Evaluation of a Traveller Mental Health Liaison Nurse: Service User Perspectives

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Authors

Brian Keogh[1]*, Anne Marie Brady[2], Carmel Downes[3], Louise Doyle[4], Agnes Higgins[2], Thomas McCann[5]

[1] Assistant Professor, School of Nursing and Midwifery, Trinity College Dublin, Ireland, Orcid ID: 0000-0001-6349-486X

[2] Professor, School of Nursing and Midwifery, Trinity College Dublin, Ireland, Orcid ID: 0000-0002-7112-6810 [AMB] 0000-0002-0631-1884 [AH]

[3] Research Fellow, School of Nursing and Midwifery, Trinity College Dublin, Ireland, Orcid ID: 0000-0001-7115-550X

[4] Associate Professor, School of Nursing and Midwifery, Trinity College Dublin, Ireland Orcid ID: 0000-0002-0153-8326

[5]Researcher and Psychotherapist, Traveller Counselling Service, Dublin, Ireland

*Corresponding author keoghbj@tcd.ie

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Abstract

Irish Travellers are a small indigenous minority group with a distinctive lifestyle and culture which sets them apart from the general population. Travellers are vulnerable to significant mental distress which is exacerbated by the social disadvantage that they experience. A Traveller Mental Health Liaison Nurse (TMHLN) was introduced in one health care region in Ireland to provide support for Travellers and increase their access to mental health services. The aim of this paper is to present the findings from an evaluation which explored Travellers access to the and reasons for accessing the TMHLN, the interventions provided and their experiences of and perceptions of the role of the TMHLN. A descriptive qualitative approach was used. Ten Travellers who used the service were interviewed. Following data analysis, three themes emerged: factors affecting Traveller mental health; accessing the TMHLN and the Travellers experiences and perceptions of the TMHLN. The participants were extremely positive about the TMHLN and valued the support provided. The findings highlight how the interpersonal skills associated with mental health nursing set against recovery orientated and culturally congruent practices are suitable approaches when working with Travellers.

Introduction and Background

*'*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, 2010, pp. 9). According to the Central Statistics Office in Ireland (CSO) (2017), there are about thirty one thousand Travellers living in the Republic of Ireland. Travellers are a marginalised group within Irish society and experience significant disadvantages which impact negatively on their health. 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*,* 2010).

Unsurprisingly, mental health difficulties are common among the community; a third of participants (n=3670) in one notable Irish study reported that depression was in their family (Traveller Health Unit, 2004). A more recent Irish survey found that 91% (*n*=481) of the Travellers surveyed believed that depression and anxiety were common among the community and 84% believed that Travellers mental health issues had worsened since the economic recession (O'Mahony, 2017). Studies conducted in the United Kingdom on the health status of Gypsies/Travellers found more self-reported difficulties with depression and anxiety compared to the non-traveller population (Van Cleemput & Parry, 2001; Parry *et al,* 2004). A later study with Gypsies/Travellers in Sheffield (United Kingdom) reported similar disparity, with Travellers linking their experiences of distress and mental health problems to poor social and environmental conditions (Goward, Repper, Appleton, & Hagan, 2006).

In Ireland, a national study of Travellers found that 11.9% of the 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 (McGorian *et al,* 2013). In the same study, 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*,* 2010). There was also an Irish study that found that there was a high level of concern among Travellers about mental health and drug and alcohol consumption (O'Mahony, 2017).

In Ireland, 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, 2010). 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 in Ireland (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 in Ireland, consequently increasing the sense of marginalisation that they experience making them even more vulnerable to suicide (O'Donnell & Richardson, 2018). 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 elucidate the experience of mental distress among Irish Travellers (Hodgins, Miller, & Marry, 2006; Abdalla et al*,* 2010; 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. 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). Abdalla et al's (2010) 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. 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 difficulties was through denial, avoidance and distraction, and they believed that suicide was a shameful topic to discuss (Pavee Point, 2015).

Mental Health Service Provision and Utilisation

In terms of accessing health services, Travellers tend not to proactively 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,* 2010; Bergin, Wells, & Owen, 2017). While many Travellers are unaware of the available mental health services (Pavee Point, 2015), there is also a lack of Traveller specific mental health services for young Travellers in Ireland. A lack of cultural competency on the part of service providers can also negatively affect Travellers' engagement with services (Carew *et al.* 2013; Department of Community, Rural and Gaeltacht Affairs, 2009). Negative interactions with services or the expectation of poor treatment is one of the reasons for Travellers not availing of health services or delaying seeking treatment (Francis 2013). Travellers also report poor quality healthcare interactions, including being treated unfairly, not being understood and they also express dissatisfaction with quality of care experience (Abdalla *et al.* 2010; Watson *et al.* 2017). Distrust of services and institutional racism have been identified as 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; Irish Health Service Executive (HSE), 2015). A national survey of Travellers 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).

Traveller Mental Health Liaison Nurse Service

To meet the needs of the one thousand plus Travellers that lived in the area where the study was undertaken, key stakeholders came together to plan an action. This group was made up of staff from the Regional Traveller Health Office, the Traveller Public Health Nurse; Local Mental Health Services, Voluntary Mental Health Organisations and staff from the Traveller Community Health Projects which included members of the Traveller community. In 2014, having received some funding they employed a Traveller Mental Health Liaison Nurse (TMHLN). This

appointment was in line with the local area strategic plan (HSE, 2015), which aimed to improve the mental health of Travellers through the provision of targeted services. The role of the TMHLM was to; increase access to mental health services through referral and signposting; increase information and knowledge exchange to help allay fears and anxieties that Travellers may have about accessing mental health services; increase the cultural capacity of staff within services, and decrease the stigma and shame Travellers experienced about using mental health services (HSE, 2015). The authors were commissioned to evaluate the TMHLN role. The aim of this paper is to present the findings from the evaluation which explored Travellers access to the and reasons for accessing the TMHLN, the interventions provided and their experiences of and perceptions of the role of the TMHLN.

Methods

This evaluation used a descriptive qualitative methodology to meet the aims and objectives of the study. A descriptive approach was suitable given not only the desire to describe the data but also to stay close to the voices of the participants (Doyle, McCabe, Keogh, Brady, & McCann, 2019). 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 (Brady & Keogh, 2014; Brown & Scullion, 2009; Wallestein & Duran, 2009). A steering committee was established and the research design was discussed with them and adapted as per the requirements of the Traveller community. A peer researcher from the Traveller community was engaged to assist with the participant recruitment and data collection to ensure the cultural congruency of the study, and the study materials and processes.

Access to and Recruitment of Participants

Travellers who had accessed the TMHLN either through her work with the Traveller Health Unit or who had met her on a one-to-one basis were invited to take part. Gatekeepers who were Coordinators of the Community Traveller Health Project in the area were used to access and recruit the participants. Potential participants were

informed about the evaluation by the gatekeepers who then went through the information sheets with the potential participants and answered any questions that they had if they were interested in taking part. If the participants agreed, arrangements were made for the participants to meet with the researchers to discuss the research further and to arrange to conduct the interview. Information was reiterated at the beginning of the data collection process, and the voluntary nature of involvement was stressed.

Data Collection

Qualitative data were collected using one-to-one interviews which were audio recorded. A topic guide was developed based on the role of the TMHLN and the aims and objectives of the evaluation (table 1). Care was taken to ensure the questions were free from jargon, were clear and phrased in a way that was understandable to the Travellers without being patronising. The topic guide was reviewed by the steering committee and questions were also checked for cultural congruency by the peer researcher which strengthened the process. The interviews took place at a time and location that was convenient to the participant and lasted between 30 and 60 minutes.

[Insert table 1 here]

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, coding the data and identifying themes and relationships in the data. The computer software package NVivo was used to assist in the management of the qualitative data.

Ethical Considerations

Ethical approval was provided by the appropriate 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. As the participants 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. To ensure that they were culturally congruent, a peer Traveller researcher and members of the steering committee reviewed the language and wording of the information and consent forms. 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. All data were password-protected and stored in accordance with Data Protection legislation.

Results

Ten Travellers who met with the TMHLN on a one-to-one basis volunteered to take part in the individual interviews (four men and six women n=10). Three main themes emerged following the data analysis process:

1) Factors affecting Traveller mental health
2) Accessing the Traveller Mental Health Liaison Nurse (TMHLN)
3) Travellers' experiences and perceptions of the Traveller mental health liaison nurse

Factors affecting Traveller Mental Health

Some of the service users had pre-existing mental health difficulties that were being treated by the mental health services. While the issues affecting the service users were similar to those of the general population, 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. Some 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.

Unemployment and financial worries were widespread, and alcohol misuse was also frequently mentioned as an issue throughout the interviews. In some interviews, they talked about illicit drug misuse, and this appeared to be an issue either for the person themselves or within their immediate families.

The service users described a patriarchal community where gender roles were clearly defined. Six 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. 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.

A major issue affecting many of the service users in this study was suicide, and all of the service users we interviewed described having a family member or someone close 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. 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. The issues of prejudice and discrimination was not discussed by all participants but when it was, it was perceived as worsening and they provided examples of discrimination in terms of accommodation, access to leisure activities and employment.

Accessing the Traveller Mental Health Liaison Nurse (TMHLN)

Service users accessed the TMHLN in a variety of ways. Most attended the Traveller Health Project based locally and heard about the TMHLN from the Traveller services that were located there. Staff who worked at the centres 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 staff 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 and made a decision to make an appointment with her based on other Travellers experiences.

The service users came to see or were referred to the TMHLN for a variety of reasons. The main reasons for attendance were for depression, anxiety, stress and resultant panic attacks which, for the most part emerged in response to an external event or situation such as the factors described earlier, although other issues were mentioned. Situations emerging from within the Traveller's family were also cited as causing stress. For example, 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*'. For the Travellers in this study, issues such as anxiety and depression were often set against a backdrop of immensely complex issues where the service users had multiple stressors that affected their mental health.

Travellers' Experiences and Perceptions of the Traveller Mental Health Liaison Nurse (TMHLN)

The service users 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. When the service users met with the TMHLN on a one to one basis, 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*'. These sentiments were repeated, and the service users described positive experiences and perceptions of the TMHLN throughout the interviews.

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. The service users also knew the Public Health Nurse (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. 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.

During the interviews the service users talked about how the TMHLN helped the Travellers 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. Important components of this interpersonal relationship were time and being listened to which were valued. 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. However, analysis revealed that the interventions could be divided into four main areas which are briefly described in table 2.

[Insert table 2 here]

Discussion

The aim of this paper was to present an exploration of Travellers experiences following the introduction of a Traveller Mental Health Liaison Nurse that was introduced to support Traveller Mental Health. The findings reveal the success of the innovation, how all of the participants were extremely positive about the role and how they valued the support that the TMHLN provided them for their mental health difficulties. The mental health difficulties that the Travellers experienced were set against the background of significant social disadvantage and highlight how mental health nursing interventions for Travellers cannot be planned or delivered without knowledge of the social determinants of health and how they affect Traveller mental health. Mental health nurses working with Travellers and other marginalised groups could benefit from using Intersectionality as a theoretical framework to help gain a deeper understanding of Traveller experience and to plan and deliver interventions accordingly. Hankivsky (2014, pp. 2) states that 'Intersectionality promotes an understanding of human beings as shaped by the interaction of different social locations. These interactions occur within a context of connected systems and structures of power. Through such processes, interdependent forms of privilege and oppression shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy are created'. Using an intersectionality perspective can help mental health nurses understand that health inequalities do not result from a single factor but emerge from the intersections of experiences, social locations and power relations (Hankisky, 2014). Crenshaw (2015) advocates that intersectionality can help people

who experience oppression frame their experiences which enables them to contend for inclusion and greater visibility. In addition, the importance of power relations and how social inequalities are shaped by power are also explored within the framework of intersectionality (Larson, George, Morgan, & Poteat, 2016).

Trygg, Gustafsson, & Månsdotter (2019) state that the concept of intersectionality has been introduced into health research as a way to better understand health inequalities and how they are approached offering a more nuanced way of addressing them. It has been long recognised that Travellers experience significant social disadvantage that makes them more vulnerable to mental health problems (Joint Committee on the Future of Mental Health Care, 2018). What is less understood is how intersectional inequalities interact and the synergistic and or antagonistic effects they may have on Traveller mental health (Trygg et al. 2019). While many of the Travellers in this evaluation experienced marked socioeconomic disadvantage, other issues such as gender and culture may interact to increase risk or protective factors. Furthermore, Travellers are not a homogenous group and an intersectional framework may assist in recognising the individuality of their experience while also allowing mental health nurses to understand their own position within the power and oppressive dynamic which is necessary before it can be deconstructed (Tomlinson 2015).

The findings from this evaluation also highlight the importance of interpersonal skills, trust, and confidentiality and how they form the foundations for any therapeutic interventions with members of the Traveller community. It is known that experiences of discrimination and structural and cultural barriers to accessing services can foster mistrust among Travellers which can negatively impact on engagement with services (McFadden et al. 2016), especially mental health services. It has been found that Travellers have lower levels of trust in health professionals than the general population (Abdella et al. 2010) and targeted efforts need to be made to forge relationships and support engagement. Culturally appropriate and low threshold 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 such as Travellers (McGorian et al. 2013). While important, cultural competence needs to couched within an interpersonal framework which fosters recovery orientated practices as advocated by current mental health policy (Department of Health, 2006). Mental health nurses have repeatedly articulated that interpersonal skills are at the centre of their practice and that the therapeutic relationship is the core foundation of their profession (Peplau, 1991; Morrissey & Callaghan, 2011). The findings from this evaluation underscore how effective these skills were to the success of the TMHLN. Key skills such as the creation of a therapeutic relationship, listening, fostering trust and communicating in a way that was culturally congruent were all valued by the Travellers in this evaluation. In addition, the apparent simplicity of the interventions used by the TMHLN in terms of supporting Travellers belie their complexity in terms of care, compassion and commitment, all key values associated with mental health nursing (Department of Health, 2016). Overall, the findings from this evaluation suggest that the TMHLN utilised recovery-orientated approaches which were 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.

The introduction of the TMHLN also speaks to a number of the strategic goals outlined in *Connecting for Life* (Department of Health, 2015), the national strategy to reduce suicide and suicidal behaviour in Ireland. In particular, the role of the TMHLN in 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 & Richardson, 2018). The role of the TMHLN also supports the recommendations contained in that report. Furthermore, the role of the TMHLN responds to

recommendations within the National Traveller and Roma Inclusion Strategy and the World Health Organisation which outlines strategies to reduce suicide and improve access to mental health services (Department of Justice & Equality 2017; World Health Organisation, 2018).

Limitations

As with most qualitative research the sample size is small and the findings cannot be generalised. While we achieved a reasonable level of diversity in terms of gender, increasing the diversity among the sample might have provided a more comprehensive evaluation. For example interviewing more young people might have provided a greater insight into the Travellers experiences across the lifespan. Given the cross sectional nature of the data, a longitudinal study examining the impact of the TMHLN over time might provide a more robust evaluation. The authors were commissioned to complete the evaluation when the TMHLN had been in place for two years. Having an opportunity to complete a pre/post intervention evaluation using mixed methods would also have enhanced the study.

Conclusion

The Travellers who took part in this study positively evaluated the role and function of the Traveller Mental Health Liaison Nurse, a role that was introduced specifically to support their unique mental health needs. Key to the success of the initiative was the TMHLN's use of interpersonal skills which were tailored to address the cultural needs of the Travellers who experienced marked social disadvantage. As mental health nurses continue to take on more specialist and advanced roles, the findings from this evaluation underscore how important the core values associated with mental health nursing are and how they can be translated into meaningful interventions to assist marginalised communities such as the Travellers in this study. More research is required to further understand the mental health needs and experiences of Travellers but this research needs to consider the intersectional nature of their experiences and the multiple lenses that their experiences need to be viewed through.

Disclosure of interest

The authors report no conflict of interest

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Interview Topic Guide
• I want to ask you about mental health and wellness, what do those things mean to you? • What are the things that Travellers might talk to the Traveller nurse about? • What are the types of things that cause stress for Travellers? • If Travellers are feeling upset or stressed, what things to they do to help themselves? • What things make it hard for Travellers to look for help when they are feeling stressed or unwell? • I want to ask you about the Traveller nurse and how you got on with her when you met her can you tell me about that? **Probes:** – How did you hear about the wellbeing nurse? – Did you have to wait a long time for an appointment to see Traveller nurse? – What things were on your mind when you went to see the Traveller nurse? • How did you get on with the wellbeing nurse? **Probes:** – Understanding of what the Traveller nurse is talking about. – Wellbeing nurse's understanding of Travellers? (look for examples) – Use of written and visual media. – Traveller's nurse's ability to explain everything and make things clear? – Trust and confidentiality, being comfortable to talk to the Traveller nurse. – Kind, polite and respectful. – Traveller nurse's ability to understand the worries that are important to you. – Did you have enough time to talk to the wellbeing nurse about the things that were on your mind and the things that you were worried about? – The Traveller's nurse's ability to listen to you. • When you met with the Traveller nurse, how did she help you? **Probes:** – finding out about the things that were worrying you? – Ideas about how to mind yourself – who could help you? – Reduce the worries – Give you support? – Tell you about other people or services that might be able to help you? – Help you to get in touch with other people or services that might be able to help you? – Telling you how to mind yourself and how to look after yourself (look for examples) – Telling you about the medication that you are on (where applicable) – General advice on how to mind yourself. • After your chat with the Traveller nurse, what happened? **Probes:** – Did you feel better after you had a chat with the wellbeing nurse? – Following the wellbeing nurses advice? – Attending other services e.g. G.P etc. – Going to see Traveller nurse again. – Coping better? – Trying out any of the things the Traveller nurse told you about (look for examples) • How did you feel when you finished talking to the Traveller nurse? • If you were to tell your family or friends about the Traveller nurse, what would you say to them? • Would you tell other people that they should visit the Traveller if they weren't feeling well or were worried about something?

Table 1: Interview Topic Guide

Intervention	Description	Exemplar
1) Therapeutic Interventions	The TMHLN's used a range of interpersonal skills to develop therapeutic relationships with service users and to work therapeutically within this relationship.	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]
2) Liaison Interventions	While the TMHLN organised appointments for the service users, for the most part this activity involved 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. This also included an advisory and advocacy role.	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]
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.	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]
4) Follow-up Interventions	The TMHLN followed up with the participants in terms of reminding them about appointments and checking to see how they got on and if they needed any further assistance.	If she [TMHLN] 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]

Table 2: Overview of TMHLN interventions as described by the participants.