

Mental health-care provision for marginalized groups across Europe: findings from the PROMO study

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Background: Providing mental health care to socially marginalized groups is a challenge. There is limited evidence on what form of mental health-care generic (i.e. not targeting a specific social group) and group-specific services provide to socially marginalized groups in Europe. **Aim:** To describe the characteristics of services providing mental health care for people with mental disorders from socially marginalized groups in European capitals. **Methods:** In two highly deprived areas in different European capital cities, services providing some form of mental health care for six marginalized groups, i.e. homeless, street sex workers, asylum seekers/refugees, irregular migrants, travelling communities and long-term unemployed, were identified and contacted. Data were obtained on service characteristics, staff and programmes. **Results:** In 8 capital cities, 516 out of 575 identified services were assessed (90%); 297 services were generic (18–79 per city) and 219 group-specific (13–50). All cities had group-specific services for the homeless, street sex workers and asylum seekers/refugees. Generic services provided more health-care programmes. Group-specific services provided more outreach programmes and social care. There was a substantial overlap in the programmes provided by the two types of services. **Conclusions:** In deprived areas of European capitals, a considerable number of services provide mental health care to socially marginalized groups. Access to these services often remains difficult. Group-specific services have been widely established, but their role overlaps with that of generic services. More research and conceptual clarity on the function of group-specific services are required.

Background

People from socially marginalized groups have limited access to social resources such as housing, income, employment, education, social support and healthcare.^{1–3} Providing good mental health care to people from marginalized groups is a particular challenge.

One reason for this is that prevalence rates of mental disorders tend to be raised in such groups. For example, as compared with the age-matched general population, homeless people in Western countries have higher prevalence rates of alcohol and drug dependence, psychoses and personality disorder.⁴ Refugees are up to 10 times more likely to suffer from post-traumatic stress disorder.⁵ Higher levels of anxiety, depression and suicide have been identified among Roma, Gypsy and Traveller populations.^{6,7} Female sex workers have higher rates of mental disorders compared with the general female population in Europe.⁸

A second reason is that people from marginalized groups can experience problems accessing health services and that services struggle to reach people with mental disorders in such groups and engage them in care. There can be administrative, financial

and attitudinal barriers to accessing health services,^{9–13} and an inequitable distribution of health resources can result in a lack of targeted programmes.¹⁴

The European Commission (EC) is committed to reducing health inequalities¹⁵ and addressing the needs of marginalized groups.¹⁶ The EC Green Paper on mental health¹⁷ states that support for vulnerable groups can improve mental health, strengthen social cohesion and avoid associated social and economic burdens. The Green Paper strategy includes both increasing access to mainstream services and opportunities, and developing targeted approaches where necessary. However, there has been no systematic research so far on the mental healthcare actually provided for marginalized groups through generic mainstream services or through targeted specific services for these groups in Europe.

Against this background, this study aimed to assess the characteristics of and programmes offered by generic and group-specific services that provide some type of mental health care to socially marginalized groups in Europe. Since appropriate care for such people may require a range of different interventions, a wide and inclusive understanding of mental health care was used. The study

identified and assessed services providing care for six marginalized groups: the homeless, street sex workers, asylum seekers and refugees, irregular migrants, travelling communities and the long-term unemployed. It focused on the most deprived areas in capital cities, assuming that marginalized groups are more frequently represented in such areas.

Methods

The PROMO study ('Best Practice In Promoting Mental Health In Socially Marginalized People In Europe') was funded by the European Commission. It was conducted in 14 countries: Austria, Belgium, Czech Republic, France, Italy, Germany, Hungary, Ireland, The Netherlands, Poland, Portugal, Spain, Sweden and the UK. The study aimed to assess all generic- and group-specific services providing some type of mental health care for one or more of the socially marginalized groups in the two highly deprived areas of each capital city. Generic services were those providing care to any member of the population, whilst group-specific services focused on one of the studied groups.

Socially marginalized groups

For the purpose of the study, the definition of homelessness comprised two categories of the ETHOS typology¹⁸: rooflessness (sleeping rough or in emergency accommodation) and houselessness (sleeping in hostels or other temporary accommodation). Asylum seekers and refugees were defined in relation to the 1951 UN Convention Relating to the Status of Refugees.¹⁹ An asylum seeker is a person who has been applying for refugee status according to the Convention, and a refugee is a person who has been granted refugee status. Irregular migrants are those who are not in possession of a legal residency permit in the host country. The definition of street sex workers focused on individuals who sell sex outdoors.²⁰ The definition of long-term unemployed was based on the EUROSTAT²¹ definition of a person of the national working age who has been out of employment for ≥ 12 months. Travelling communities were defined as any community that is committed to a nomadic or travelling lifestyle and/or regard travelling as an important part of their cultural identity. This definition included also those who are settled but face marginalization because of associations with travelling lifestyle tradition.

Identification of deprived areas

In each capital, two highly deprived areas were identified using available indices of deprivation (the two most deprived areas if feasible). The population size of each area was intended to be between 80 000 and 150 000 inhabitants, with some flexibility to accommodate different local contexts and administrative boundaries. If the chosen areas were too small, contiguous areas were combined to achieve the target size.

Identification of services

In each area, we identified all services providing any type of mental health care to people from any of the included marginalized groups, applying an inclusive understanding of mental health care to accommodate different health and social care systems. Services were first identified using available directories and lists, as well as information from local clinicians and local experts for one or more of the target groups. In interviews with services, the lists were then consistently complemented. Services located outside the area, but providing care for people from that area, were also included. In several cities, there were services providing care to people from both areas. To avoid double counting of these services, data for the two areas in each city were analysed and presented together.

Recruitment and classification of services

The managers of the identified services were contacted and informed about the aims of the project. Interviews were carried out either face-to-face or over the phone. The assessments were conducted with the service managers themselves or with other members of staff with relevant knowledge.

The services were classified as either generic or group-specific. If $\geq 50\%$ of the people using a service were from one of the marginalized groups, the service was classified as specific for that group. In cases where this was difficult to assess, the self-definition of the service was used as the key criterion.

Assessment of services

Using an iterative process involving researchers from all participating countries, a structured questionnaire was developed for assessing services and translated into the languages of all participating countries. Three pilot interviews were carried out in each country to assess the applicability and suitability. The final questionnaire obtained data about service organization including the type of provider, funding, accessibility, routine data collection, characteristics of staff and programmes provided to people with mental health problems from marginalized groups.

We assumed that data of at least 70% of all relevant services in the two areas would enable us to analyse the roles of generic and group-specific services in the given capital.

Data analysis

Since the study assessed areas and services meeting the defined inclusion criteria, and made no claim to generalize the findings to other areas, we restricted the analysis to descriptive statistics, using SPSS, version 18 (SPSS Inc., Chicago, IL, USA).

Results

Number and type of services

In total, 811 services were identified and 617 assessed across 14 European capital cities. In six capitals, $< 70\%$ of services identified were assessed (Prague: 19 services assessed out of 38 identified services; Budapest: 5/12; Rome: 34/80, Stockholm: 5/11; Madrid: 17/40; Lisbon: 21/55). These six capitals, with a total of 101 assessed services, were not included in the analysis presented in this article.

The following areas were chosen for assessment in the eight capitals included in the analysis (the two most deprived ones except in Paris):

Vienna: District 16 and District 20; Brussels: Schaerbeek & St Josse and Molenbeek; Paris: the Flandre sector in the 19th arrondissement of Paris and La Courneuve & Aubervilliers in Seine-Saint-Denis; Berlin: Wedding and Kreuzberg; Dublin: Dublin North Central and Dublin West; Amsterdam: Bos en Lommer & De Baarsjes & Geuzenveld-Slotermeer and Amsterdam Zuid Oost; Warsaw: Praga Polnoc and Wola; and London: Hackney and Tower Hamlets.

In these eight capital cities, 575 services were identified and 516 (90%) assessed. [Table 1](#) shows the number of identified and assessed services in each capital. Non-assessed services could not be classified as generic or group-specific because of the lack of information on them.

In total, 297 services were generic and 219 services were specific to one of the marginalized groups, with the highest number for the homeless and the smallest for irregular migrants and travelling communities. Specific services for the homeless, street sex workers and asylum seekers/refugees existed in all cities. Services for irregular migrants, travelling communities and the long-term unemployed were found only in some cities. The number of

Table 1 Number of services identified and assessed in eight European capital cities

Capital cities	Number of services identified	Number of services assessed	Number of services assessed per type of service							
			Generic services	Group-specific services	Services specific to PROMO target groups					
					Homeless	Street sex workers	Asylum seekers/refugees	Irregular migrants	Travelling communities	Long-term unemployed
	<i>N</i>	<i>N</i> (%)	<i>N</i>	<i>N</i>	<i>N</i>	<i>N</i>	<i>N</i>	<i>N</i>	<i>N</i>	<i>N</i>
Vienna	49	46 (94)	18	28	4	2	8	1	2	11
Brussels	60	54 (90)	34	20	3	1	6	1	–	9
Paris	62	62 (100)	41	21	7	4	6	3	1	–
Berlin	140	129 (92)	79	50	30	3	8	2	–	7
Dublin	87	80 (92)	37	43	19	3	8	1	5	7
Amsterdam	41	37 (91)	24	13	5	2	6	–	–	–
Warsaw	57	42 (74)	26	16	8	2	2	–	–	4
London	79	66 (84)	38	28	13	4	3	2	3	3
Total	575	516 (90)	297	219	89	21	47	10	11	41

group-specific services varied across cities, particularly those for the homeless and the long-term unemployed.

Characteristics of services

The type of provider, the accessibility of services and routine data collection are shown in table 2.

More than 90% of services were provided by the state or not-for-profit organizations. Out of all services, 43% operated outside normal office hours and 36% had no exclusion criteria. Among group-specific services, those for street sex workers were the most accessible ones: 95% accepted self-referrals, 52% operated outside normal office hours, 62% had no exclusion criteria and only one service had a waiting list.

Declared patient involvement in the management and delivery was reported for 36% of services, with higher percentages in group-specific services.

Overall, 85% of services routinely collected data about the characteristics of their patients and 46% about patient satisfaction and experience. Only 38% of services made such data publicly available. The latter percentage was higher in group-specific services than in generic ones.

Professional background of staff

Table 3 summarizes the professional background of staff in the assessed services.

Generic services employed staff from a wider range of professional backgrounds. Social work was the only background that was represented in >50% of both generic and group-specific services. There were some differences among the specific services for different groups, i.e. services for the homeless more often had social workers and services for the long-term unemployed more often had counsellors.

Programmes provided

The programmes provided by the services are listed in table 4.

Generic services more often provided health interventions of a medical nature, i.e. individual and group psychotherapy, occupational therapy, medication and alcohol and substance abuse treatment. Group-specific services more often tended to provide outreach and social support in the form of social welfare support, housing advice and support, legal advice, job coaching and befriending. However, most types of programmes were provided by a similar percentage of generic and group-specific services. The difference between the percentages of services that provided a defined programme was $\leq 20\%$ for 13 of the 17 assessed types of programmes, and only for four programmes $>20\%$.

There was considerable variation in the programmes provided by specific services for different groups. For example, 95% of services for street sex workers, but only 30% of those for irregular migrants, did outreach work. Some of these differences were linked to the specificities of the each target group, e.g. a higher percentage of housing advice and support in services for the homeless and more job coaching in services for the long-term unemployed.

Discussion

Main findings

A substantial number of services are involved in providing mental health care for socially marginalized groups in deprived areas in eight European capitals. The absolute numbers are difficult to compare across the eight cities, because of the differences in the national health and social care systems and the different sizes of the areas studied. In Berlin alone, 140 services providing mental health care for two deprived areas were identified (and 129 of them assessed).

Group-specific services providing some form of mental health care exist in each city, although not necessarily for all of the groups. They tend to offer more outreach programmes and social support but fewer medical interventions. However, there is a large overlap in what generic and group-specific services provide and the differences are not clear cut, either in terms of the professional background of staff or with respect to the programmes offered.

Strengths and limitations

The study assessed mental health care for several marginalized groups using a similar methodology in several European countries and analysed data from more than 500 services. The inclusion of six groups and the availability of data from eight countries allow more general conclusions to be made than a narrower focus on only one group or one country. We used the same criteria to identify services in all countries, and asked all interviewees about further services in the area, so therefore the list of services for each area is likely to have been comprehensive. In the eight cities that were included in the analysis, we had an overall response rate of 90%, which can be regarded as very good for this type of research.

All services were assessed using the same instrument which had been developed and piloted in collaboration with all partners.

The study also had several limitations. In 6 out of 14 cities, we failed to assess $>50\%$ of services, and therefore did not include the data in the analysis. The exact definitions of the marginalized

Table 2 Characteristics of services

Characteristics	Generic services <i>N</i> = 297 <i>n</i> (%)	Group-specific services <i>N</i> = 219 <i>n</i> (%)	Services specific to PROMO target groups						Total Services <i>N</i> = 516 <i>n</i> (%)
			Homeless <i>N</i> = 89 <i>n</i> (%)	Street sex workers <i>N</i> = 21 <i>n</i> (%)	Asylum seekers/refugees <i>N</i> = 47 <i>n</i> (%)	Irregular migrants <i>N</i> = 10 <i>n</i> (%)	Travelling communities <i>N</i> = 11 <i>n</i> (%)	Long-term unemployed <i>N</i> = 41 <i>n</i> (%)	
Provider									
State	126 (42)	46 (21)	20 (23)	3 (14)	11 (23)	2 (20)	3 (27)	7 (17)	172 (33)
Not-for-profit	141 (48)	167 (76)	66 (74)	18 (86)	36 (77)	7 (70)	8 (73)	32 (78)	308 (60)
Other	30 (10)	6 (3)	3 (3)	–	–	1 (10)	–	2 (5)	36 (7)
Accessibility									
Accepting self-referrals ^a	222 (75)	179 (83)	69 (78)	20 (95)	35 (76)	10 (100)	10 (91)	35 (85)	401 (78)
Open outside normal office hours	137 (46)	85 (39)	43 (48)	11 (52)	14 (30)	2 (20)	4 (36)	11 (27)	222 (43)
Open at weekends	124 (42)	70 (32)	48 (54)	7 (33)	6 (13)	2 (20)	1 (9)	6 (15)	194 (38)
Requiring 'out of pocket' fee payment	120 (40)	53 (24)	36 (40)	3 (14)	6 (13)	3 (30)	1 (9)	4 (10)	173 (34)
Operating a waiting list ^b	137 (47)	61 (28)	26 (29)	1 (5)	17 (36)	2 (20)	2 (18)	13 (32)	198 (39)
Professional interpreters always available ^c	79 (27)	64 (29)	20 (23)	8 (38)	25 (53)	5 (50)	1 (9)	5 (12)	143 (28)
No exclusion criteria ^d	105 (37)	74 (34)	27 (30)	13 (62)	18 (38)	3 (30)	5 (46)	8 (20)	179 (36)
Patient involvement									
Patient involvement in management or delivery of services ^e	87 (30)	95 (44)	33 (37)	9 (45)	18 (40)	6 (60)	5 (46)	24 (59)	182 (36)
Routine data collection									
Patients' socio-demographic characteristics ^f	251 (85)	183 (84)	77 (88)	15 (71)	39 (83)	9 (90)	7 (64)	36 (88)	434 (85)
Patient satisfaction and experience ^g	128 (44)	105 (48)	38 (43)	7 (33)	21 (45)	4 (44)	5 (46)	30 (73)	233 (46)
Data publicly available ^h	82 (29)	104 (50)	41 (48)	12 (60)	22 (49)	6 (75)	6 (60)	17 (42)	186 (38)

a–h: Valid percent reported (number of missing values for a = 4; b = 3; c = 3; d = 12; e = 14; f = 4; g = 6; h = 22).

Table 3 Professional backgrounds of staff (% of services employing staff with the given qualification)

Professional background of staff	Generic services <i>N</i> = 297 <i>n</i> (%)	Group-specific services <i>N</i> = 219 <i>n</i> (%)	Services specific to PROMO target groups						Total services <i>N</i> = 516 <i>n</i> (%)
			Homeless <i>N</i> = 89 <i>n</i> (%)	Street sex workers <i>N</i> = 21 <i>n</i> (%)	Asylum seekers/refugees <i>N</i> = 47 <i>n</i> (%)	Irregular migrants <i>N</i> = 10 <i>n</i> (%)	Travelling communities <i>N</i> = 11 <i>n</i> (%)	Long-term unemployed <i>N</i> = 41 <i>n</i> (%)	
Psychiatrists ^a	100 (34)	20 (9)	9 (10)	3 (15)	6 (13)	2 (22)	0	0	120 (24)
Psychologists/Psychotherapists ^b	140 (48)	52 (24)	16 (18)	3 (15)	18 (39)	3 (33)	1 (9)	11 (28)	192 (38)
Counsellors ^c	46 (16)	55 (26)	7 (8)	6 (30)	17 (37)	2 (22)	3 (27)	20 (50)	101 (20)
Social workers ^d	156 (54)	109 (51)	57 (66)	7 (35)	25 (54)	4 (44)	2 (18)	14 (34)	265 (53)
Occupational therapists ^e	64 (22)	13 (6)	4 (5)	2 (10)	4 (9)	0	0	3 (8)	77 (15)
Medical doctors (non-psychiatric) ^f	77 (26)	32 (15)	13 (15)	6 (30)	9 (20)	3 (33)	0	1 (3)	109 (22)
Nurses ^g	130 (45)	41 (19)	25 (29)	6 (30)	5 (11)	2 (22)	1 (9)	2 (5)	171 (34)

a–g: Valid percent reported (number of missing values for a: 12; b: 14; c: 13; d: 14; e: 11; f: 11; g: 12).

groups studied varied in the different national contexts. Also, the understanding of the categories and of the terminology used in the questionnaire is likely to have varied across countries and, to a lesser extent, even among interviewees in the same country. All data are based on interviews with staff. The answers may have been influenced by a lack of information or biased in the direction of social desirability. As a result, the exact percentages of answers should be interpreted with caution. Finally, although we found commonalities across the six studied groups and eight cities, findings cannot necessarily be generalized to other marginalized groups (e.g. ex-prisoners or isolated elderly) or to areas outside capital cities.

Organization of services

All cities had group-specific services playing a role in the provision of mental health care for the homeless, asylum seekers and refugees, and street sex workers. Services targeting irregular

migrants or travelling communities were relatively rare. In the case of irregular migrants, this may be due to their limited entitlement to health care in most EU countries.¹¹ With regard to travelling communities, the low provision of specialized services may reflect a lack of awareness of these groups, a reluctance to overcome the barriers of reaching them or a low political priority to fund targeted services.⁶

The availability of professional interpreters was low in both generic and group-specific services with somewhat higher figures for asylum seekers/refugees and for irregular migrants. This appears problematic given the frequent language barriers with these groups.^{22–25} The payment of an 'out-of-pocket' fee was required by a proportion of generic- and group-specific services. Among group-specific ones, the rate was particularly high in services for the homeless, in some cases reflecting the ethos of fostering the self-reliance of the patients. However, reports suggested that even a small up-front charge can deter homeless people from accessing healthcare.¹⁰

Table 4 Programmes/activities provided for patients with mental disorders

Types of programmes	Generic services	Group-specific services	Services specific to PROMO target groups						Total services
			Homeless	Street sex workers	Asylum seekers/refugees	Irregular migrants	Travelling communities	Long-term unemployed	
			<i>N</i> =297 <i>n</i> (%)	<i>N</i> =219 <i>n</i> (%)	<i>N</i> =89 <i>n</i> (%)	<i>N</i> =21 <i>n</i> (%)	<i>N</i> =47 <i>n</i> (%)	<i>N</i> =10 <i>n</i> (%)	
Active outreach ^a	110 (37)	107 (49)	41 (46)	20 (95)	18 (38)	3 (30)	6 (55)	19 (46)	217 (42)
Home visits ^b	179 (61)	94 (43)	41 (46)	13 (62)	24 (51)	3 (30)	6 (55)	7 (17)	273 (53)
Counselling ^c	208 (71)	130 (60)	55 (63)	12 (57)	28 (60)	5 (50)	1 (10)	29 (71)	338 (66)
Individual psychotherapy ^d	137 (46)	48 (22)	13 (15)	8 (38)	17 (37)	6 (60)	2 (18)	2 (5)	185 (36)
Group psychotherapy ^e	93 (32)	24 (11)	5 (6)	2 (10)	13 (28)	1 (10)	0	3 (7)	117 (23)
Self-help support ^f	117 (40)	67 (31)	27 (30)	8 (38)	15 (33)	4 (40)	2 (18)	11 (28)	184 (36)
Occupational (work) therapy ^g	93 (31)	24 (11)	10 (11)	1 (5)	6 (13)	1 (10)	0	6 (15)	117 (23)
Medication ^h	142 (48)	44 (20)	22 (25)	6 (29)	12 (26)	4 (40)	0	0	186 (36)
Alcohol and substance misuse treatment ⁱ	126 (43)	36 (17)	20 (23)	4 (19)	7 (15)	1 (10)	2 (18)	2 (5)	162 (32)
Practical help in patients homes ^j	83 (28)	43 (20)	25 (28)	5 (24)	8 (17)	0	1 (9)	4 (10)	126 (25)
Befriending ^k	76 (26)	73 (34)	36 (41)	10 (48)	13 (28)	4 (40)	1 (9)	9 (22)	149 (29)
Leisure activities support ^l	166 (56)	103 (47)	44 (49)	13 (62)	23 (49)	3 (30)	4 (36)	16 (39)	269 (52)
Mental health advocacy ^m	159 (54)	101 (46)	38 (43)	14 (67)	27 (57)	3 (30)	6 (55)	13 (32)	260 (51)
Social welfare support ⁿ	157 (53)	134 (61)	68 (77)	11 (52)	25 (53)	6 (60)	4 (36)	20 (49)	291 (57)
Housing advice and support ^o	170 (58)	155 (71)	78 (88)	15 (71)	28 (60)	6 (60)	4 (36)	24 (59)	325 (63)
Legal advice ^p	126 (43)	113 (52)	45 (51)	15 (71)	25 (53)	8 (80)	2 (18)	18 (44)	239 (47)
Job coaching ^q	145 (50)	142 (65)	56 (64)	15 (71)	27 (57)	3 (30)	6 (55)	35 (85)	287 (56)

a–q: Valid percentages reported (number of missing values for a: 1; b: 1; c: 6; d: 3; e: 4; f: 5; g: 2; h: 2; i: 5; j: 2; k: 3; l: 1; m: 1; n: 3; o: 2; p: 2; q: 5).

Overall, only a minority of services made data about patient characteristics and experiences publicly available. This is in line with findings that only in a minority of European countries does the public health culture include programme evaluation.³ More group-specific than generic services made their data publicly available, possibly due to the predominance of funder-orientated not-for-profit organizations.

Assuming that marginalized groups are difficult to reach, active outreach programmes appear required to overcome barriers and engage people from these groups in mental health care. Yet, the provision of outreach was low in both generic and group-specific services. In addition, most services had exclusion criteria and did not operate outside office hours, and many had waiting lists. Considering all these restrictions, the question arises as to whether services for marginalized groups still tend to be organized in traditional ways that are not sufficiently flexible to facilitate access for people with mental disorders.^{26–28}

Individual and group psychotherapy was provided by a relatively small number of group-specific services, with the highest rates in services for irregular migrants and asylum seekers/refugees. This is likely to reflect the high prevalence of post-traumatic stress disorder and other mental disorders that may occur as consequences of war and political persecution.^{5,29}

Implications

The findings have several implications for health policies for marginalized groups in Europe. First, the high number of services providing some sort of mental health care requires coordination. For any clinician working in a deprived area, it will be difficult to be fully aware of the dozens of other services that also provide some type of mental health care and with which they might collaborate to provide optimal care for a given patient. Such information will be even more difficult to obtain for people in marginalized groups who seek help. Thus, if so many services are established and funded, there is a need to make information about the services easily available and to coordinate their activities.

Secondly, data about how services are used by their target groups and about the experiences and outcomes of patients

should be regularly obtained and made publicly available. This will provide more transparency, support service development, underpin funding decisions and facilitate the required coordination.

Thirdly, as suggested by the EC Green Paper on mental health, generic mainstream services and group-specific services do play a role in mental health care for marginalized groups. However, the exact function of the two types of services and their differences are not totally clear. The programmes provided by generic and group-specific services overlap substantially. One might argue that group-specific services should focus on case finding, outreaching, engaging with marginalized groups and then facilitating access to larger generic services, while the generic services should provide a wide range of expertise and health programmes. The data from this study show that the reality is not so clear cut and that accessibility of services may often remain difficult. In any case, a debate is required about the ideal balance between generic and group-specific services, what the aims and programmes of each type of service should be, what clinical or non-clinical professional expertise of staff is required to achieve these aims and how the functions of different services are best coordinated across the sectors of health and social care. Such debate should be informed by more research. The result may well vary depending on the context of areas, the characteristics of the health and social care system and the needs of the targeted socially marginalized group.

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Conflicts of interest: None declared.

Key points

- A substantial number of generic and group-specific services provide some form of mental health care to socially marginalized groups in deprived areas of European capitals.
- All cities had group-specific services for the homeless, street sex workers and asylum seekers/refugees, but not for irregular migrants and travelling communities.
- Both generic and group-specific services often have organizational characteristics that may restrict accessibility to people with mental disorders from marginalized groups.
- The differences between generic and group-specific services were not clear cut, either in terms of the professional background of staff or with respect to the programmes offered.
- Policies on mental health care for marginalized groups should ensure that the large number of services involved are coordinated, that services are accessible and that group-specific services have a clearly defined role that is distinct from that of generic services.

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