‘giving themselves a treat’, even if it was something small like having their hair or eyebrows done. Another participant said that the TMHLN made them believe in themselves and by doing that they believed in their ability to help themselves.

Just [TMHLN] used to tell me how good of a person I was like. And how I’d [number of] lovely children. I needed to; I didn’t see it in meself. So, do you know, she’d be talking to me. Like counselling like, do you know? And do you know, she made me believe in meself so like, do you know? [Participant 1]

### 5.5.2 Liaison Interventions

The TMHLN’s liaison role has already been briefly described earlier and this mainly revolved around helping the service users to access the appropriate help they need where necessary. While this sometimes meant that the TMHLN organised appointments for the service users, for the most part, it was signposting and pointing the participant in the direction of the health professional or agency that could help. Where necessary, this was mostly signposting to the participant’s GP or to the mental health service. In addition to providing contact details, the TMHLN also encouraged the person make contact with the service and offered support and reassurance if they were apprehensive.

And I had anxiety problems, and do you know I had things like that, and she was able to, do you know, make me feel better, and do you know, point me in the direction of [Mental Health Service] and do you know, other places. If it was the case it was in [location] do you know, or wherever like. So, she was able to, if I ever needed a number for a place, or if I needed, we’ll say her to type up a letter for me or, she was good that way, you know. [Participant 9]

The service users placed great faith in the TMHLN’s ability to access other services; one of the service users suggested that the TMHLN was able to get an earlier appointment within the mental health services for her. There were also reports within the interviews of the TMHLN intervening when appointments were missed. For example, the TMHLN contacted the mental health services and arranged for a new appointment to be made for one of the service users after she had missed a number of appointments. In addition to signposting to primary care or liaising with the mental health services, there was also liaison with other agencies, in particular, those that dealt with the issues that were affecting the service users at that particular time. Many of the service users experienced issues around accommodation, and the TMHLN either liaised directly with the agency involved or signposted the participant to the appropriate service. In one example, the TMHLN signposted the participant to the Citizens Information Service to help with writing a letter to the County Council about the mildew she was experiencing in her family home.

This liaison role was not limited to the service users themselves, and some of them recounted how the TMHLN helped members of their family to access services. In the next quotation, the participant talks about how the TMHLN was able to speed up the referral process for her son.

She, like she, see January they weren't going to see me son until January, or February. And I said to [TMHLN] I'm not going to wait that long to get him seen. So [TMHLN] actually, I got a letter saying that [son] won't be seen until February. So, I said it to [TMHLN] and [TMHLN] kind of rushed, do you know, the appointment to get it closer now. Me son was seen last week. Whereas if [TMHLN] didn't intervene I wouldn't been seen, he wouldn't have been seen until February. So, them kind of things, do you know. [Participant 1]

In addition to signposting and liaising directly with services, the TMHLN also tried to make sure that the service users kept appointments by sending out reminders via text or phoning service users in advance. This is exemplified in the following quotation.

I've only missed a couple of appointments up here. And I was all depressed when that happened because I couldn't remember. Yea and then what she does now is, she texts me with me time and date. You know, like she might do, say like, if I'd an appointment now, say tomorrow. Well [TMHLN] will send me a text the day before, your appointment is tomorrow [participant's name] you know. Yea, yea. And that's very helpful to me as I say, because I did miss appointments. And then you're put back again, you know what I mean, so. [Participant 8]

The liaison role also had a strong advisory and advocacy component. During interactions with the service users, advice was given about the best course of action, as well as how to take this action. For example, in the next quotation, the participant describes how the TMHLN advised him that he might be on the wrong medication and to tell his doctor, but also advised him about what to say to the doctor.

She'd have like, tell her I was on medication is all she said. Tell your doctor she said, you can tell like, if the medication is not working for you. It wasn't at first like, the medication made me sick. And she [TMHLN] said, get the right medication, tell the doctor to get the right medication. And if you don't ask they won't, you have to tell them it's not suiting you. And they'll put you on the right medication she said. And I did that then, and the doctor put me on the right medication. I was on like a load of different tablets as first. I was getting sick like, it upset me stomach. And I must've tried about say about four or five different tablets like. And they weren't working for me. And then I got the right tablets [names medication]. [Participant 2]

In some cases, the TMHLN would offer to call the allied health professional, and there were also references to her writing to agencies on the participant's behalf.



### 5.5.3 Educative Interventions

Educative interventions stemmed from health promotion activities which centred on helping the service users to recognise their mental health needs and to help them incorporate wellness strategies into their lives. From the descriptions made by the service users, this was holistic and incorporated both the physical and mental health domains. Within the physical domain, service users were taught about the importance of good physical health and the relationship it has with mental health. The service users talked about the importance of a good diet, taking regular exercise and getting enough rest. In the quotation below the participant identifies how the TMHLN emphasised the importance that lifestyle, particularly diet, has on an individual's wellness.

Do you know like, and I've put on weight and do you know like, so I'm eating better. Do you know and that's important that's what [TMHLN] said to me, she said like are you eating properly? And I'd say, well I had me dinner. No, but you need to have your breakfast, do you know? It's the most important part of the day and stuff like that. You know she kind of say like, you know, even would you eat fruit? Would you eat an apple? Do you know bring an apple with you. I bring an apple with me she says every time. Most times anyway she says I'd have an apple, do you know she kind of, she'd throw things out there do you know. Do you know lifestyle-wise like you know? [Participant 9]

Exercise was another wellness strategy that was discussed by many of the service users. Throughout the interviews, the service users talked about how they were told about the importance of exercise and how they should incorporate it into their daily lives. Going for a walk, in particular, was stressed by the TMHLN as not just a good form of exercise, but also a good way to manage stress and anxiety. In addition, it could help the service users to get some time to themselves.

She'd tell me like walking she said, even if you do the walking she said. And try and get out of the room she said. And try to get like, don't be sitting in the room, the more you're sitting in a room she said, the worse you'll get. You get out and about and start talking to people she said and then walking. [Participant 2]

The service users also talked about strategies that would help their mental health and how the TMHLN taught them about strategies to help them cope with stress, and about the importance of looking after themselves. While going for a walk was a key strategy here, other things that were mentioned were getting out of the house, talking to people, meeting people, relaxation techniques such as deep breathing, listening to music and meditating, among others. This was sometimes described as 'minding yourself' by the service users. In the following quotation the participant talks about how the TMHLN told her how to 'up' herself and keep her 'mental health [distress] at bay' and some of the strategies that might help to achieve this.

Oh definitely, definitely yea, and it's about try and up yourself. It's about going for a walk if it's only ten minutes. Just doing that for yourself to keep your mental health, you know, at bay like. If it's only meeting up with a friend, which I told her I have a friend in the settled community, and we're very close; and so, I do call her me other sister. But, and I was telling

[TMHLN] about her. And I said, [TMHLN] we do go for a coffee sometimes, and that is great, that's brilliant, if it's only to get out for that twenty minutes, half an hour whatever she said. Just go for that cup of coffee, she'll always encourage you to, you know what I mean, to keep yourself. [Participant 8]

In the next quotation, the participant describes how the TMHLN taught her to look after herself and that even a few minutes to herself were helpful.

So, at home now myself I light's a candle in the lamp piece. Just to remind me of [TMHLN] here and of course then about the little hand [cream] thing [rubbing in hand cream]. And puts it up in me shelf on the window. And sure, I'm all the time into the window. And I remember things what [TMHLN] said, that little two minutes, five minutes is your own time for yourself. If you're looking out the window at the birds, you're doing it. [Participant 3]

Throughout the interviews, the service users appeared to take on board the health messages that were recounted to them during their interactions with the TMHLN, and they appeared to practice the strategies as part of their own wellbeing plan.

#### 5.5.4 Follow-up Interventions

As mentioned earlier, the service users talked about how the TMHLN reminded them of their appointments by telephoning or texting them. The TMHLN also followed up the service users in other ways. Many of the service users reported having her mobile phone number and ringing her when they were in need of some support. The service users suggested that the TMHLN was very reliable and would do her best to see them when she could, depending on her availability. In addition, the TMHLN also telephoned or texted the service users to catch up with them. One of the service users talked about how she sometimes went to stay with relatives when things got on top of her, and the TMHLN would phone her to see if she was alright and this made a big difference as the participant knew that the TMHLN cared for her wellbeing.

And with that I just, I said, I have to do this, I have to do this. So, I went and [TMHLN] told me to go, and I went; I went up and she rang me when I was in [names relative]. And she said to me even me voice on the phone sounded different. Yea. Oh, she do, that's what she does now. If she knows I'm going away for, to [names relative] for a few days, she'll always ring me. Make sure I'm alright do you know, so very, very, very good of her like, so. Yea, it's just great support, great support do you know what I mean? Because you set yourself on, you know there's someone that cares. [Participant 8]

The same participant talked about how she was experiencing some physical symptoms and had to get blood tests. Prior to meeting the TMHLN, the participant would have been a 'ball of nerves' but having the TMHLN to talk to about them allayed some of the anxiety while waiting for the results.



## 5.6 Traveller Wellbeing Groups

The TCHWs were involved in running Traveller Wellbeing Groups to a number of Traveller women in both Carlow and Kilkenny. We conducted a focus groups with three groups to explore the Travellers perceptions of the Traveller Wellbeing Groups. As part of the Traveller Wellbeing Groups, the TMHLN attended and provided information specific to mental health and to provide a positive space that supports Traveller women to develop self-care skills. The Traveller Wellbeing Groups were recovery-orientated and were adapted to meet the needs of the Travellers in terms of their specific needs, strengths and circumstances. Throughout the focus groups with the Travellers, they talked positively about the TMHLN and about how kind and nice she was. They talked about how they enjoyed the activities that they were involved in, especially the craft-based activities and there appeared to be a good relationship among the members themselves. However, there appeared to be varying levels of understanding about the purpose of the Traveller Wellbeing Groups from a mental health perspective. Despite this, they were able to talk about stress and the things that caused stress for Travellers, particularly discrimination and stigma. When the Travellers were asked about wellbeing activities, they did report that they remembered hearing about them during the Traveller Wellbeing Groups, but it was not always clear if they understood the relationship between the self-care activities and their mental health or wellbeing. They did suggest that they practiced these at home, for example, going for a walk or talking to a friend if they were feeling stressed. Some of the Travellers talked about mental health and mental illness as being the same thing. Overall, the Travellers who attended the focus groups were very positive about the TMHLN and really valued what she did.

# CHAPTER SIX

## KEY STAKEHOLDERS FINDINGS

### 6.1 Introduction

The aim of this chapter is to present the findings relating to the key stakeholders' perceptions and experiences of the TMHLN in the Carlow and Kilkenny area. In particular, it will examine the role of the TMHLN in the following areas:

1. Traveller Community Health Projects and Men's Health Projects.
2. Links to specialist mental health services.
3. Interagency working

### 6.2 Traveller Community Health Projects and Men's Health Projects

As Part of the evaluation we spoke to a range of key stakeholders who were involved in the Traveller Community Health Projects:

- Traveller Community Health Workers (TCHWs),
- Manager of the Traveller Health Project,
- Traveller Health Project Coordinators,
- Traveller Men's Health Worker,
- PHN for Travellers,
- Regional Traveller Health Nurse, and
- Regional Traveller Health Coordinator.

Throughout the interviews, there was an extremely positive perception of the role of the TMHLN and the need for this role in the Carlow and Kilkenny area. The TMHLN and her interface with the Traveller Health Project in Carlow is clearly explained in the following quotation.

Yea. So [TMHLN] has been, first of all in her nursing capacity and as a mental health nurse. You know, she has been supporting clients that I have referred to her on a one-to-one, individual basis. So, we provide a room for [TMHLN], on a regular basis that we can schedule in some one-to-one appointments. She's also, as you know, doing a lot of outreach as well. So, sometimes with some of the people I might refer to her, they mightn't feel comfortable coming into the centre, which is fine; you know, and it's great that [TMHLN] has the capacity to be able to do the outreach. Because they might not engage with her otherwise, where at least if she arranges then to meet them somewhere else that they feel more comfortable with. And just to break the ice and to get that support started. And then [TMHLN] has also



been a great support to our groups here. So, the TCHWs might've mentioned, or [TMHLN], we've had a wellness group, meeting regularly, you know. Now we'll do that in blocks you know what I mean. And it is to progress it as well. But [TMHLN], now has also rolled out some WRAP training you know to support the programme. As in, when [Travellers Men's Health Worker] was here and the Men's Shed, which is hugely important. So, kind of in our plan for 2018, that would be a part of it as well. Not only to get maybe [TMHLN] trained up in the WRAP programme and possibly as a facilitator for it. But to get [Travellers Men's Health Worker] on board again as well, with the men that [TMHLN] is hoping to engage with, in the Men's Shed. Around their mental health and around the WRAP programme as well. [Key Stakeholder 14]

Trust was consistently identified as essential in any work with the Traveller community and the stakeholders talked about how the TMHLN was able to develop this trust and connect with the Travellers. Her ability to do this was seen as important in terms of getting the Travellers to engage with her and consequently engage with the wider health and mental health services.

Yea. [TMHLN]'s work, [TMHLN]'s position, she really, from day one she really connected with the Travellers. I think you know, maybe because she had worked in [name of organisation]. And she had kind of familiarity with a lot of them. I think that was a real plus, very positive. Because children are huge in the Traveller community. So, I think from very early on, she had an in there. And they trusted her. Trust is really important with the Travellers. And I think they had a feeling that you know, they knew her, and they were safe with her. So, the women engaged very quickly with [TMHLN]. And she did a lot of mindfulness. She brought the WRAP and elements of the WRAP into the work that she was doing. [Key Stakeholder 4]

The TCHWs talked about their role in promoting wellness and the in-reach and outreach work that they do.

We do outreach then as well. We deliver different health topics every week. And then we assist the Traveller community with like, for a lot of them they have literacy issues. We help fill out medical card forms. We like follow up for appointments for them, like for hospitals, if they're waiting on an appointment. And if they haven't heard anything from it in ages; well we can ring up for them and get a follow-up for them. [FG with TCHWs]

Part of this work involved delivering a Traveller Wellbeing Group and the TMHLN worked alongside them in the delivery of this group. In addition, the TCHWs could also refer Travellers to the TMHLN if they were experiencing mental distress. The activities that occur in the Traveller Wellbeing Groups have been described earlier (Section 4.7). The TCHW were well aware of the problems that existed for the Traveller community and were able to speak about them in an open and frank manner. They also described the stigma that was attached to the mental health services and how this stigma impacted on uptake and engagement with the mental health services. They also mentioned the lack of understanding about the nature of mental health and mental illness. However, they believed that initiatives like the introduction of the TMHLN was having a positive impact, although there was still a long way to go.



Sure, a lot of Travellers, I think up to like a few years ago like, when they heard the word like mental health, you're mentally unwell. The Travellers they would've thought, right I'm going to be put into an institute because they're mentally unwell. But I think now, like with the last couple of year, even since we've started working here. Since we've linked in with the services, with the likes of [TMHLN]. She can link them further, the likes of [TMHLN]. They've kind of; there is a lot of stigma still a bit around it. But their attitude has kind of changed towards it. They understand it a little bit better that just because you're mentally unwell. Doesn't mean like, you've to go to the likes of the hospital in Kilkenny, or to an institute place. That doesn't always mean you're going there if you're mentally unwell. But yea, it has changed towards a few years like, their attitude towards it. [FG with TCHWs]

The TCHWs talked about the title of the TMHLN's position and agreed the term 'Mental Health Nurse' might have put off Travellers from attending and perhaps contributed to the stigma that already existed. They also mentioned how the TMHLN did not wear a uniform, which also helped to break down some of the barriers that existed around mental health.

Do you know because everyone has different reasons. And if they say, I have an appointment with the Mental Health Nurse. Do you know, someone could say, oh don't go there, do you know, you don't [know] what will happen. You know there's different, everyone has their different opinions. So, a Wellbeing Nurse sounds kind of better, and then do you know when you get a person in there, and you can go through everything. And reassure them that just because they're meeting a Mental Health Nurse doesn't mean their mental, do you know. So that's mainly one of the reasons why it's changed to Wellbeing Nurse. Which is a very good idea. [FG with TCHWs]

The TCHWs were a key point of access to the Traveller community, especially for outreach work. Not only did they provide access to the Traveller Wellbeing Groups run by the project they were also able to refer people who were experiencing mental health problems in the community to the TMHLN. The TMHLN was then able to negotiate access to the person which was facilitated by the TCHWs as well as other key stakeholders such as the Traveller Health Project Coordinators, the Traveller Men's Health Worker or the PHN for Travellers. Similarly, the other members of the Traveller Health Project were also able to refer directly to the TMHLN, and this was generally an informal arrangement where the stakeholders made contact with the TMHLN about the person they were concerned about with the Travellers consent, and the TMHLN would then arrange to see them at a suitable time. For the most part, referrals only occurred where the stakeholders felt that the person required more specialist intervention beyond what they could offer.

In addition to referrals, the TCHWs, as members of the Traveller community, were able to tell other Travellers about the TMHLN and what she did. In one of the focus groups, there was a suggestion that the number of people accessing the services provided by the Traveller Health Project, especially the drop-in service, had increased. They believed that since the TMHLN had been introduced, there was a greater uptake in service use generally and a greater likelihood of Travellers engaging with services consistently rather than at crisis points.



Well, we're engaging with communities, and we're asking them to attend and to come down even for the bigger opening days and things. We would always say there's a Wellbeing Nurse down there. And there's [TMHLN]. And we'd name them, and they'd say, well who's she? She's the PHN, but [TMHLN] is actually our being well nurse, do you know what I mean. And she's in-house, and she's just promoting awareness, you know we're not throwing it at them. We're not dragging them in, you know. But it's just awareness. [FG with TCHWs]

One of the things that the TCHWs were very strong on was the perception that the TMHLN was able to 'open doors' in terms of accessing services. The TCHWs talked about how the TMHLN was able to get appointments for doctors or counsellors whereas if they tried themselves, they would be 'months' trying to get an appointment. This was seen as a particular selling point for the service, and the TCHWs often used it when encouraging other Travellers to attend the Traveller Wellbeing Groups or one-to-one sessions with the TMHLN.

If we tried to refer them to somewhere, it could be a month, sometimes months waiting for a phone call back. We've often left messages or tried to get through to a certain service, and there'd be no one at the end of the line. You'd get nothing trying to ring them. We could be months and months trying. Whereas with [TMHLN] it could be just a couple of weeks and you're getting there quicker. [FG with TCHWs]

The TCHWs were also aware of the importance of confidentiality and were clear to reiterate that what the Travellers talked about with the TMHLN was private and would not be repeated to them. The TCHWs talked about the work that the TMHLN did with Travellers and described her as 'brilliant'. They spoke positively about her interactions with the Traveller community in the Traveller Wellbeing Groups and praised the approaches that she used and the manner in which they were delivered. They talked about how the TMHLN had attended the Traveller Cultural Awareness Programme that was delivered in St Catherine's Community Services Centre, and how she knew a lot about the cultural needs of Travellers prior to taking up the position anyway.

Throughout the interviews with the TCHWs, there was a sense that one of the main contributions that she made as part of her role was breaking down the barriers around mental health and mental illness. This could only be done because of the TMHLN's positive relationships with the Travellers, the way she was able to communicate with them, and her ability to allay the fears that they had about the mental health services. According to the TCHWs, the TMHLN was able to speak to the Travellers in a language that they understood which facilitated a positive response to her interventions. The TCHWs talked about how the TMHLN was able to go out to the sites and was now able to visit people at home or in their trailers, and this was all related to the trust that she had with them. There was also a perception that more men were engaging with that service and that 'even men' were now asking the TMHLN into their trailers for a cup of tea and a chat.

She broke down the fear that Travellers have. Like a lot of them, your story again, will have the fear of their children being taken. Like just say for example, if myself needed to go into one of them hospitals for a week or two. If I wasn't well. Well, I could be thinking right the

children are going to be taken. Going to be sent away or whatever. It's not, she has broken the barrier of fear from the families, telling them like that doesn't happen. That's not how it works; you only go in there if you need to go in there yourself. Like she doesn't, oh you're mentally unwell, so you have to go into the likes of Kilkenny or whatever. They've a completely different way of viewing it now like since [TMHLN] started. [FG with TCHWs]

She's linking with families over in [location] that don't, they wouldn't really come in here. They've been in once or twice and they actually love seeing, like from feedback I've got, they actually love seeing [TMHLN] coming. Even some of the men out there that you'd never. That we've never seen in here. Like they welcome [TMHLN] in, they'll offer a cup of tea or coffee. And they'll actually sit down and talk to her. Whereas they never come in here. And the women like, you'd be lucky if you see them in here maybe once or twice in the year. [FG with TCHWs]

As well as breaking down barriers with the Travellers themselves, there was also a perception that the TMHLN was breaking down barriers between the Travellers and the staff that worked in the mental health services. The TCHWs talked about how the TMHLN had facilitated Mental Health Nurses and other mental health professionals to attend the Traveller Cultural Awareness Programme and how they were beginning to develop better relationships with the mental health services since the TMHLN started. This was accredited to the TMHLN for championing Travellers and helping the services, particularly the mental health services to understand their cultural needs and how cultural factors impacted on Travellers engagement with health services.

Yea she, [TMHLN] has come over and visited us on several occasions and does more, like nurses and doctors and things would come over. That hasn't been happening before. And we have also on our culture when we deliver culture awareness or anything. They come on board as well, and they've stood the full day, so it's great like, and [TMHLN] has done all that, so. [FG with TCHWs]

In addition to the TMHLNs work with the Travellers, the TCHWs also talked about the work that she did with them. They talked about how their role was stressful and that even when they were not working, they were often called upon out-of-hours for advice and assistance. This is exemplified in the following quotation.

The other part on that is the TCHWs carry quite a lot. And maybe in the interview, you would've heard them say, we're never off the clock. And that's very real because I might finish here at one o'clock and go home. But they don't. They might finish at one o'clock and their day is only starting when they go home. Off the clock also means it's Friday, Saturday night being called to maybe a hospital, where somebody is that needs a family member to be present. And they will be called. And that may not be within the County Carlow, County Kilkenny. It can be outside of that. I've seen the TCHWs come in on a Monday morning, with very pale faces and exhausted. [Key Stakeholder 15]

The TMHLN and other members of staff were aware of the stresses and strains that the TCHWs



experienced and ensured that they were supported. This was well received by the TCHWs and is probably best described in their own words.

But she helps us out as well. She's brilliant. She does the mindfulness with us. But we're coming to the end of the year of, we have. Because this is a very, very stressful job that we have here. And we're all drained, now it's coming up to Christmas, we're all drained. Because there's that much on, with the last couple of weeks, we're completely drained out. So like, she'll come in, and she'll do mindfulness with us. Or she might do nails; you know nail painting or just creams on our hands. And just something just to relax us out. And it's really, really beneficial. So like, she's very good to us here [in the Traveller Health Project] as well. We'd be lost without her, really good, so. I do think we need someone like [TMHLN] all over the country, we really do. [FG with TCHWs]

For other key stakeholders in the Traveller Health Projects, the TMHLN filled a gap in service provision where there was a perceived lack of knowledge and experience. While the stakeholders were able to provide some level of general/specific health interventions and support to Travellers, it was the mental health piece that they felt that they lacked.

And now I pass the clients onto [TMHLN] for her expertise. Because I'm not mental health trained. I have compassion for the people I work with you know, and I have the listening ear. And most importantly, I have the trust. Because like, I worked directly for fourteen years, with the groups. I'm fourteen years in situ, so you know, you build up the trust of the families, over the years. [Key Stakeholder 15]

Throughout the interviews, there were references to the TMHLN's expertise in the area of mental health and how it made a substantial difference to the services that the Traveller Health Projects were able to deliver. This expertise was of particular value when a crisis emerged and even if the TMHLN was not available she was able to provide support and advice over the phone which helped de-escalate the situation. However, one of the challenges identified was that the TMHLN service was divided over two counties and this sometimes meant the service user had to wait a week to see her. However, as mentioned, a telephone intervention was sometimes utilised.

Before [TMHLN] came I would have been dealing with everything and since [TMHLN] came, [TMHLN] has psych training, so [TMHLN] would be what we know as a Wellbeing Nurse and [she] is a fantastic help to me with regards that because I'm not psych trained, I would have had one client that I really didn't know what to do with or how to signpost him to the right services because, like I said, I'm not psych trained so I would have had to ring somebody who had that experience to kind of guide me, but since [she] came that's all taken off my hands now. [Key Stakeholder 5]

The key stakeholders who worked as part of the Traveller Health Project made many references to the experience of mental distress that were prevalent among the Traveller community. However, before the TMHLN was appointed, there was a perceived lack of knowledge, skills and comfort about the nature of mental distress and how they could help the person. This included a lack of awareness of

the services that were available in the community and knowledge about the best service to match the needs of the Traveller at that particular time. Another issue that emerged was time and the amount of time it took firstly, to engage with people who were experiencing distress, and also, the time consumed following them up and making sure that they attended appointments. In addition, the TMHLN fulfilled an educational role, and the Traveller Health Project were able to pick up some of the skills and interventions that the TMHLN used. This is highlighted in the following quotation where the stakeholder suggests that her mental health skills were 'zero', but she has been able to pass on wellbeing messages to the Traveller community.

But I've my; I wouldn't, my mental health skills, I would feel I had you know, zero. So, I've learnt a lot about all the, you know, what we talked about earlier. The keeping yourself well, working on the issues of, or the, all the things that keep yourself well, the food, sleep, linking to people, relaxation, walks. You know all the different ways of maintaining your health. So, I've learnt an awful lot of that. So, we can actually, you know I could give some of those messages now myself. [Key Stakeholder 16]

Mapping the health services was identified as a challenge, and this presented another difficulty in terms of meeting the mental health needs of the Travellers. In the following quotation, the stakeholder describes his frustrations at navigating the mental health services, and this impinged on his ability to advise on what services he could suggest to Travellers in need. This was identified as a major issue that was worsened by the diverse needs of the Traveller community, although it began to resolve when the TMHLN was appointed. This is clearly identified in the following two quotations:

I found it hard, I found it awfully difficult, I found understanding the health services excruciatingly painful. I didn't know what the hell was going on. I didn't know like, they had problems with their doctors. Problems with the doctor's receptionist, problems getting on to waiting lists. Getting on to the medical cards, getting into hospital, whatever it was. So, there were lots of things like that that I found. And I wasn't really, I didn't have the training, or the information, or the knowledge or the background, to be able to kind of, sit down and pull it together a little bit. [Key Stakeholder 4]

And I would honestly say, from the day [TMHLN] arrived it was like she was my salvation. You know, I think her role; yea has evolved as time has gone by. But the fact that she was a Mental Health Nurse was huge. She understood stuff, you know. So, whenever I had a problem with [Traveller man], I could phone up [TMHLN] and say, listen I'm here with the [TMHLN]. And this is the scenario. And I could say, are you staying there for an hour, I'll be out. So, she'd arrive out, we'd sit down, we'd talk through stuff. That to me was exactly what I needed. I think knowing the interior, internal workings of the health services was huge. And knowing how to kind of orchestrate things or get things moving was really supportive. So, there was something really fabulous you know, just about her arrival. [Key Stakeholder 4]

While the overall experience of the TMHLN was identified as positive and the work she did was valued, there were a number of challenges discussed in the interviews. As previously mentioned, the



availability of time was identified as a challenge for two reasons. Firstly, the time that was required to spend with each Traveller who was experiencing distress was substantial and this impacted on the TMHLN's availability. Secondly, as the TMHLN worked over two counties, this limited her availability to see Travellers in each county. From an infrastructure position, the availability of St Catherine's Community Services Centre in Carlow provided a hub of activity and resources for Travellers. It was mentioned in the interviews that Travellers didn't mind coming to St Catherine's because it offered a cloak of protection in terms of their confidentiality as they could be accessing any type of service. However, the same infrastructure was not available in Kilkenny which was seen as a limitation. Finally, at the time of data collection, there were some personnel changes at St Catherine's, the Men's Health Worker has left and had been replaced. In addition, there was a new Traveller Project Manager. Both of these stakeholders suggested that as they were relatively new in their respective positions, that they were only starting to make an impact in terms of supporting the work of the TMHLN.

### 6.3 Links to Specialist Mental Health Services

As part of the evaluation, we spoke to a number of Mental Health Nursing staff in Carlow and Kilkenny who worked in a variety of positions. This section will discuss the links that the TMHLN has made with the mental health services and their teams and the outcomes of these connections for mental health professionals. All of the Mental Health Nurses that we talked to were aware of the TMHLN and her role with the Traveller community. Two of the nurses were members of the Traveller Mental Health Advisory group and from that had fairly regular updates on her activities. One of the nurses was in a senior position and was involved in the governance arrangements and met with the TMHLN frequently as well. They were all aware of the challenges that presented when working with the Traveller community and were able to talk about how mental health difficulties impacted on the Traveller community. They were also familiar with the cultural needs of the Travellers and had attended the Traveller Cultural Awareness Programme. The nurses talked about how they had Travellers as part of their caseloads and how it was difficult to engage with them due to the stigma that they had around mental health. While the Travellers experienced issues similar to the settled population, the nurses were aware of the other social factors that impacted on the Travellers ability and willingness to engage the mental health services. This is identified in the following quotation:

But yea we have some; I have some Travellers on me [my] caseload. What do you call it; a lot of them don't want to be coming in. It's a big stigma for anyone, but especially for Travellers. Especially the men, they don't like admitting that there's anything wrong. For some it's depression; some it's psychosis, some it's bipolar. There's a mix of all mental health issues. It takes a long time for them to get used to you calling out. They mightn't like you calling out. But they don't want to come up here. So, it's trying to find somewhere then to meet them in between, for some of them. There's others then that are long-term in the service. And are used to being in the service. So, they don't mind as much. Some of them will come in and go, ah it's only the nurse, it's alright, do you know. But it takes a while to get them used to you. [Key Stakeholder FG 2]

There was a positive perception of the work that the TMHLN did and a general sense that the role was successful. This is exemplified in the following quotation.

Her key role is about signalling and signposting people who are not currently in the mental health services. And who require inputs I suppose from GPs, from primary care and from [TMHLN] herself. For those people who need more and who need a secondary specialist, mental health services, it's about signposting and directing those service users into the sector of mental health services, which is us. That has worked very well in the sense that there's appropriate referrals coming to the secondary mental health services from [TMHLN]. And where appropriate then, the supportive and the educational; and the, I suppose advice you know, that's appropriate at primary level. [Key Stakeholder 22]

The stakeholders also talked about how, since the TMHLN's appointment, service users were accessing the mental health services, and there was a general sense that things were operating more smoothly. A challenge that was noted in some of the interviews was the manner in which the Travellers were informed of their appointments. They were often written to, and it was perceived that this might be a barrier as many of the Travellers have literacy problems. Another challenge was that if the Travellers missed consecutive appointments, they were discharged and referred back to their GP. In the following quotation, the key stakeholder described a typical scenario that might have occurred prior to the TMHLN's appointment.

They're not aware of that, do you know. And you're saying to them, like you know, right, make sure and come to your next appointment. But like [TMHLN] said, sending out the letter, they mightn't be able to read it. They mightn't want to ask someone else, who can read to read it. Because they don't want them knowing. And they don't come, so they get discharged. Then the mood drops again, or whatever way it is, and they become unwell. And they're presenting in crisis, or the GP is ringing you going, something has to be done. And it's just. And then it's the relinking back in again. It's like starting, reinventing the wheel all over again. [Key Stakeholder FG 2]

The TMHLN worked with the mental health services in a number of ways. Firstly, she made referrals to the mental health services for Travellers who required more specialist or medical intervention, and these were mostly done through the Traveller's GP. Secondly, the TMHLN supported the mental health services in terms of helping Travellers who were existing service users to stay linked to the services. For those Travellers who had been in contact with the service but had missed their appointments for whatever reason, and were subsequently discharged, the TMHLN was able to help Travellers re-establish links and reconnect with the services. This involved helping and supporting the Traveller to get in contact and make the appointment themselves or in some cases, contact the services on the Traveller's behalf and renegotiate an appointment. Once the appointment was made, then the TMHLN worked with the Travellers to make sure that they attended and helped them understand and follow any instructions following the appointment. Similarly, when new referrals received appointments, the TMHLN worked to ensure that the Travellers kept those appointments and provided support and reassurance if they were anxious about attendance. In some cases, when appointments were missed, the community nurses were able to get in contact with the TMHLN if they were unable to contact the



Traveller to see if anything had happened. The TMHLN would then make contact with the Traveller to see what was going on and try and support adherence with appointments or health instructions. It was suggested that the TMHLN could de-escalate a crisis that was occurring because the Travellers trusted her and were open to her suggestions in terms of accessing help. Some of the Travellers did not have a Community Mental Health Nurse even though they were under the care of the mental health services; this was seen as a challenge, and it was perceived that they required additional supports to keep appointments and remain well. In these cases, the TMHLN was able to provide some support although she did not take on the role of Community Mental Health Nurse. Where Travellers did not want a Mental Health Nurse calling around to their homes, the TMHLN worked with the Traveller and either encouraged access to the services or arranged alternative supports through the networks that she was aware of.

The TMHLN could also link Travellers who were using the mental health services to the Traveller Health Projects which helped them to remain socially connected. Attending Traveller Wellbeing Groups run by the Project was encouraged, and Travellers were able to benefit from the activities that happened there. As many of the activities promoted positive mental health, they were considered useful. In addition, the Traveller Wellbeing Groups tried to break down some of the barriers around mental health and present a more positive perception of engagement with the services. Furthermore, as the Traveller Wellbeing Groups were recovery-focused, the approaches that were used supported the overall mental health agenda in terms of supporting wellbeing and accessing the mental health services when appropriate. However, it must be noted that this improvement was a subjective perception and there were no statistics available to confirm the increases in referrals or numbers of Travellers attending services. At the time of writing there was no ethnic identifier in the Mental Health Services for Travellers.

Yea that's greatly improved. Yea we've seen a huge difference in that area like, I mean that. Even the little fact that [TMHLN] might remind them, do you know? Because like, they have a lot of time if someone is doing okay, their appointment might not be for three months. I'm hard set to remember myself an appointment in three months. And like that, I know some people use calendars and stuff or keeping; you know, to avoid the crisis and hospital admissions. Certainly, it runs a lot smoother. But I think [TMHLN]'s work is recovery-orientated. So you know, and her work would be around looking at the importance of why maybe, to be compliant with appointments, medication, links in the community, supporting Traveller ladies, or men; even attending the groups that are run over in St Catherine's. Some of them might not know about them, or yes, an awareness of what's going on around. [Key Stakeholder FG 2]

Another important role the TMHLN fulfilled was an educative one, and this role is perhaps best explained in the following quotation.

The knowledge would've been; prior to [TMHLN]'s appointment, I suppose the knowledge would've been limited. And I suppose with [TMHLN]'s appointment, [TMHLN] has done huge work in relation to I suppose develop and educate our own core mental health staff. So [TMHLN] has met our team, come to our MDTs [multidisciplinary team meetings], has

spoken about the diversities, and I suppose the cultural issues, around Travellers. And she has provided huge impact to our team. And I suppose in the absence of [TMHLN] doing that I suppose, we would've been at a lesser knowledge level, you know than what we currently are. That has been an invaluable piece that [TMHLN] has contributed to our team. And I suppose the diversities and the cultural issues and the specific Traveller cultural issues that we wouldn't have been too au fait with. And [TMHLN] has I suppose, enhanced our knowledge. Has I suppose educated us and I suppose has broken down barriers within our own services around the diversities and the cultural-specific issues with Travellers. [Key Stakeholder 22]

## 6.4 Interagency Working

As part of the evaluation, we interviewed a range of professionals from both the statutory and voluntary services who were working across Carlow and Kilkenny. The vast majority provided services to the community and therefore were not Traveller-specific. The professionals provided a network of services that could be accessed by the Traveller community depending on need. All of the services were aware of the TMHLN and her role. For the most part, there was a reciprocal arrangement between the TMHLN and the services. The TMHLN either referred Travellers to the specific service for support, or the service referred the Traveller to the TMHLN for mental health support where necessary. As many of the socioeconomic problems that caused stress for the Travellers revolved around housing and accommodation, there was a strong link between the TMHLN and the housing authorities in both Carlow and Kilkenny.

In terms of accommodation, there were Social Workers who were specifically employed to assist with Travellers' accommodation issues. The Social Workers were well placed to identify Travellers that were experiencing distress, and where appropriate would refer them to the TMHLN with the Traveller's permission. Likewise, they would also refer Travellers to the PHN for Travellers. The Social Workers were aware that both the TMHLN and the PHN for Travellers had spent considerable time developing trust and building relationships with the communities. This meant that when it was suggested that the local authority contact them for support, the Travellers were generally open to this. In addition, the Social Workers had built positive relationships with the Travellers as well, and the TMHLN was able to draw from these relationships in her work. For Travellers whose accommodation status was negatively impacting on their mental health, the TMHLN often made representation to the local authority on the Traveller's behalf. While there was a perception that these referrals to the TMHLN did not happen that often, there was a positive perception of this relationship.

Yea sure. It's a two-way process, very often people who I would be dealing with have health concerns, or mental health concerns, or substance misuse, or domestic violence concerns. In incidences where I think there's a relevance to [TMHLN], I will contact [TMHLN] and let her know. Reciprocally, if there are issues in which accommodation is brought up as a central kind of problem, then [TMHLN] will say, look we have to be able to sort out, we have to be able to separate the two different problems. I can help you with your



mental health problem. But I'll refer you straight onto [Stakeholder] here to deal with the accommodation problem. [Key Stakeholder 9]

Likewise, when the TMHLN made representation to the local authority on behalf of a Traveller, this was well received and attempts made to resolve the issues where possible.

Well, I found it positive and I suppose from a local authority point of view; not speaking just from myself, but my colleagues and I have found [TMHLN]'s representations to be valid and positive on people's behalf. And referrals that we get from [TMHLN] have been valid and positive. Sometimes we've been able to help in those; sometimes we don't have the resources to deal with them. And you know, we try to keep those issues on the housing side, we try to keep engaged with the individual on housing issue, to allow [TMHLN] to do the work that she does. [Key Stakeholder 9]

In some cases, Social Workers were able to contact the TMHLN and seek advice from her about particular Travellers that they were assisting which is exemplified in the following quotation:

I would say like, if I know, you know, would you like me to get in touch with her and I can bring her out to meet you if you, you know, in our policy now on the odd occasion I might actually ring [TMHLN] you know anonymously, or you know confidently and say listen, I have this situation and I am a bit worried about so and so what do you think? Like, do you think I am kind of on the right pathway you know, and she might say yes, I am, you know? If she said yes, I would say well, you know what do you think? Are you available to meet with them or whatever? And if she said so I would get a bit of, depending on the situation or depending on how I would know the person as in the Traveller, I would might get a bit of advice from [TMHLN] kind of confidentially first. [Key Stakeholder 10]

There were similar arrangements among many of the other key stakeholders that we interviewed as part of the evaluation, and throughout there were positive perceptions of the relationships between the agencies. Many of them described how the TMHLN referred Travellers to them for support under specific circumstances and that they referred Travellers to her where necessary. This was completed on an ad hoc basis, and the respondents were not able to quantify how often it occurred.

The key stakeholders in the Substance Misuse Services reported an increase in the number of Travellers presenting to their service. They attributed this to the relationship that the Substance Misuse Service had formed with the TMHLN and the Traveller Men's Health Worker who sought support from the Substance Misuse Services for members of the Traveller community who required these services. From their initial meeting with the Traveller, stakeholders in the Substance Misuse Services adopted a more integrated approach to care and established clear lines of referral. What the TMHLN and the Traveller Men's Health Worker brought with them was their knowledge of Traveller culture and well-established relationships with Travellers and their families. The stakeholders at the Substance Misuse Services believed that they were able to 'piggyback' on this trust and forge their own relationships with Travellers once they were referred to them. Typically, the TMHLN would refer the person who was using substances to the service, and another family member would bring them to the centre.

Following initial assessment in the Substance Misuse Service, the TMHLN was instrumental in keeping the person engaged with the process and worked to motivate them to attend. The Substance Misuse Service team also provided a service to Traveller's family members, as they recognised that some people are not ready to engage with treatment and the family members needed to be supported to cope as well. The stakeholders at the Substance Misuse Service also talked about how completing the Traveller Cultural Awareness Programme was essential to understanding how to approach working with Travellers and how they had to respond differently to Travellers. They also suggested that many of the Travellers that used opiates and attended the Substance Misuse Service were also experiencing some form of trauma; stakeholders in the Substance Misuse Services felt that it was difficult to engage Travellers in the therapeutic process at this point, as many Travellers saw drug replacement therapy as a solution, rather than dealing with the issues that were underpinning their drug taking behaviours.

A lot of the Travellers that are even coming down here. You'd want to see some of the trauma that I didn't even get into, that they're coming with. So, I'm saying that I think this is the start of it. We're getting more and more Travellers here, and it's great that they're doing that. But they're kind of dipping their toe in the water. I think there's, half of them testing us. But they're coming up so traumatised; I'm not surprised that there's PTSD [Post-Traumatic Stress Disorder], or anything with these lads. I'm not surprised. And even the way they talk. There's post, you know, they talk all the time about the background in the present. [Key Stakeholder FG 1]

The Family Resource Centre in Carlow and in Kilkenny were keen to improve their involvement with Travellers as part of their strategic developments. The TMHLN along with the Traveller Health Projects were able to support these initiatives and help them to foster relationships with the Travellers in the areas and to subsequently create links to other services and resources that are available at the centres. To that end, a Traveller Wellbeing Group was organised at the centre which was led by one of the TCHWs and the TMHLN. This provided an opportunity for the staff at the resource centre to meet with Travellers and to tell them about the services that they provided. The fact that a nurse was helping to facilitate the Traveller Wellbeing Groups was perceived as lending credibility to the group and attracted a lot of Travellers to it. The process and the success of the initiative is exemplified in the following quotation.

But it kind of alarmed me to think that you know, that they actually had absolutely no idea that there was a counselling service. Or that there were support workers, or that any other support could be obtained from here. So, our kind of, our initial engagement with the Travellers was directly as a result of the session of the wellbeing morning, and I think because the TCHWs were involved. But really, because there was a nurse, you know the ladies told me afterwards that they really, the buy-in I suppose, or the interest from them was because it was actually a nurse. And it gave them the sense of being supported and it being official. And since that happened, I work with quite a number of the families then on an individual basis. Do you know from a family support community development point of view? I've really worked intensely with a lot of them, in relation to accommodation, or their children and circumstances, even health, social welfare, things like that. So, we're hitting



a lot of the issues that they're experiencing all round, between the nursing element of it obviously. The TCHWs and then myself. So, it's allowing us to really support the families. And word is spreading, because people are phoning me up then saying, oh so and so told me to come up to you. I can't read my letters; I can't fill out my forms, things like that so there's a lot of that happening now as well. Accommodation is the main issue as you can imagine. [Key Stakeholder 13]

Once these links were established with the Traveller community, a reciprocal referral arrangement was in place, similar to what has been described previously. For example, in the following quotation, the stakeholder had referred Travellers to the Mental Health Services but had found attendance and adherence had been a particular problem. However, since the TMHLN's appointment, she was able to support the people to attend and help allay any fears or anxieties that they have.

And particularly with the men. They weren't inclined to engage. And so that took a lot for them to open up. But once they did, there are huge mental health issues for generations when you start to delve into it. And I suppose we were doing a lot of referring on to other services then, around mental health. But it just wasn't really working; they would go do one or two sessions, and that was kind of it, wouldn't go back, or just felt that they weren't being understood. So, I suppose when the Mental Health Nurse post came here to Kilkenny, it was a godsend. It just was, it was fantastic to be able to refer to that person. And then I would do the first initial meeting with the families that I work with. And she's just you know, she's very open, and I just found that it's been a great help. To be able to have somebody there to refer onto that really understands the needs. And I think this particular person; she really understands the needs of the Traveller community. She would've had a background there, so that has really proved to be a great asset I think to Kilkenny city. [Key Stakeholder 12]

Finally, the wrap-around service that the TMHLN discussed as part of her role is best exemplified through her work with the youth services. In this instance, the TMHLN would signpost young people to the youth service if she believed that they were vulnerable to or experiencing distress, or if they were perhaps contributing to the distress that was being experienced by the Traveller parent. Problems talked about here included early school leaving, drug taking or other risky behaviours and being bullied to name a few. The youth service has an integrated service and was able to refer young Travellers to other more suitable services following initial referral. In addition, they also had a Traveller-specific youth programme which supports people up to the age of 24. While the work that the TMHLN was specific to adults, she was able to refer other family members where appropriate in a family-centered way.

## DISCUSSION AND RECOMMENDATIONS

The overall aim of this study was to evaluate the role of the TMHLN from multiple perspectives including ascertaining the views of the Travellers who access and use the service. This chapter presents a discussion of the findings under a number of headings which dovetails with the aims of the evaluation. Recommendations based on the findings will conclude this chapter. Prior to looking at specific features of the TMHLN's role, the overall impact of the initiative will be discussed using the RE-AIM framework.

### 7.1 RE-AIM Framework

The RE-AIM Framework (Glasgow et al., 1999; Gaglio et al., 2013) is a conceptual model which measures the impact of health interventions using five criteria which are presented and briefly explained in Figure 6.1. While the RE-AIM framework is used primarily with qualitative and quantitative data, the criteria will be discussed with reference to the qualitative data that was collected as part of this evaluation.

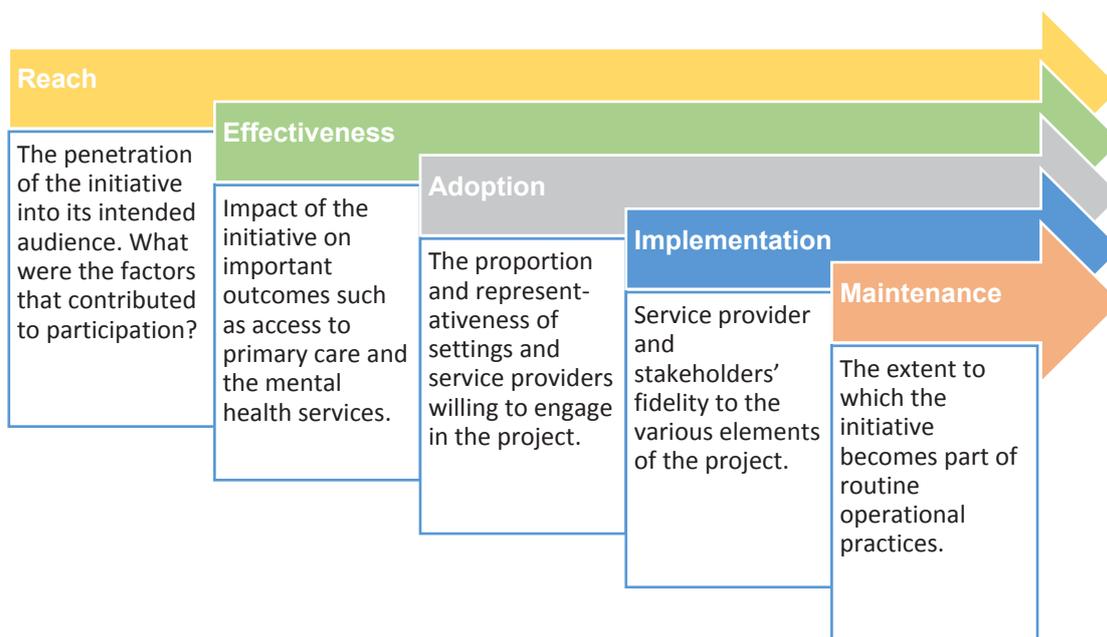


Figure 7.1: RE-Aim Framework (Glasgow et al., 1999; Gaglio et al., 2013)

### 7.1.1 Reach

The activities of the TMHLN demonstrated considerable success in terms of reach when the number of Travellers who were provided with an intervention is taken in to consideration. From year one to year two there was a considerable increase in the number of Travellers being referred or self-referring to the TMHLN. A number of factors supported this. Firstly, the strong infrastructure that existed to support Travellers, particularly the Traveller Health Project in both counties provided a backdrop for the work of the TMHLN to flourish. The trust and relationships that the TMHLN built with the communities also contributed to this reach. The TMHLN also demonstrated considerable reach through her outreach work which is demonstrated by the diversity of the locations where she practiced. In addition, statutory and voluntary organisations were aware of the TMHLN and her role. Her contact with these stakeholders and the reciprocal referral arrangements also contributed to the reach of the initiative. There was also evidence of reach beyond the boundaries of the initiative with the TMHLN involved in membership of committees and other Traveller-related fora.

### 7.1.2 Effectiveness

There was evidence from the interviews with Travellers that the work of the TMHLN was effective and that it was making a difference to the lives of the people she saw on a one-to-one basis. These Travellers placed a high value on the work that she did and there is evidence to support the role as a health educator, health promotor, referral agent and sign-poster to other services. For Travellers that took part in individual interviews, all had formed a therapeutic bond with the TMHLN; this space provided Travellers with an opportunity to address their mental health needs and to get a greater understanding of the concept of mental health. For many of the Travellers, the TMHLN was able to offer recovery-orientated wellbeing interventions and refer to primary care where necessary. In the Mental Health Services there was a greater understanding of the mental health needs of the Traveller community and the TMHLN was a focus point for information and supported engagement with the mental health services for those Travellers who required it. Likewise, among other statutory and voluntary organisations, there was evidence of the effectiveness of the TMHLN's liaison role and her role in supporting outreach work in other organisations such as the Family Resource Centres. There is also evidence that the TMHLN raised awareness of the mental health needs of Travellers and contributed to challenging some of the barriers to access primary care via advocacy and education. There was less evidence to support the TMHLN's work with the Traveller Wellbeing Groups that were run as part of the projects. However, it was clear that the TMHLN was valued, and the Traveller service users engaged with the Traveller Wellbeing Groups and enjoyed the wellbeing activities that were taught there. The Traveller Wellbeing Groups were a source of referral for the TMHLN and also offered a medium for peer support for the Traveller women that mostly attended.

### 7.1.3 Adoption

There was strong support for the TMHLN, particularly from the Traveller Health Projects. There was a clear understanding of her role and the referral pathways that existed between the Traveller Health Project, and the TMHLN provided evidence of adoption. Similarly, adoption was demonstrated in the relationships that were formed by the TMHLN with the mental health services and other statutory and voluntary organisations, and the reciprocal referral pathways that existed between services and organisations. The visibility of the TMHLN among the Traveller community in both Carlow and Kilkenny and their increased willingness to engage with her is further evidence of adoption.

### 7.1.4 Implementation

There was strong leadership that supported the role of the TMHLN. This emerged from the Social Inclusion Office and the governance arrangements that were in place for the TMHLN. While a job description was in place, the TMHLN demonstrated flexibility to meet the needs of the Traveller community while also staying true to the values, vision and aims associated with the role. The Traveller Health Projects and the allied health and social care professionals were key drivers of the TMHLN activity across Carlow and Kilkenny. While there was organisational support for the role, there was a perceived lack of peer support from other Mental Health Nurses; although this did not adversely affect implementation.

### 7.1.5 Maintenance

Financial stability for the role was addressed early in the initiative with funding for the role emerging from the HSE Social Inclusion Office and governance arrangements put in place between the Mental Health Divisions and the Social Inclusion Office. There is recognition that the governance structures need to be reviewed in light of some clinical situations and the implementation of explicit policies and protocol will strengthen these governance arrangements. The awareness of the TMHLN's role throughout Carlow and Kilkenny and among allied health, social and voluntary services also provide evidence that the role can be sustained over time. The volume of work that the TMHLN has to contend with and the demands on her time given the nature of her work may be detrimental to enhanced sustainability over time, especially as she becomes more embedded across the two counties. Current plans are underway to extend outreach work and this needs to be examined in light of current workload commitments. The role of the external clinical supervisor should support the sustainability of the initiative and this time should continue to be protected. While the work of the TMHLN is effective and valued, it does not constitute a service in that it relies exclusively on one person, introducing vulnerabilities to the sustainability of the role.



## 7.2 Job Description and Role of the Traveller Mental Health Liaison Nurse (TMHLN)

The job description initially submitted to the St Stephens Green, Social Inclusion, Mental Health Department is detailed in Box 7.1.

Provision of an outreach service to Travellers to promote positive mental health and to bridge the gap between Travellers accessing primary care and mental health services, to break down the barriers which prevent Travellers who are experiencing mental health difficulties and contemplating suicide from accessing mainstream supports, in line with the Traveller Health Unit 5-year Strategic Plan.

The Staff Nurse (Mental Health) will:

- Provide mental health case management support to Travellers with emerging, ongoing, or crisis mental health needs. All supports aim to increase access to local mental health services.
- Develop working links to Primary Care Teams, Adult Mental Health Services, Child and Adolescent Mental Health Services, Community Mental Health Supports, Community Services and Traveller Health Projects in Carlow and Kilkenny.
- Work closely with Traveller Health Projects to support the Traveller Health Workers to raise awareness of mental health issues and support services that can be accessed.
- Assist in the professional development of Clergy / Religious and other agencies and organisations who meet with Travellers in the course of their daily work, to be in a position to refer / signpost to primary and mental health services where needs are identified.
- Will provide ongoing support to a small number of Travellers who are interested in developing skills in the area of Mental Health in order to be a resource in their own community.
- Will promote and encourage involvement with peer support training and education, and engage with the Recovery College developments in the Mental Health Service.

*Box 7.1: TMHLN Job Description*

The post was originally advertised as a mental health staff nurse position working in the Community with Travellers in Carlow and Kilkenny. The role of the nurse was firmly situated within outreach work, and while their role in liaison was evident in the job description, it did not feature strongly. Many of the roles as detailed in the job description are being carried out, but the role has developed over time to reflect the needs of the community it serves. An analysis of the main components of the job description is presented in Table 7.1.

The overall aim of the post firmly situated the role of the TMHLN in outreach work, but the evaluation demonstrates that her work mainly operates across in-reach, outreach, liaison and educative domains and this should be reflected in the job description. MHLN has been defined as ‘the application of Mental Health Nursing knowledge and skills to non-psychiatric health settings’ (Roberts 1997: p.103), and in that sense the emphasis on liaison nursing in the title of this role is appropriate. However, most MHLNs are operating in the context of Clinical Nurse Specialists and this should be considered for this role. A diagrammatic representation of the main components of the TMHLN’s role is presented in Figure 7.2.

## Analysis of the Job Description of the Traveller Mental Health Liaison Nurse (TMHLN) Role in the Context of Evaluation Findings

<p>Provide mental health case management support to Travellers with emerging, ongoing, or crisis mental health needs. All supports aim to increase access to local mental health services.</p>	<p>Mental health case management was conducted by the TMHLN. Many of the Travellers were referred to the primary care services or to other health or social care agencies. Where necessary, Travellers were referred to the specialist mental health services or linked back into the service if they were already known. For many of the Travellers, no further intervention was required apart from a listening service with advice about self-care management. Considerable time was spent following up Travellers to ensure that they attended appointments.</p>
<p>Develop working links to Primary Care Teams, Adult Mental Health Services, Child and Adolescent Mental Health Services, Community Mental Health Supports, Community Services and Traveller Health Projects in Carlow and Kilkenny.</p>	<p>This was evident throughout the interviews with the TMHLN, the key stakeholders and the Traveller Health Projects.</p>
<p>Work closely with Traveller Health Projects to support the Traveller Health Workers to raise awareness of mental health issues and support services that can be accessed.</p>	<p>The TMHLN worked closely with the Traveller Health Projects, and there was evidence that they could support individual Travellers, and where necessary, refer to the TMHLN for a more comprehensive intervention or referral. The TMHLN was a key support to the TCHWs alongside the coordinators and managers of the projects.</p>
<p>Assist in the professional development of Clergy / Religious and other agencies and organisations who meet with Travellers in the course of their daily work, to be in a position to refer / signpost to primary and mental health services where needs are identified.</p>	<p>While there was mention of the importance of the clergy for members of the Traveller community, this aspect of the role did not feature strongly in the interviews.</p>
<p>Will provide ongoing support to a small number of Travellers who are interested in developing skills in the area of Mental Health in order to be a resource in their own community.</p>	<p>While the TMHLN did support the TCHW and other members of the Traveller Health Projects, this piece did not feature strongly in the interviews. It was clear from the interviews with the Traveller Health Project that the TCHWs were already a key resource in their respective communities.</p>
<p>Will promote and encourage involvement with peer support training and education and engage with the Recovery College developments in the Mental Health Service.</p>	<p>There was some evidence a couple of Travellers had been involved in the Recovery college doing WRAP, but generally, the interviews did not speak to this aspect of the role.</p>

Table 7.1: Analysis of the Job Description of the Traveller Mental Health Liaison Nurse (TMHLN) Role





Figure 7.2: An Overview of the Role of the TMHLN

### 7.3 Governance Structures

There is a Joint Management Structure for managing the work of the TMHLN between the Social Inclusion and Mental Health Division. Findings from the evaluation indicate that while there is a perception that the governance arrangements were working, it was suggested that they needed to be strengthened. The joint governance arrangements are unusual in the context of Mental Health Nursing but have the potential to be innovative as registered nurses begin to work outside traditional governance structures and extend into new areas of practice. The joint structure in place here is appropriate, as input from both primary care and the mental health service are required. According to the HSE (2012), there are ten principles for good clinical governance; namely, patient first, safety, personal responsibility, defined authority, clear accountability, leadership, inter-disciplinary working, supporting performance, open culture and continuous quality improvement. A literature review on the topic of shared governance in nursing yielded little information on models of shared governance used with MHLN in outreach or community settings. Several papers, however, reported on issues linked to the principles outlined by the HSE (2012). Two papers discussed MHLNs; one examined the origins and definitions (Roberts 1997) while the other reported on an evaluation of the MHLN role in an Emergency Department setting (Wand 2005).

Most of the other literature focused on shared governance as a concept or the ways shared governance could be measured (within the Magnet Model in the United States) (Anderson, 2011; Barden et al. 2011; Hess 2011; Clavelle et al. 2017; Hess 2017; Porter-O’Grady 2017). Others described the design and implementation of a shared model (Bretschneider et al. 2010; Hoying and Allen 2011; Burkoski and Yoon 2013; Cadmus et al. 2015; Fisher and Hubbard 2015). One paper reported on a 10-year review of shared governance in an academic medical centre (McDowell et al. 2010). There was one Irish paper, which looked at the importance of role clarity for clinical governance operationally but did not examine shared governance (Davies et al. 2015). Overall, there was little in the literature that could shed light on the TMHLN’s current governance arrangements or how they might be enhanced.

The Health, Information and Quality Authority (2012) states that all service providers should have clear governance and management structures to ensure clear accountability arrangements to ensure the delivery of high-quality care. As such, the HSE (2016) states that governance for quality means that the requisite structures, processes, standards and oversight necessary for effective and person-centred services are in place. The HSE’s vision for quality governance is presented in Box 7.2.

Governance for quality and safety is an integral component of governance arrangements where:

1. Each individual, as part of a team, knows the purpose and function of leadership and accountability for good health and social care.
2. Each individual, as part of a team, knows their responsibility, level of authority and to whom they are accountable.
3. Each individual, as part of a team, understands how the principles of quality and safety can be applied in their diverse practice.
4. A culture of trust, openness, respect and caring is evident among managers, staff and service users.
5. Each individual, as part of a team, consistently demonstrates a commitment to the principles of quality and safety in decision-making.
6. Quality and safety is embedded within the overall corporate governance arrangements for the Organisation to realise improved outcomes for service users.

<https://www.hse.ie/eng/about/who/qid/governancequality/>

*Box 7.2: Governance for Quality and Safety (HSE 2016)*

The Governance structures in place for the TMHLN has the potential to provide a blueprint for shared governance arrangements in Ireland. However, as mentioned, the structures need to be strengthened, and this will require a clear explication of the roles and responsibilities of each of the governing agencies. In addition, the job description needs to be explicit about the boundaries of the TMHLN’s role, providing clear guidance about where the boundaries of her responsibility lie. In addition, these governance arrangements need to be reviewed on a regular basis.



The governance arrangements can be described as a tripartite arrangement, which mirrors Proctors (1987) Model of Clinical Supervision which has been widely used in nursing. The Office of the Nursing and Midwifery Service Director (2015) have also adopted Proctor’s Model in their Clinical Supervision Framework for Mental Health Nursing. The Model identifies three interrelated levels of supervision which are presented in Table 7.2. Using Proctor’s Model of Clinical Supervision as part of the governance arrangements can help to ensure that the interrelated nature of the governance processes are explicit.

Level of Supervision	Function
<i>Normative/Managerial</i>	Helps ensure that the professional standards and professional/organisational roles are met.
<i>Formative/Educative</i>	Focuses on developing skills, understanding and ability, by reflecting on and exploring the work of the person being supervised.
<i>Restorative/Supportive</i>	Gives attention to the emotional needs of the nurse, how they have been affected by the work with patients, and how to deal with them constructively.

Table 7.2: Proctors Model of Clinical Supervision (Carney 2005)

## 7.4 Traveller Mental Health Advisory Group

The Traveller Mental Health Advisory Group was formed as a subgroup of the South East Traveller Health Unit who wanted to work towards improving access to mental health services for Travellers. The current terms of reference were outlined earlier (Section 4.9). While the group has no governance function or responsibility, it meets regularly, and the TMHLN provides an update about her activities. While some of the activities described in the terms of reference pre-date the appointment of the TMHLN, the group were instrumental in applying for the original funding and establishing the role. However, throughout the interviews, there was a lack of clarity about the purpose and scope of the group beyond the reporting and updating arrangements. It is likely that this group could re-examine its terms of reference in light of the TMHLN’s current role and how they might support her. In addition, the role of the group as a support to the governance arrangements already in place could also be explored.

## 7.5 The Day-to-Day Work of the Traveller Mental Health Liaison Nurse (TMHLN)

The day-to-day work of the TMHLN has been described in considerable detail in Chapter 4 of this report. While a variety of interventions are used in practice, they are all underpinned by a recovery approach. Recovery according to Anthony (1993) is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness. The petals of recovery as described by Higgins and McBennett (2007) present the core components of recovery as a process and as an approach to care and are shown in Figure 7.3.

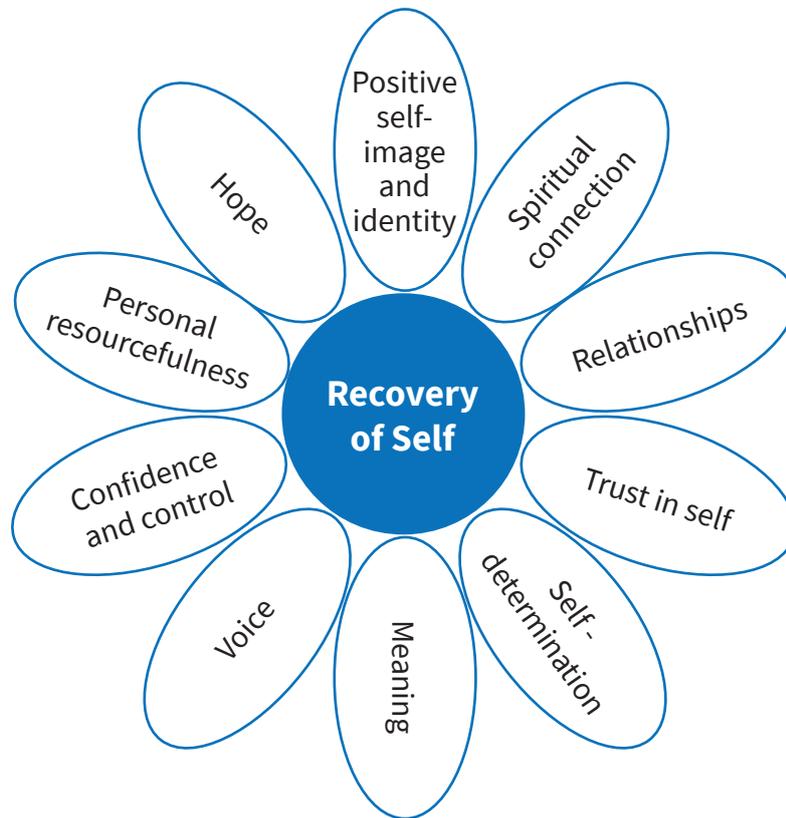


Figure 7.3: The Petals of Recovery (Higgins and McBennett 2007)

According to the Mental Health Commission (2005, p.4):

‘The recovery approach in mental health services emphasises the expectation of recovery from mental ill health and promotes both enhanced self-management for mental health service users and the development of services which facilitate the individual’s personal journey towards recovery.’

The principles values and attitudes associated with recovery according to the Mental Health Commission (2008) are:

- Optimism about recovery,
- Personal meaning,
- Person-centred services,
- Mobilising personal resources/individualised self-management plans,
- Service user operated services or peer support,
- Respect for expertise by experience,
- Social inclusion, and
- Multiplicity of perspectives.

According to A Vision for Psychiatric/Mental Health Nursing (Cusack & Killoury 2012), the principles and values associated with the recovery approach will inform Mental Health Nursing across all clinical domains. In the implementation of recovery, Smith-Merry et al. (2011) found that four ‘technologies’ come together to promote and support the delivery of recovery-orientated services. Each of these will be discussed briefly in the context of the work of the TMHLN with the Traveller community.

### 7.5.1 Recovery Narratives

In this context, recovery narratives speak to the importance of the Travellers being able to tell their own story, in their own way and at their own pace. This is of particular importance as it draws from and supports the oral traditions that exist among the Traveller community. The importance of the narrative approach was alluded to throughout the interviews with service users; they referred to having someone to listen to them, and someone providing them with a safe, confidential space to talk about the issues that affected them. The narrative approach also placed less emphasis on medical or psychiatric ‘treatment’, and the unhurried, relaxed and comfortable atmosphere allowed the Travellers to share their stories.

### 7.5.2 The Scottish Recovery Indicator (SRI)

The SRI is a self-assessment tool for measuring the extent to which a service is recovery-orientated and consists of ten indicators:

1. Basic needs are identified and addressed,
2. Goals are identified and addressed,
3. Personalised services are provided,
4. Service is strength-based,
5. Service promotes social inclusion,
6. Service promotes and acts on service user involvement,
7. Informal carers are involved,
8. Service encourages advance planning and self-management,
9. Staff are supported and valued, and
10. Practice is recovery-focused.

In the interviews with the service users, the TMHLN and the Traveller Health Projects, each of the SRI indicators are evident and are supported by the qualitative data that was collected in this evaluation.

### 7.5.3 Wellness Recovery Action Planning (WRAP)

WRAP is a self-management programme, which emerged in the 1990s and has gained considerable traction in Ireland as a vehicle to promote recovery-orientated practices. There is some evidence to support the use of WRAP from an evidence-based perspective (Starnino et al. 2010; Cook et al. 2012; Higgins et al. 2012; Cook et al. 2013). For the TMHLN, the principles of WRAP underpinned her work with the Traveller community and she had completed a WRAP facilitator's programme. However, WRAP in its purist sense, as a formalised process-orientated activity, was not adhered to and instead, WRAP was used in an elective fashion depending on the needs of the individual that presented. While this was partly to do with literacy levels, no assumptions about Traveller literacy or ability were made and every opportunity was given to the Traveller to complete the WRAP in its entirety. In fact, there were some Travellers who had completed the 2-day WRAP programme. WRAP was used in a more principle-orientated way with principles such as hope, personal responsibility, education, advocacy and support used to underpin practice. Furthermore, within the WRAP programme, elements such as 'wellness tools', 'recognising triggers', 'early warning signs' etc. were adapted to meet the needs of the Traveller community. In addition, much of the WRAP work followed the oral tradition with the TMHLN and the Traveller talking about the issues, or the TMHLN transcribed the triggers while the Traveller talked about them. In some cases, the Travellers themselves could complete the paperwork but not in its entirety. Therefore, Travellers were at a disadvantage if they were unable to read and write. However, the use of WRAP in this way is not unusual and while purists advocate for completion of the entire plan, elective use has been found in the literature (Keogh et al. 2014). In addition, the TMHLN minimised references to mental illness when using WRAP which fitted in with the emphasis on wellness rather than illness, and that the principles associated with WRAP were valuable across both physical and mental health domains.

### 7.5.4 Peer Support

The final recovery technology as described by Smith-Merry et al. (2011) is peer support. Peer support according to Mental Health Ireland (2017) may be defined as the help and support that people who have experienced mental distress are able to give to each other. In the context of the TMHLN's work with Travellers, peer support was used in a number of ways. Firstly, wellbeing messages often revolved around getting support from family and friends or other members of the Traveller's immediate social network. In addition, Travellers were informed about the Traveller Wellbeing Groups that were being run by the Traveller Health Projects as a means of encouraging peer and social support. Furthermore, Traveller men were also referred to the Men's Shed that was in operation. The Traveller Wellbeing Groups and the Men's Shed approach in the main are peer-led and there is evidence that these can reduce distress, improve social support and improve quality of life (Canadian Mental Health Association 2005). The findings from this evaluation suggest that one-to-one interventions with Travellers were more successful in terms of transmitting messages about mental health and wellbeing. There was less evidence to support this conclusion in Traveller Wellbeing Groups, although this is not to say that it didn't happen. It may be that the service users who we interviewed from the Traveller Wellbeing Groups did not clearly articulate their experiences or they were not able to speak to their mental



health awareness on that day. There was strong support for the Traveller Wellbeing Groups among the key stakeholders from the Traveller Health Projects, including the TCHWs and the TMHLN. In addition, they allowed Travellers to get to know the TMHLN and many of the Travellers self-referred to the TMHLN from the Traveller Wellbeing Groups. Furthermore, the nature of mental health and distress is complex and can be difficult to articulate for both Travellers and the general population.

Overall, the findings from this evaluation suggest that the recovery-orientated approaches used by the TMHLN are well suited for use with the Traveller community. Of primary importance is the philosophy associated with recovery, which moves the focus away from signs and symptoms and into the real world of the Travellers where the experience of trauma is common. In addition, the prevalence of social factors affecting mental health provides for meaningful personal recovery as advocated by Slade (2009) among others, with less focus on clinical outcomes. In addition, given the Traveller community's poorer general health outcomes, the approach to wellbeing is important, which stresses the significance of both physical and mental health. The implementation of recovery has often required a cultural change within mental health services, however many of the characteristics associated with recovery (Higgins and McBennett 2007) were already in place within the Social Inclusion Office and the Traveller Health Project. In addition, the TMHLN's experience in mental health and community development dovetailed with existing values and beliefs. These values and approaches allow for the delivery of a culturally congruent service which is tailored to meet the needs of each individual. This is aligned with recommendations from the National Traveller and Roma Inclusion Strategy (Department of Justice and Equality 2017), which advocates that health services should be delivered and developed in a way that is culturally appropriate.

As part of the evaluation, we reviewed the methodologies and materials that have been used as part of the TMHLN's work with the Traveller community. There was an acute awareness that literacy could be an issue among members of the community; however, this was coupled with the fact that this was a sensitive subject. In addition, the TMHLN was careful not to make assumptions about levels of literacy which has been mentioned earlier. This meant that a cautious approach had to be used when written materials were used. When written materials were used, the materials used plain, simple English, and where possible, pictures were used to promote understanding. Materials that were used in the assessment process were recovery-orientated and designed in response to service user need when the TMHLN was first appointed. The use of forms was kept to a minimum and introduced slowly and cautiously. The TMHLN also recorded outcomes in an Excel sheet that she designed herself. A range of information was recorded on the Excel sheet, and the Travellers consented to this information being stored. While some of this information was shared at the Traveller Mental Health Advisory Group, the rationale for recording this information was not clear. In the Social Inclusion Office, only data on the number of Travellers interacting with the service is recorded. Consideration needs to be given to what information needs to be recorded, why it needs to be recorded and what will be done with it once collected.

## 7.6 Connecting for Life

Suicide was a common theme that ran through the interviews with service providers, and they were acutely aware of the disproportionate impact that completed suicide had on members of the Traveller community, especially Traveller men. In the service user interviews, all of the service users had been affected by suicide in some way, and some of them had described being suicidal and had attempted suicide in the past. In addition, the TMHLN talked about meeting Travellers who were experiencing complicated grieving. Current national policy for the prevention of suicide and self-harm in Ireland is called Connecting for Life which was published in 2015. Within the policy, Travellers are identified as a priority group. Seven strategic goals for Connecting for Life are identified (Department of Health 2015 p.29):

1. To improve the nation's understanding of and attitudes to suicidal behaviour, mental health and wellbeing.
2. To support local communities' capacity to prevent and respond to suicidal behaviour.
3. To target approaches to reduce suicidal behaviour and improve mental health among priority groups.
4. To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour.
5. To ensure safe and high-quality services for people vulnerable to suicide.
6. To reduce and restrict access to means of suicidal behaviour.
7. To improve surveillance, evaluation and high-quality research relating to suicidal behaviour.

The introduction of the TMHLN speaks to a number of the strategic goals outlined in Connecting for Life, in particular, enhancing accessibility, consistency and care pathways of people vulnerable to suicide. In addition, a report exploring suicide among middle-aged men in Ireland further emphasises Traveller men as a group that warrants priority (O'Donnell and Richardson 2018). The role of the TMHLN outlined in this evaluation supports the recommendations contained in that report. Furthermore, the role of the TMHLN responds to recommendations within the National Traveller and Roma Inclusion Strategy which outlines strategies to reduce suicide and improve access to mental health services (Department of Justice and Equality 2017).

## 7.7 Facilitators and Barriers to the Development and Sustainability of the Traveller Mental Health Liaison Nurse (TMHLN) Role

In this section, a number of facilitators and challenges to the implementation and sustainability of the TMHLN role are presented.

### 7.7.1 Facilitators

- The existence of the Traveller Health Project in both Carlow and Kilkenny provided the backdrop for the TMHLN to operate within. Without this, accessing the Travellers, in particular in outreach work, would have been made more difficult if not impossible.
- The commitment of the staff who were employed as part of the Social Inclusion Office, the Traveller Health Projects and the Traveller Mental Health Advisory Group was instrumental to



the implementation of the TMHLN. Firstly, their vision for the role was central to the TMHLN's appointment in terms of recognising the service deficit and applying for funds to appoint a Mental Health Nurse. In addition, their commitment to improving the mental health of the Traveller community was evident throughout the interviews.

- The ethos of the Traveller Health Projects which valued strengths-based and person-centred approaches was also important to the implementation of the role where there was an emphasis on wellness and recovery-orientated interventions.
- The decision to appoint a Mental Health Nurse enabled easier access and more acceptance of the role within the Traveller community. The perception of nurses among Travellers as being professional, trustworthy and knowledgeable was important to establishing and implementing the role of the TMHLN.
- The presence of a South East Traveller Health Unit Strategy (2015 – 2020) to guide the direction of the Traveller Health Unit also provides direction and guidance for the TMHLN, and for Traveller Health generally, and can be seen as a facilitator.
- The personal attributes of the TMHLN can also be identified as a facilitator to the implementation and sustainability of the role. The TMHLN's prior experience of working with Travellers in a family support context was frequently mentioned as a source of knowledge that was drawn upon. In addition, her creativity, flexibility, interpersonal skills, knowledge of services, cultural awareness, and ability to foster trusting relationships, among other skills were attributes that were commented on throughout the interviews with Travellers and other stakeholders.
- The universal support for the TMHLN from all stakeholders, including Travellers, provides evidence that not only is the role valued, but it is also necessary.

### 7.7.2 Barriers and Challenges

However, a number of barriers and challenges must be acknowledged. These may threaten the sustainability of the TMHLN role over time.

- The risks associated with a single-post holder such as the TMHLN must be recognised. For example, the lack of a service that is provided during periods of absence (e.g. annual leave) poses a challenge to both the implementation and sustainability of the role.
- Similarly, the volume of work has increased significantly, and this is likely to increase further as the role becomes more embedded. This will also challenge a single- post holder.
- The provision of a service across two counties which includes both in-reach and outreach work also challenges the implementation of the role.
- Furthermore, as a single-post holder and a Mental Health Nurse working in isolation to traditional mental health teams, this poses a challenge in terms of sustainability of the role over time.
- The multiple needs of the Traveller community and the diversity and complexity of the issues that affect them can make working with this community difficult and stressful.
- The governance arrangements in place were also perceived as a challenge, which was being addressed at the time of writing this report.

# RECOMMENDATIONS

## Recommendations for the Development of the Traveller Mental Health Liaison Nurse Role

- The job description of the Traveller Mental Health Liaison Nurse has changed over time and should be amended to reflect the current roles and responsibilities, with an emphasis on the role of the Traveller Mental Health Liaison Nurse as a Mental Health Liaison Nurse.
- The complexities of the interventions and the specialist nature of the work of the Traveller Mental Health Liaison Nurse should be reflected in the grade; current and future Traveller Mental Health Liaison Nurses should be employed at Clinical Nurse Specialist grade.
- The core concepts set out in the Framework for the Establishment of Clinical Nurse Specialists (2008) outline the key roles of the Clinical Nurse Specialist and these should be used to detail the Traveller Mental Health Liaison Nurses activities. The role should continue to have a strong clinical focus and should be aligned with the core values of Mental Health Nursing as described by the Department of Health and Nursing and Midwifery Board of Ireland (2016). Other core concepts of Clinical Nurse Specialist role activity include patient/client advocacy, education and training, audit and research and consultancy.

## Recommendations to Support the Current Traveller Mental Health Liaison Nurse

- The Current Traveller Mental Health Liaison Nurse should be supported to meet the criteria for Clinical Nurse Specialist as outlined by the Department of Health (2017). This should include educational support to help develop skills in audit and measurement of clinical outcomes.
- Audit and research are essential roles of the Clinical Nurse Specialist. The Traveller Mental Health Liaison Nurse should audit and evaluate nursing practice to ensure there are improvements in health and social care outcome for Travellers.
- The Traveller Mental Health Advisory Group should support the audit and evaluation activities of the Traveller Mental Health Liaison Nurse and formulate key performance indicators to ensure quality outcomes.



## Recommendations for the Traveller Mental Health Liaison Nurses' Clinical Practice

- The Traveller Mental Health Liaison Nurse should continue to advance a recovery-orientated ethos in the area of Traveller mental health and recovery-orientated approaches should continue to underpin the role.
- Consideration should be given to using a standardised recovery-orientated assessment tool (e.g. the Recovery Star), which could be adapted for use with the Traveller community.
- It is recommended that the Traveller Mental Health Liaison Nurse forge links with the Recovery College in the area with a view to increasing their knowledge of Traveller mental health and widening Traveller access to the services and courses provided.
- The Traveller Mental Health Liaison Nurse should continue to receive external clinical supervision.

## Recommendations for the Governance of the Traveller Mental Health Liaison Nurse Role

- The Traveller Mental Health Liaison Nurse should continue to be located within the primary care services.
- Governance structures need to formalise the professional relationships between the Traveller Mental Health Liaison Nurse, the Mental Health Nursing Division and the South East Traveller Health Unit in consultation with the HSE National Social Inclusion Office and the Health Service Executive.
- There needs to be clear policies in place to support the work of the Traveller Mental Health Liaison Nurse. The current policies that are in place to guide the work of the Traveller Mental Health Liaison Nurse need to be made explicit, and a plan put in place to address gaps in policy provision. Key areas within these policies must identify:
  - Risk assessment/escalation policy
  - The Traveller Mental Health Liaison Nurse's scope of practice
  - The boundaries of the Traveller Mental Health Liaison Nurse's role
  - Referral pathways and accelerated referral pathways
  - Data Protection Policy/Health Service Executive Data Protection Policy, and
  - Contingency plans for sickness and other absences.

The governance arrangements should be reviewed regularly.

## Recommendations for the Traveller Mental Health Advisory Group

- The terms of reference for the Traveller Mental Health Advisory Group should be reviewed.
- The Traveller Mental Health Liaison Nurse should be a member of the Group.
- Consideration should be given to the role of the Group in the strategic development of Traveller mental health initiatives in the area.

## Recommendations for Sustainability of the Traveller Mental Health Liaison Nurse Role

- The South East Traveller Health Unit should scope out the business case for the provision for a more comprehensive service.
- In light of the risks associated with single-postholders such as the Traveller Mental Health Liaison Nurse, it is recommended that a critical mass of Traveller Mental Health Liaison Nurses be created within each Traveller Health Unit.
- An evaluation of the professional development needs of the Traveller Mental Health Liaison Nurse should be completed. This should include access to peer networks for both professional development and supportive needs.

## Recommendations for Resources to Support the Traveller Mental Health Liaison Nurse Role

- Resources should be available to support activities used by the Traveller Mental Health Liaison Nurse to engage in shoulder-to-shoulder work with Traveller men and women.

## Recommendations for Future Research

- To support research activities, it is recommended that the Traveller Mental Health Advisory Group build a relationship with an academic environment to develop a research strategy to support the work of the Traveller Mental Health Liaison Nurse.
- Future research could explore the relationship between consistent engagement with the Traveller Mental Health Liaison Nurse and the frequency of crisis presentations among Travellers.
- Future research could explore gender differences in the mental health needs of Travellers.
- Future research could explore the work of the Traveller Mental Health Liaison Nurse using a longitudinal mixed methods approach.



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