HEALTH PROMOTION RESEARCH CENTRE, NATIONAL UNIVERSITY OF IRELAND GALWAY

PROMO Project: Best Practice in Promoting Mental Health Amongst Socially Marginalised People in Europe

Feedback from Ireland: Report

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Section 1: Introduction

Promoting mental health and preventing mental ill health amongst socially marginalized people is a major challenge to European societies. There are various policies and services to achieve this in EU member states, but information on what constitutes best practice is fragmented and consistent guidelines do not exist.

It is evident that groups of the population who experience social marginalization are more likely that than the rest of the population to experience mental health problems. They are also more likely to be over-represented (in terms of their proportion of the population) in psychiatric hospital admissions. It is clear that the social determinants of health are relevant here. Factors such as no money, discrimination, social exclusion, lack of education and poor housing standards have a major impact on the mental health of socially marginalised people (CSDH, 2008 - WHO Commission on the Social Determinants of Health). The health promotion literature shows that individuals who are socially marginalized have restricted lifestyle choices and fewer and less effective means of coping with psychological distress. They are also more likely than others to make lifestyle choices that put their mental health at risk. This can include, among other things, the misuse of drugs and alcohol.

The focus of the PROMO project (Best Practice in Promoting Mental Health in Socially Marginalised People in Europe) is on the delivery of health and social care for people with mental health problems who belong to one of the six following groups: (1) long-term unemployed; (2) homeless; (3) prostitutes/sex workers; (4) refugees and asylum seekers; (5) illegal immigrants/undocumented workers; (6) travellers.

The PROMO group consists of a multidisciplinary consortium of experts from 14 diverse EU member states (covering more than 85% of the total EU population) to consolidate knowledge in the field, and identify best practice. The project reviews legislation and policies, and – focussing on major cities - assesses systems of health and social services for the people concerned. The project, which is funded by the European Commission, is coordinated by Professor Stefan Priebe, Queen Mary

University of London. The Health Promotion Research Centre at the National University of Ireland Galway is the participating partner for the Irish section of the study.

The overall aim of the project is to define guidelines for best practice in promoting mental health amongst socially marginalised people, to highlight barriers for the implementation of the guidelines and suggest solutions, and to disseminate the findings widely among the relevant stakeholder groups in Europe.

Objectives of the study

1. To review policies and legislation in each country related to promoting mental health and preventing mental ill-health amongst socially marginalised groups.

2. To select the two most deprived areas in each of the 14 participating capitals cities and within these areas to: a) obtain information on services providing health and social care for marginalised people with mental health problems; b) assess the overall quality of care for marginalised people with mental health problems.

Section 2: Methodology

2.1 Legislation and Policies

A review of policies and legislation in relation to mental health care for persons from the PROMO target groups was conducted using a number of sources. These included a general review of all relevant documents, policies and legislation and consultation with experts from relevant statutory and voluntary agencies.

2.2 Identification of target areas

The two most deprived areas in Dublin City were identified using the Haase Deprivation Indices[1] (An Pobal). The Haase indices use three dimensions of affluence/disadvantage to calculate deprivation levels - 'Demographic Profile', 'Social Class Composition' and 'Labour Market Situation'. These dimensions are based on census based indicators such as age, educational level attained, skill or social class of the head of the household, the average number of persons per room and male and female unemployment rates. The current deprivation indices are based on the 2006 national census.

Both identified areas did not meet the required catchment area population levels (80,000-150,000) for inclusion in the study. Therefore, the HSE catchment areas within which each area is situated, Dublin North Central and Dublin West, were selected as the two target areas.

2.3 Assessment of services in each area

The aim was to identify and assess all services that potentially serve individuals with psychological/psychiatric disorders who belong to the six target groups. Services were identified according to the following typology:

[1] An outline of the deprivation indicies and the relevant data and report can be found at - http://www.pobal.ie/WhatWeDo/Deprivation/Pages/InformationforBeneficiaries.aspx.

- A1) group specific mental health services
- A2) generic mental health services
- B1) group specific social care services
- B2) generic social care services
- C1) group specific general health services
- C2) generic general health services

Services were identified through contact with various co-ordinating bodies (e.g. the Homeless Agency), through databases and directories both online and published (e.g. HSE directory of Statutory Services) and through information provided by individuals from other identified services.

The services were assessed via a structured phone interview with a designated staff member. Each interview was based specifically on a questionnaire developed by the project co-ordinating centre in London. The questionnaire was initially piloted with two services in each of the 14 participating countries and covered the following headings:

1. Provider and funding information
2. Staffing
3. Service accessibility
4. Profile of clients
5. Services provided to target groups
6. Co-ordination with other services
7. Service evaluation

A copy of the questionnaire was sent out in advance of the interview to allow the interviewee to become familiar with the information required and to collate any relevant data. The full questionnaire can be seen in Appendix A.

The main focus was on assessing services located within the two catchment areas. However, there was also provision to assess services outside these areas if individuals from the target population residing in either catchment area were regularly attending these services. Services were included in this instance if they were acknowledged in the course of other interviews as having a key role in the provision of care.

The data was analysed using a SPSS database developed by the co-ordinating centre in London.

2.4 Assessment of the Overall Quality of Care Provided in Each Area

In order to assess the overall quality of mental health care provision for each target group, semi-structured interviews were conducted with 'experts' in mental health/social care for each group. One interview was conducted in each area specific to each target group, leading to 12 interviews in total (6 x 2 areas) with 12 different experts. The relevant experts were identified during the services assessment interviews and were then invited to participate in the semi-structured interviews.

The interviews consisted of (1) two case vignettes to assess the pathways to mental health care for people from the target group with mental health problems; and (2) general questions regarding the quality of mental health care for the target groups in the area. An example of the semi-structured interview template can be seen in Appendix B.

Section 3: Results

3.1 Legislation and policy review

3.1.a Legal provision for mental health care for Long-Term Unemployed

There are no legal provisions for mental health care for Long-Term Unemployed people.

The following policy document is relevant.

Vision of Change: Report of the Expert Group on Mental Health Policy (Department of Health and Children, 2006)

Belonging and participating: Social Inclusion

Long-term unemployment is specifically referred to in relation to urban disadvantage.

Chapter 4 deals with social inclusion of marginalised people and makes the following recommendations:

4.5: Mental health services should take account of local deprivation patterns in planning and delivering mental health care.

4.1: Access to employment, housing and education for individuals with mental health problems should be on the same basis as every other citizen.

4.6: Evidence-based approaches to training and employment for people with mental health problems should be adopted.

4.10: The National Mental Health Service Directorate should be specifically represented in the institutional arrangements which implement the National Action Plan against Poverty and Social Exclusion, with specific targets to monitor action in achieving greater social inclusion for those with mental health problems.

3.1.b Legal provisions for mental health care for Sex-Workers

There are no legal provisions for mental health care for Sex Workers.

Prostitution itself is not illegal in the Republic of Ireland. However, the Criminal Law (Sexual Offences) Act of 1993 prohibits soliciting or importuning another person in a street or public place for the purpose of prostitution (This offence applies to prostitute and client.). It also prohibits loitering for the purpose of prostitution, organizing prostitution by controlling or directing the activities of a person in prostitution, coercing one to practice prostitution for gain, living on earnings of the prostitution of another person, and keeping a brothel or other premises for the purpose of prostitution.

3.1.c Legal provision for mental health care for Homeless people

There are no legal provisions for mental health care for Homeless people.

The following legislation and policy documents are relevant:

Legislation

*The **Housing Act** (Govt of Ireland, 1988)* sets out the legal definition of homeless persons to include those for whom no accommodation exists, which they could be reasonably expected to use, or those who could not be expected to remain in existing accommodation and are incapable of providing suitable accommodation for themselves.

Strategies and Policies

1. A Key to the Door A Homeless Agency Partnership Action Plan on Homelessness in Dublin 2007-2010 (Homeless Agency, 2007)

2. Vision of Change: Report of the Expert Group on Mental Health Policy (Department of Health and Children, 2006)

*Sections relevant to homelessness**:***
15.2 Mental health services for homeless people
15.2.4 Delivering mental health services to homeless people
4.7 Housing
12.10 Accommodation needs of people with severe mental illness

3. National Economic and Social Forum (NESF): Mental Health and Social Inclusion (NESF, 2007)

Sections relevant to homelessness:
8.39
8.41
8.51

4. National Action Plan for Social Inclusion 2007-2016 (Government of Ireland, 2007)

Sections relevant to homelessness:
5.6.4. Housing and Accommodation
Chapter 6 Goal 10: Housing

5. The Way Home: A strategy to address adult homelessness in Ireland 2008-2013 (Department of the Environment, Heritage and Local Government, 2008)

For a more in depth coverage of these documents please see Appendix C (i).

3.1.d Legal provisions for mental health care for Refugees & Asylum Seekers

There are no legal provisions for mental health care for Refugees &Asylum Seekers.

The following Policy documents are relevant:

1. National Economic and Social Forum: Mental Health and Social Inclusion (NESF, 2007)

Migrants, Asylum Seekers and Refugees
8.44 Recommendations include the provision of culturally sensitive services and training and support for community initiatives providing care and support for the mental health needs of people from diverse cultures.

8.45 Better equipped mental health services should be provided which recognise:

- That culture profoundly influences an individual's health beliefs, practices, behaviour and the outcomes of health care
- The need to respond respectfully and effectively to people of all cultures
- That the worth and dignity of individuals, families and communities are respected (Pierce, 2003)

5.58 In relation to asylum seekers and refugees a HSE West Report (2006) highlighted the need to:

- Improve integration and community networks; encourage people to join local community activities and work in partnership with minority ethnic groups
- Provide training to service providers in cultural competencies and offer training to asylum seekers and refugees in the Irish system
- Appoint cultural diversity officers
- Ensure the available of psychological support to these groups and to those working with them (HSE West, 2006)

9.44 The NESF concludes that strengthening communities to support positive mental health is critical to any successful social inclusion strategy. This should include sufficient and effective resources for community-wide initiatives, as well as offering integrated supports for those experiencing mental ill-health.

2. National Action Plan for Social Inclusion 2007-2016 (Government of Ireland, 2007)

Goal 12: Integration of Migrants
Develop a strategy which will include resources for language supports in the education sector and for improvement of access to other public services through translation of information.

6.3.3. Health
A range of health services being provided for minority groups including an ethnic identifier, to facilitate more evidence-based planning through identification of needs, measurement of uptake of services, and evaluation of outcomes. This will be rolled out from 2007.

6.3.6 Migrants

Integration is one of the most important challenges being faced by Irish society over the coming years. It is planned to make available appropriate interpretation services in all local offices of the Department of Social and Family Affairs and the Department`s web-site will have information available in eight different languages (Arabic, Chinese, French, Polish, Portuguese, Romanian, Russian, and Spanish).

3.1.e Legal provisions for mental health care for Illegal Immigrants

There are no legal provisions for mental health care for Illegal Immigrants.

3.1.f Legal provisions for mental health care for Travelling communities

There are no legal provisions for mental health care for Travellers.

The following Policy documents are relevant:

1. The National Traveller Health Strategy 2002-2005 (Department of Health and Children, 2002) sets out a clear response to the relatively poor level of health and inequities experienced by the Irish Traveller communities. To this end structures were put in place, such as a Traveller Health Advisory Committee in the Department of Health and Children and a Traveller Health Unit involving Travellers themselves in each health board.

2. National Economic and Social Forum: Mental Health and Social Inclusion (NESF, 2007)

There has been increased focus on the mental health needs of Travellers **(4.46)**. The Traveller Health Unit Eastern Region has recently established a Mental Health Sub-Group to examine the key issues, including access to services, barriers to mental health and the apparent rise in suicide rates. In addition, the forthcoming *All-Ireland Traveller Health Study (2007-2009)* has been commissioned by the Department of Health and Children in conjunction with Northern Ireland's Department of Health, Social Service and Public Safety.

5.55 The recommendations outlined from the HSE West Conference Report (2006) are worth noting and are supported here (by NESF) in relation to Travellers, asylum seekers and refugees. In relation to Travellers, that report makes recommendations including that:

- General Practitioners should have training on multi-cultural health
- Travellers should be involved in the design of services and training as health care workers
- Clear user-friendly information on mental health should be available for Travellers

5.67 Vulnerable groups need targeted action to cater more effectively for their particular needs, such as Travellers and homeless people.

3. National Action Plan for Social Inclusion 2007-2016 (Government of Ireland, 2007)

6.3.5. Travellers are less than 1% of the population (Census, 2002) and have significantly inferior health outcomes compared to the population generally. Among a range of programmes to address their needs the following are included:

- Funding to local authorities to aid their second Traveller Accommodation Programme, 2005-2008
- The All-Ireland Traveller (2007-2009) Health Strategy.

3.1.g Legal provisions for mental health care for marginalised groups in general

There are no legal provisions for mental health care for marginalised groups in general.

The ***National Disability Strategy*** *(Government of Ireland, 2004)* builds on the existing strong legislation and infrastructural framework for equality. Some key points of the ***Disability Sectoral Plans*** (July 2006) include the following:
(1) Housing: The development of the ***National Housing Strategy for People with Disabilities*** (by 2009, Department of Environment, Heritage and Local Government), " *with particular regard for people who experience mental illness"* (p.64).
(2) Employment: Developing an integrated strategic approach to rehabilitation services.

Reach Out *(Department of Health and Children, 2005)* is the ***National Strategy for Action on Suicide Prevention***.
The *Programme for Government 2007-2012* commits to reducing suicide by 20% by 2012, and to " *increase services and supports for marginalised groups, particularly those with mental health difficulties."*

The ***National Intercultural Health Strategy 2007-2012*** *(Health Service Executive, 2007)* aims to ensure that provision of health services is equal, accessible, and culturally sensitive and appropriate to meeting the needs of minority ethnic communities.

Vision of Change: Report of the Expert Group on Mental Health Policy *(Department of Health and Children, 2006)*

Relevant Sections:

Chapter 4 Belonging and participating: Social Inclusion

Chapter 5 Fostering well-being: Mental Health Promotion
5.6 Priority issues in mental health promotion:

National Economic and Social Forum: Mental Health and Social Inclusion *(NESF, 2007)*

The NESF advises government on policies to achieve greater equality and social inclusion. This report looks at ways to increase the social inclusion of people with mental ill-health as well as identifying broader strategies and actions to promote mental well-being across Irish society.

Relevant Sections:

10.4
10.6 (c)
10.6 (d)
10.12 (b)

8.15
10.12 (c)
10.13 (c)

National Action Plan for Social Inclusion 2007-2016 *(Government of Ireland, 2007).*

A strategic multi-disciplinary approach to address the multi-dimensional nature of poverty and social exclusion.

Relevant Sections:

3.5.1. Employment and Employability
3.5.4. Health

Chapter 5 has recommendations pertaining to People with Disabilities:
5.6.4. Housing and Accommodation.

Chapter 6 relates to Communities:
6.5.5 Community Development
6.5.7 Community Services Programme

For a more in depth coverage of these documents please see Appendix C (ii)

3.2: Assessment of Services

Overall, 87 services were identified and 80 agreed to participate in the study - 54 in Dublin North Central, 18 in Dublin West and 8 outside both areas.

1. Description of the services assessed

Table 1.1 Number of services assessed according to area and service type

Service Typology	*Area 1: DNC*	*Area 2: Dublin West*	*Outside Area*	Total
A1_Group specific mental health services	3*	0	3	**6**
A2_Generic mental health services	17	12	1	**30**
B1_Group specific social care services	29	3	3	**35**
B2_Generic social care services	3	3	0	**6**
C1_Group specific general health services	1	0	1	**2**
C2_ Generic general health services	1	0	0	**1**
Total	**54**	**18**	**8**	**80**

* Two of these services are pilot projects. One of these pilot projects has ceased operation since the interview process was completed.

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Table 1.2 Specific breakdown of services assessed across all areas (n=80)

Service Type	N	%
A1_homeless specific mental health	3	3.8%
A1_refugee specific mental Health	2	2.5%
A1_travlller specific mental	1	1.3%

Health		
A2_generic mental health	30	37.5%
B1_LTU specific social care	7	8.8%
B1_homeless specific social care	15	18.8%
B1_sex workers specific social care	2	2.6%
B1_refugee specific social care	5	6.25%
B1_ill immigrant specific social care	1	1.3%
B1_traveller specific social care	4	5.0%
B2_generic social care	6	7.5%
C1_homeless specific general health	1	1.3%
C1_sex workers specific general health	1*	1.3%
C1_refugee specific general health	1	1.3
C2_generic general health	1	1
Total	***80***	***100%***

*A new mobile health clinic for women only (the main target group is women in prostitution) has been launched in Dublin recently. It is not included in the overall service assessments.

2: Provider and funding information

Table 2.1 Who is the provider of the service/institution? (n=80)

State Sector	40 (50%)
Not for profit sector (NGO's)	40 (50%)

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Table 2.2 What is the source of funding for your service/institution? (n=80)

Type of Funding	**Yes**	Overall % of funding
Local/Community/Municipality	20 (25%)	14.1%
National/Regional	71 (88.8%)	74%
Official Project Grants	8 (10%)	3.6%
Donations/Fundraising	16 (20%)	7.6%
Insurance Companies	0	0
Other*	5 (6.3%)	.7%

*Other sources of funding were Rental Income (4) and Therapy Charges (1)

- HSE funded services were documented as National/Regional
- Dublin City Council funded services were documented as Local/Community/Municipality

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Table 2.4 What was the system of funding for your service in last budget year? (n=80)

System of funding	**Yes**	**Overall % of funding**
Lump sum for the budget	79 (93.8%)	89.9%
Number of clients served	10 (12.6%)	7.7%
Specific activities with clients	3 (3.8%)	1.5%

Other*	2 (2.5%)	.5%

*Other included Funds & Rent (1) and United Nations Fundraising and Income Generation Activities (1).

3: Staff Information

Table 3.1 Number of Whole Time Equivalent Paid Staff (n=80)

Sum	869.7
Mean (average)	10.87
SD	22.33
Minimum	.5
Maximum	150

*Two hospital based services had a much higher number of staff in comparison to other services (n=130 & 150). When removing both services from the analyses the results were as follows:

Table 3.1a Number of Whole Time Equivalent Paid Staff (n=78)

Sum	589.7
Mean (average)	7.56
SD	8.06
Minimum	0.5
Maximum	43

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Table 3.2 Professional Background of Staff (n=80)

	Total no. of staff	**Average number of staff**	**Standard Deviation**	**Maximum number of staff**	**No. of services with such staff**
Admin Staff	94.2	1.18	2.47	20	45
Counsellors	23.25	.29	1.08	7	11
Medical Doctors	25.98	.32	2.29	20	5
Nurses	244	3.05	13.94	110	25
Occupational Therapists	10.5	.13	.46	3	7

Psychiatrists	42.9	.53	2.25	19.5	10
Psychologists /Psychotherapists	26	.33	1.05	5	9
Social Workers	43	.54	1.13	6	20

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Table 3.3 Supervision for staff (60 minutes or more at least once a month) (n=78)

	Yes	**No**
Internal Supervision	46 (57.5%)	34 (42.5%)
External Supervision	15 (19%)	65 (81.3%)

4: Service Accessibility

Table 4.1 When is your service open to clients? (n=78*)

	N (%)
Normal Office Hours	42 (52.5%)
Normal Office Hours + Weekends	7 (8.8%)
Normal Office Hours + Some Evenings	10 (12.3%)
Outside Office Hours Only	2 (2.5%)
All Of The Above**	17 (21.3%)

*2 Services (pilot projects) open insufficient hours to be included in analysis

**The majority of the services open 'all of the above' were homeless accommodation services

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Table 4.2 Do clients have to pay an 'out of pocket fee' for any aspect of the service? (n=80)

Yes	16 (20%)
No	64 (80%)

Type of payments included - rent/accommodation within homeless services (10), counselling charges (2), attendance fee at A/E (1), contribution to training (1) long term elements of care at a psychiatric hospital (1).

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Table 4.3 Is there a waiting list* for any aspect of your service? (n=80)

Yes	44 (55%)
No	36 (45%)

*Waiting list was defined as anything over 2-3 weeks

Table 4.5 Do you arrange access to professional interpreting services for clients? (n=80)

'Always'	18 (22.5%)
'Sometimes'	24 (30%)
'Never' & 'There has never been a need for an interpreter'*	38 (47.5)

*The 'there has never been a need for an interpreter' option was only included in the last 35 interviews. Therefore, the 'never' and 'there has never been a need for an interpreter' options are combined.

5: Client Profile

Table 5.2 Which of the following form part of the inclusion criteria for your service? (n=80)

	Yes	No	If yes please specify
Age*	64 (80%)	16 (20%)	16-18+ (50), Older Adults (2)
Location	44 (55%)	36 (45%)	Location relates to study target areas
Specific Social Problem	26 (32.5%)	54 (67.5%)	Intravenous drug users (1), domestic violence (1). Other responses related to target groups (e.g. homelessness)
Manifest Mental Health Problem	28 (35%)	52 (65%)	The majority of services (25) who responded 'yes' will include any type or degree mental health problem
Gender	8 (10%)	72 (90%)	4 female only services, 4 male only services
Ethnic Group	9 (11.3%)	71 (88.7%)	Travellers (5), Non Irish Nationals (4)

*Only services aimed at clients aged 16-18 upwards were included in the study

Table 5.3 Exclusion criteria (n=80)

	Yes	**No**
Lack of Motivation	7 (8.8%)	73 (91.3%)
Command of Language of host country	5 (6.3%)	75 (93.8%)
Addiction*	17 (21.3%)	63 (78.8%)
Criminal History	6 (7.5%)	74 (92.5%)
Aggressive behaviour*	16 (20%)	64 (80%)
Other**	7 (8.8%)	73 (91.2%)

*There were difficulties with interpreting both addiction and aggressive behaviour as exclusion criteria e.g. are they currently using or are they currently sober but are being treated for addiction; whether they are currently being aggressive or have they been aggressive in the past.

****Other* these replies included the exclusion of those with more serious health care needs (n=4)

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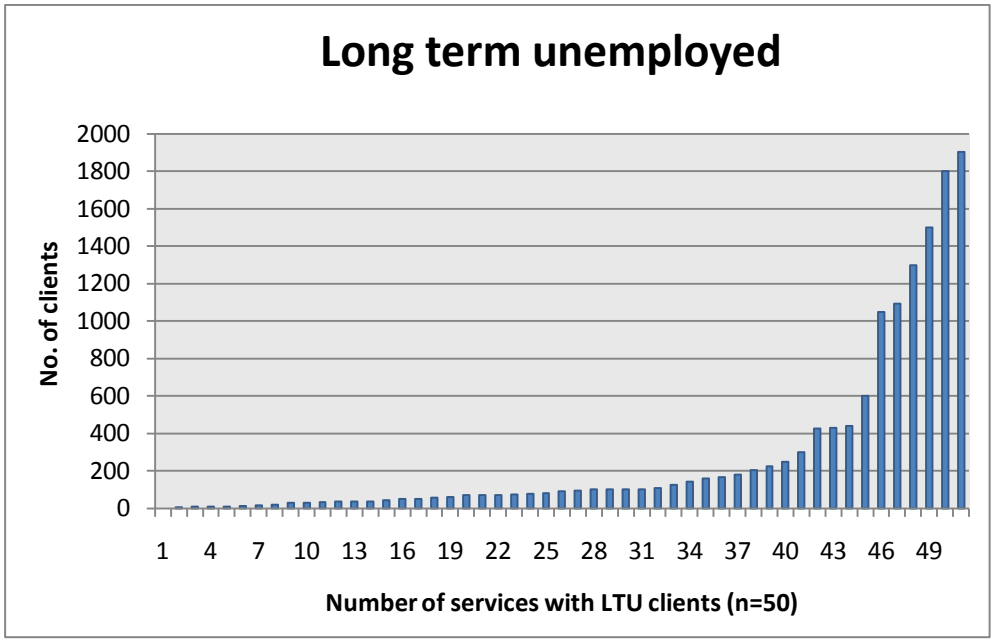
Table 5.4 Are clients (either former of current) involved in the delivery of care or any other work in the service? (n=80)

	Yes	**No**
Other than direct contact with clients (paid role)	6 (7.5%)	74 (92.5%)
Delivery/direct contact with clients (paid role)	2 (2.5%)	78 (97.5%)
Other than direct contact with clients (paid role)	8 (10%)	72 (90%)
Delivery/direct contact with clients (paid role)	6 (7.5%)	74 (92.5%)

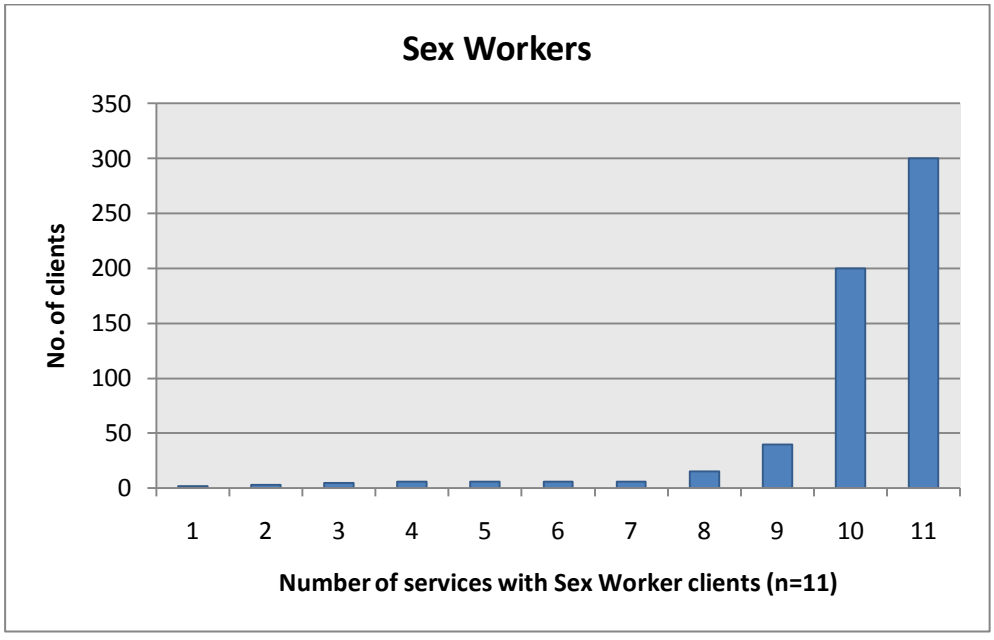
6: Services provided to target groups

Figure 6.1a How many Long Term Unemployed used your service in the past year? (n=50)



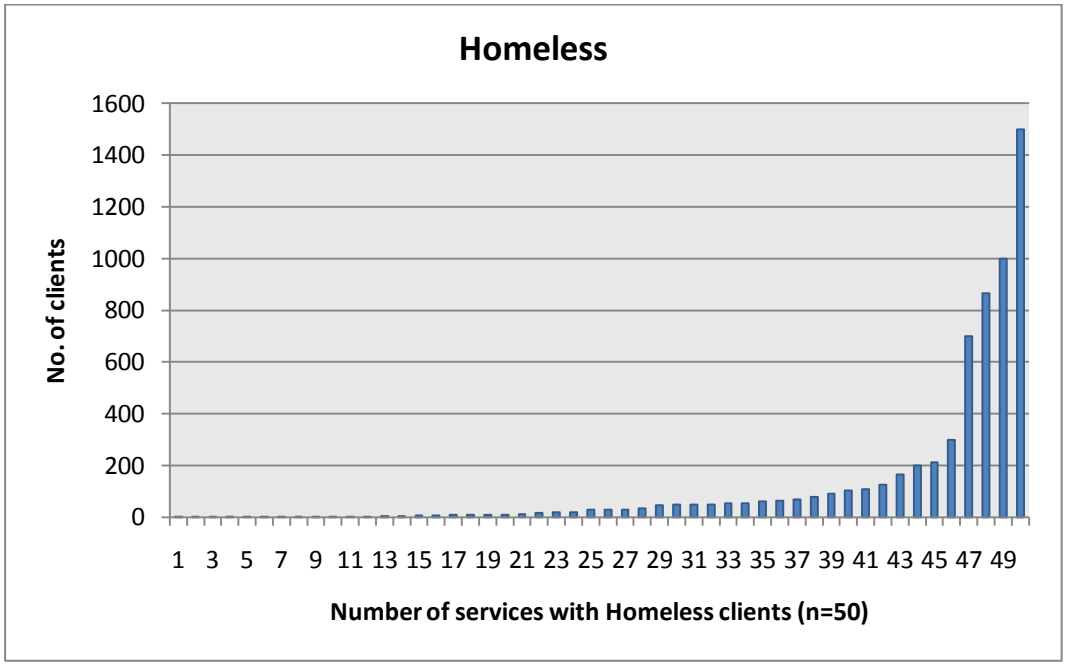
*The figures provided for the number of clients are largely based on estimates

Figure 6.1b How many Sex Workers used your service in the past year? (n=11)



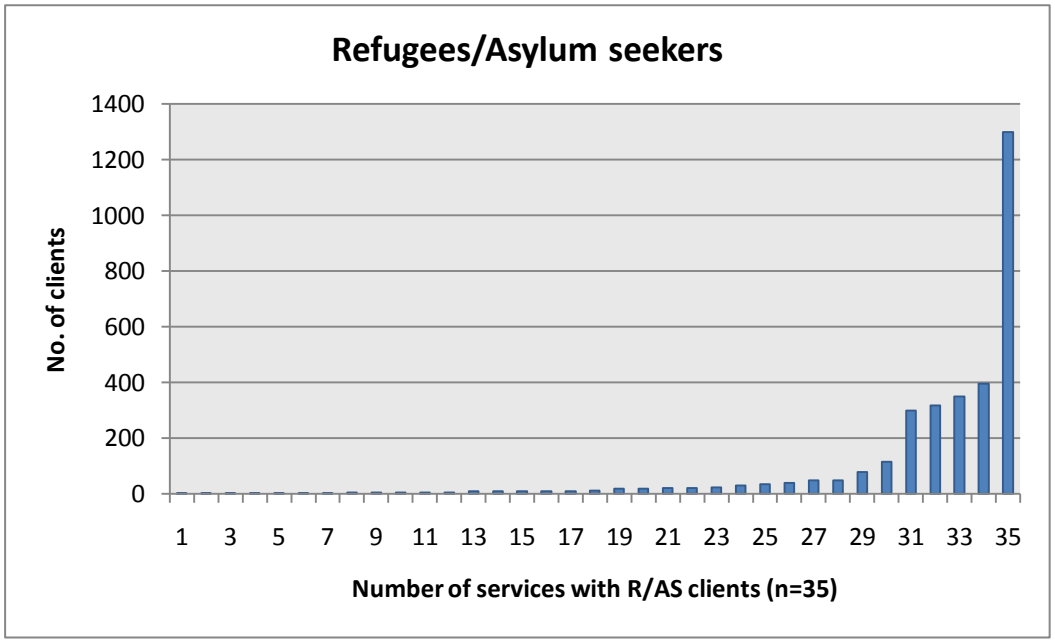
*The figures provided for the number of clients are largely based on estimates

Figure 6.1c How many Homeless people used your service in the past year? (n=50)



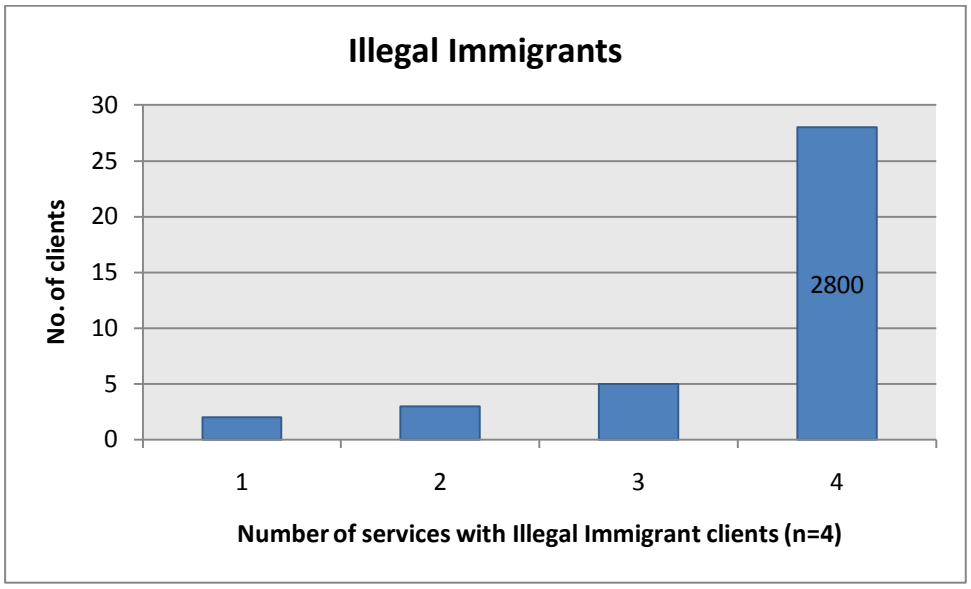
*The figures provided for the number of clients are largely based on estimates

Figure 6.1d How many Refugees/Asylum Seekers used your service in the past year? (n=35)



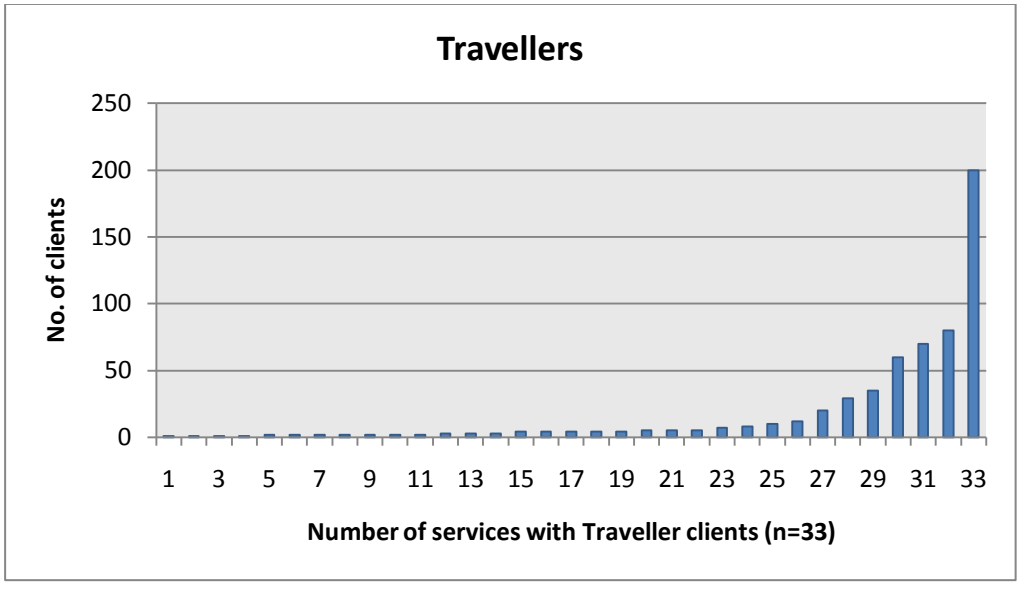
*The figures provided for the number of clients are largely based on estimates

Figure 6.1f How many Illegal Immigrants used your service in the past year? (n=4)



*The figures provided for the number of clients are largely based on estimates

Figure 6.1f How many Travellers used your service in the past year? (n=33)



*The figures provided for the number of clients are largely based on estimates

Table 6.2 Does your service directly provide any of the following programmes/activities to clients? (n=80)

	Yes	No	Clients helped to access these services elsewhere
Active Outreach	44 (51.3%)	36 (55%)	10 (12.5%)
Case Finding	19 (23.8%)	61 (76.3%)	7 (8.8%)
Home Visits	32 (40%)	48 (60%)	7 (8.8%)
Counselling	34 (42.5%)	46 (57.5%)	43 (53.8%)
Psychotherapy Individual	27 (33.8%)	53 (63.2%)	33 (41.3%)
Psychotherapy Group	11 (13.8%)	69 (86.3%)	32 (40%)
Self-help support	32 (40%)	48 (60%)	34 (42.5%)
Occupational Therapy	16 (20%)	64 (80%)	26 (32.5%)
Medication	26 (32.5%)	53 (66.3%)	25 (31.3%)
Detox and acute withdrawl treatments	12 (15%)	68 (85%)	38 (47.5%)
Drug addiction treatment	9 (11.3%)	71 (88.8%)	47 (58.8%)
Alcohol addiction treatment	13 (16.3%)	67 (83.8%)	52 (65%)
Direct practical help in clients homes	27 (33.8%)	53 (66.3%)	19 (23.8%)
Befriending	24 (30%)	56 (70%)	23 (22.8%)
Leisure activities support	32 (40%)	48 (60%)	24 (30%)
Mental health advocacy	45 (56.3%)	35 (43.8%)	17 (21.3%)
Social welfare support	46 (57.5%)	34 (42.5%)	25 (31.3%)
Housing/accommodation advice and support	46 (57.5%)	34 (42.5%)	36 (45%)
Legal advice and support	24 (30%)	56 (70%)	40 (50%)

Job coaching/finding	41 (51.3%)	39 (48.8%)	29 (36.3%)
Mental health promotion measures	54 (67.5%)	26 (32.5%)	17 (21.3%)
Other	21 (26.3%)	59 (73.8%)	2 (21.3%)

7: Co-ordination with other services

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

Yes	42 (52.5%)
No	38 (47.5%)

*It is not definite that in all cases the meetings occur at least once a month

Table 7.1a Were any of these meetings specific to one of the target groups? (n=80)

	No. of services with meetings specific to a target group (n=80)
Long term unemployed	10 (12.5%)
Sex Workers	5 (6.3%)
Homeless	16 (20%)
Refugees/Asylum Seekers	5 (6.3%)
Illegal Immigrants	0
Travellers	4 (5%)

.....

Table 7.2 Did your service receive referrals* from other services/institutions in the last year? (n=80)

Yes	77 (96.2%)
No	3 (3.8%)

*The definition of 'referrals' in this instance was not stringent as in involving letters or direct contact between services in all cases

Table 7.2a Were any of these referrals specific for any of the target groups? (n=80)

	No. of services receiving referrals specific to a target group (n=80)
Long term unemployed	20 (25%)

Sex Workers	8 (10%)
Homeless	41 (51.3%)
Refugees/Asylum Seekers	23 (28.8%)
Illegal Immigrants	2 (2.5%)
Travellers	15 (18.8%)

.....

Table 7.3 Does your service accept self-referrals? (n=80)

Yes	40 (50%)
No	40 (50%)

Table 7.3a Did your service receive self-referrals from clients belonging to any of the following target groups in the last year? (n=80)

	No. of services with self referrals specific to target groups (n=80)
Long term unemployed	15 (18.8%)
Sex Workers	8 (10%)
Homeless	20 (25%)
Refugees/Asylum Seekers	18 (22.5%)
Illegal Immigrants	2 (2.5%)
Travellers	12 (15%)

.....

Table 7.4 Did your service refer* clients to any other services/institutions in the last year? (n=80)

Yes	73 (91.3%)
No	7 (8.8%)

* The definition of 'referrals' in this instance was not stringent as in involving letters or direct contact between services in all cases

Table 7.4a Were any of these referrals specific to one of the target groups? (n=80)

	No. of services referring clients specific to target groups (n=80)
Long term unemployed	35 (43.8%)
Sex Workers	6 (7.5%)
Homeless	42 (52.5%)
Refugees/Asylum Seekers	20 (25%)
Illegal Immigrants	3 (3.8%)
Travellers	7 (8.8%)

8: Evaluation

Table 8.1 Does your service systematically collect and enter into a database any of the following data? (n=80)

Socio-demographic characteristics	50 (62.5%)
Data on input and attendance	53 (66.3%)
Outcome data on satisfaction and experience	26 (32.5%)

.....

Table 8.2 Does your service document whether a client belongs to one of the following groups? (n=80)

	No. of services documenting target groups
Long term unemployed	34 (42.5%)
Sex Workers	11 (13.8%)
Homeless	49 (61.3%)
Refugees/Asylum Seekers	35 (43.8%)
Illegal Immigrants	12 (15%)
Travellers	28 (35%)

.....

Table 8.3 Are the results of any evaluations publicly available*? (n=78)

Yes	27 (33.8%)
No	52 (65%)

*Publicly available was defined as accessible to the public via the internet or annual reports etc.

9: Service provision in group specific services

Table 9.1: Service provision in all group specific services (n=43)

	LTE (n=7)	Sex Workers (n=3)	Homeless (n=19)	Refugees & Asylum Seekers (n=8)	Illegal Immigrants (n=1)	Travellers (n=5)
	Yes	Yes	Yes	Yes	Yes	Yes
Active outreach	**5** *(71.4%)*	**3** *(100%)*	**8** *(42.1%)*	**5** *(62.5%)*	**0**	**4** *(80.0%)*
Case finding	**4** *(57.1%)*	**2** *(66.7%)*	**8** *(42.1%)*	**0**	**0**	**3** *(60.0%)*
State Sector	**3 (***42.9%)*	**1** *(33.3%)*	**6** *(31.6%)*	**5** *(62.5%)*	**0**	**2** *(40.0%)*
NGO	**4 (***57.1%)*	**2** *(66.7%)*	**13** *(68.4%)*	**3** *(37.5%)*	**1**	**3** *(60.0%)*
Does your organisation accept self-referrals?	**7** *(100%)*	**3** *(100%)*	**6** *(31.6%)*	**4** (*50.0%)*	**1**	**4** *(80.0%)*
External supervision	**1** *(14.3%)*	**1** *(33.3%)*	**2** *(10.5%)*	**3** *(37.5%)*	**0**	**1** *(20.0%)*
Services with mental health staff[2]	**2** *(28.6%)*	**1 (***33.3%)*	**7** *(36.8%)*	**3** *(37.5%)*	**0**	**1** *(20.0%)*
Services with social care staff[3]	**0**	**1** *(33.3%)*	**10** *(52.6%)*	**4** *(50.0%)*	**0**	**1** *(20.0%)*
Do services provide any mental health therapy?[4]	**1** (*14.3%)*	**2** *(66.7%)*	**5** *(26.3%)*	**2** *(25.0%)*	**0**	**2** *(40.0%)*
Do services provide any addiction programmes?[5]	**1** (*14.3%)*	**2** *(66.7%)*	**5** *(26.3%)*	**1** *(12.5%)*	**0**	**2** *(40.0%)*
Do services provide social programmes[6]	**7** (*100%)*	**3** *(100%)*	17 *(89.5%)*	**5** *(62.5%)*	**1**	**4** *(80.0%)*
Do services have any exclusion criteria[7]	**4** (*57.1%)*	**0** *.0%*	**11** *(57.9%)*	**2** *(25.0%)*	**0**	**3** *(60.0%)*
Socio-demographic characteristics of clients systematically collected?	6 (85.7%)	1 (33.3%)	16 (84.2%)	6 (75%)	1	3 (60%)
****Data on input and attendance***	6 (85.7%)	3 (66.7%)	13 (68.4%)	5 (62.5%)	1	3 (60%)

[2] psychiatrists, psychologists, counsellors or mental health nurses
[3] either an occupational therapist or a social worker
[4] counselling or psychotherapy (group or individual)
[5] detoxification treatments, drug addiction treatments or alcohol addiction treatments
[6] social welfare support, housing support, legal advice and support or job coaching/finding
[7] Lack of motivation, command of language of host country, addiction, criminal history or aggressive behaviour

Table 9.2: Number and professional background of staff in group specific services (n=43) (Sum and average)

	LTE (n-7)	Sex Workers (n=3)	Homeless (n=19)	Refugees & Asylum Seekers (n=8)	Illegal Immigrants (n=1)	Travellers (n=5)
Number of Whole Time Equivalent (WTE) paid staff	**137.00** *(19.57)*	**18.00** *(6.00)*	**158.2** *(8.33)*	**86.70** *(10.84)*	**3.00** *(3.00)*	**18.00** *(3.60)*
Administrative staff	**21.00** *(3.00)*	**4.00** *(1.33)*	**18.50** *(.97)*	**26.30** *(3.29)*	**.00**	**.40** *(.08)*
Counsellors	**5.00** *(.71)*	**.00**	**1.25** *(.07)*	**.00**	**.00**	**.60** *(.12)*
Medical doctors (non-psychiatric)	**.00**	**.50** *(.17)*	**4.25** *(.22)*	**1.23** *(.15)*	**.00**	**.00**
Nurses	**1.00** *(.14)*	**.50** *(.17)*	**17.00** *(.89)*	**2.50** *(.31)*	**.00**	**.00**
Occupational (work) therapists	**.00**	**.50**	**3.00** *(.16)*	**.00**	**.00**	**.00**
Psychiatrists	**.00**	**.00**	**5.10** *(.27)*	**.30** *(.04)*	**.00**	**.00**
Psychologists/ Psychotherapists	**3.00** *(.43)*	**.00**	**.00**	**4.52** *(.57)*	**.00**	**.00**
Social workers	**.00**	**3.0** *(1.00)*	**22.20** *(1.17)*	**5.80** *(.73)*	**.00**	**4.00** *(.80)*

10. Quality Index of Service Organisation

In order to identify best practice in the provision of mental health services for the target groups a Quality Index of Service Organisation was developed by the co-ordinating centre in London. The index is based on the data obtained via the PROMO services assessment questionnaire.

The quality index is focused on the following six domains and has a maximum score of 15 points

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

(**max 15 points**).

For a full description of the quality criteria please see Appendix D.

Figure 10.1: Spread of quality scores across assessed services in Ireland (n=80)

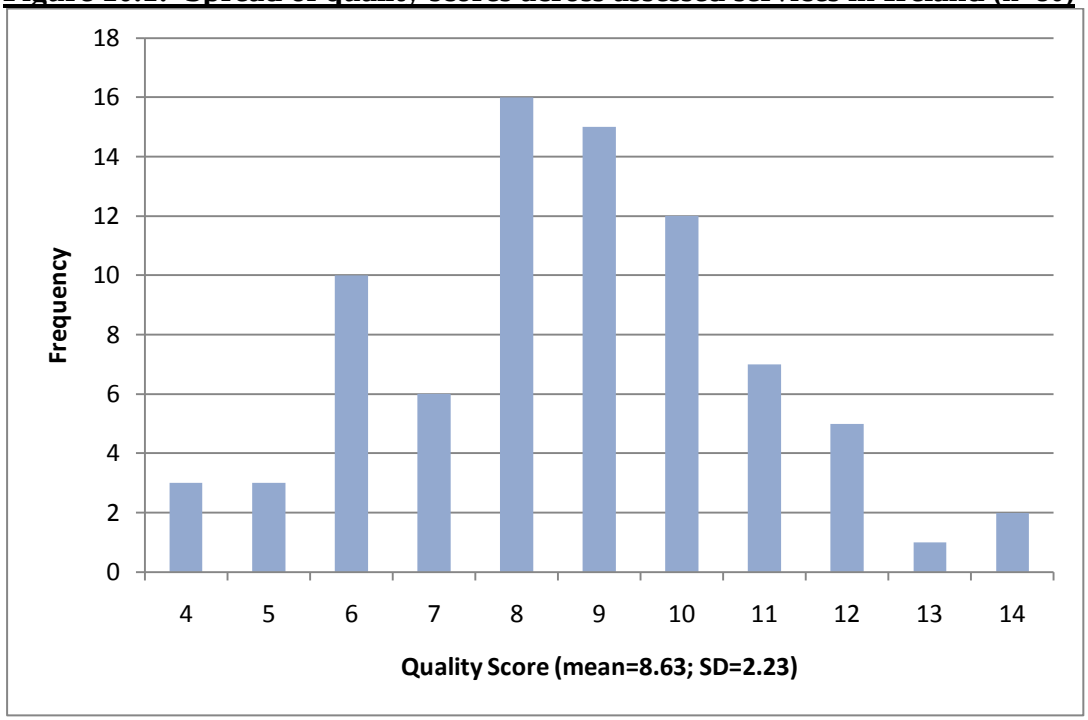


Figure 10.2: Quality index of service organisation per group specific services (n=43)

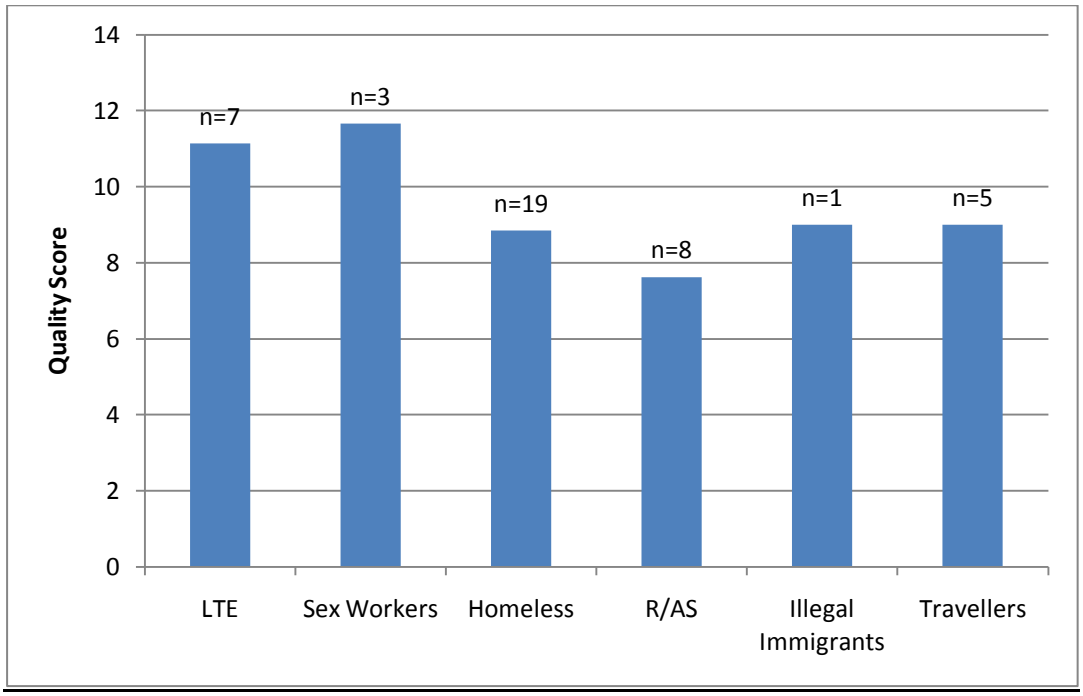
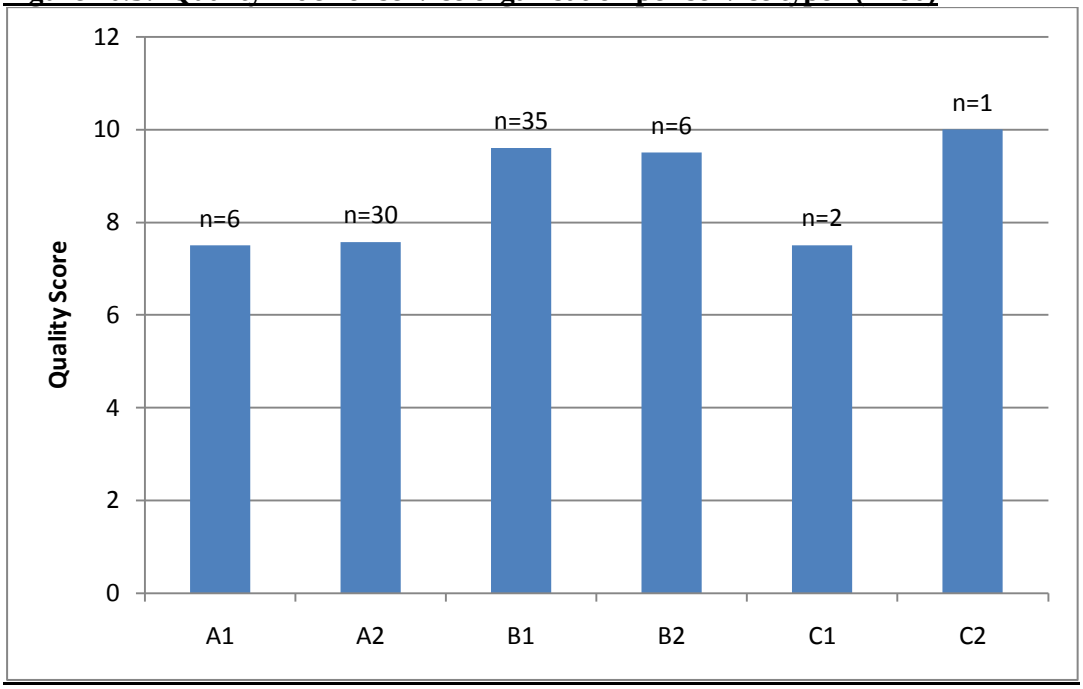


Figure 10.3: Quality index of service organisation per service type* (n=80)



* Service Typology: (A1) group specific mental health services (A2) generic mental health services (B1) group specific social care services (B2) generic social care services (C1) group specific general health services (C2) generic general health services

11: Comparisons with assessed services in other European countries

Table 11.1 A selection of results from the Irish target areas and a comparison with the equivalent results from the European target areas**

		Ireland (n=80)		Europe (n=513)	
		N	%	N	%
Does service engage in *active outreach?	***Yes***	44	55.0%	157	30.7%
Does service engage in *case finding?*	**Yes**	23	28.8%	110	21.5%
***Does service accept *self-referrals*?**	***Yes***	40	50.0%	431	84.7%
***Is service provided by the *State or NGO*?**	**State**	40	50.0%	177	37.1%
	NGO	40	50.0%	300	62.9%
***Does service have *mental health staff*[8]?**	**Yes**	41	51.3%	339	67.8%
***Does service have *social care staff*[9]?**	**Yes**	26	32.5%	316	63.3%
***Does service provide any *mental health therapy*[10]?**	**Yes**	35	43.8%	403	79.8%
Does service provide any *addiction type programmes*[11]?	**Yes**	24	30.0%	151	29.7%
Does service provide *social type programmes*[12]?	**Yes**	60	75.0%	418	82.6%
***External supervision* for staff at least once a month?**	**Yes**	15	18.8%	247	49%
***Socio-demographic characteristics* of clients systematically collected?**	**Yes**	53	66.3%	450	88.4%
***Data on input and attendance* systematically collected**	**Yes**	50	62.5%	427	84.1%
Outcome data on satisfaction and experience	**Yes**	26	32.5%	242	47.2%
Does the service have any *exclusion criteria*[13]?	**Yes**	30	37.5%	256	53.8%

***Significant differences (P<0.05)**

****data from two of the participating countries was omitted from the analysis due to the low quantity of services assessed in these countries

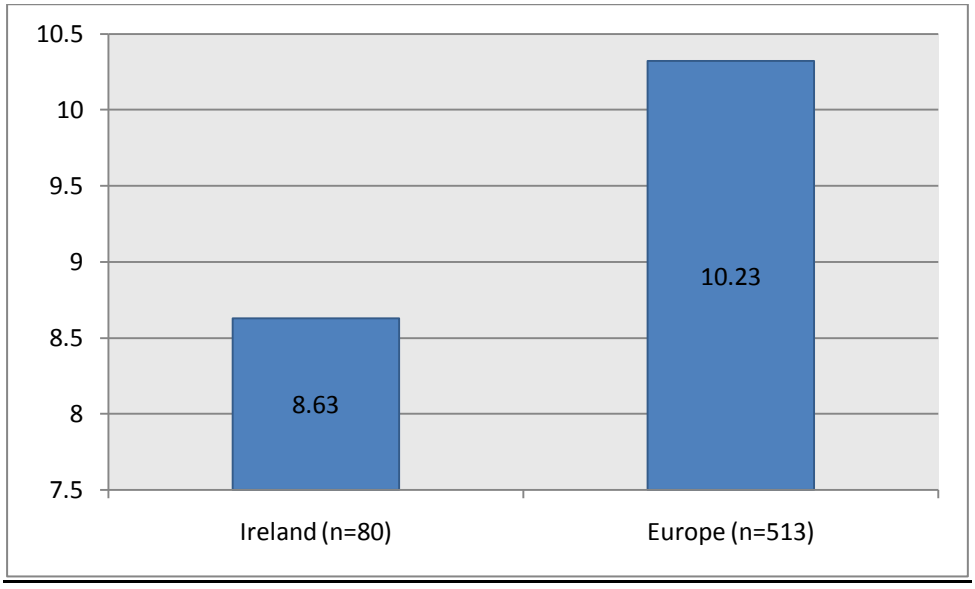
[8] psychiatrists, psychologists, counsellors or mental health nurses
[9] either an occupational therapist or a social worker
[10] counselling or psychotherapy (group or individual)
[11] detoxification treatments, drug addiction treatments or alcohol addiction treatments
[12] social welfare support, housing support, legal advice and support or job coaching/finding
[13] Lack of motivation, command of language of host country, addiction, criminal history or aggressive behaviour

Table 11.2: Comparison of staff and professional background across Irish and European assessed services

	Ireland (n=80) Sum (average)	**Europe (n=513)** (sum/average)
Number of Whole Time Equivalent (WTE) paid staff*	**869.68** (10.87)	**17006.71** (33.81)
Professional background- Administrative staff	**94.20** (1.18)	**1853.50** (3.69)
Counsellors	**23.25** (.29)	**790.69** (1.58)
Medical doctors (non-psychiatric)*	**25.98** (.32)	**1078.16** (2.14)
Nurses	**244.00** (3.05)	**2775.81** (5.53)
Occupational therapists	**10.50** (.13)	**276.95** (.55)
Psychiatrists	**42.90** (.54)	**573.34** (1.14)
Psychologists/Psychotherapists*	**26.02** (.33)	**1047.10** (2.09)
Social workers*	**43.00** (.54)	**1476.70** (2.95)

***Significant differences (p<0.05)**

Figure 11.1: Comparison of Quality Index of Service Organisation scores across Irish and European assessed services*



Significant difference (P<0.05)

3.3: Overall Quality of Care

The interviews to assess the overall quality of care in each area consisted of (1) two case vignettes to assess the pathways to mental health care for people from the specific target group with mental health problem; (2) general questions regarding the quality of mental health care for the six target groups. The data from the interviews was assessed by thematic analysis, grouping similar responses within each question into categories.

Section 1: Case vignettes

Vignette 1

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

Q1: 'Who would be likely to notice his problems and initiate help?'

Specific Target Groups

- **Long-term unemployed (LTU)** and **Traveller** responses focussed on family and friends.
- **Sex Worker** answers focused on outreach 'van' services provided by Ruhama[14] and the Women's Health Project[15]. These vans are positioned rather than being active/engaging in case finding.
- **Refugees & Asylum Seekers** are more in a 'system' in a sense so their problems are more likely to be noticed within that system e.g. in a hostel, legal service, community welfare officer, police. Whether their families will notice depends on their circumstances i.e. are their families with them?

[14] Ruhama is a charitable support service for Women in Prostitution and Trafficking.

[15] The Women's Health Project is a statutory service specifically for Women in Prostitution which offers a drop in clinic providing medical services and an outreach service.

- The situation for the **Homeless** individual is more random, probably owing to the fact that the individual in the vignette is sleeping rough e.g. police, passer-by, Simon outreach services.
- **Traveller** interviewees mentioned the Traveller Primary Health Care projects[16] as a service which may do so.
- For **Illegal Immigrants** it was concerned citizens, the persons own family or community and possibly homeless outreach services.

Summary

Family and friends were the most common response (11), followed non health related scenarios such as a passer-by or police (6) and then street outreach services (5, not mental health specific).

The types of people/organisations identified who are most likely to notice such problems and initiate help are different for each group. LTU and Illegal Immigrants are more likely to be noticed by family and friends, for Sex Workers it was outreach van services specifically aimed at sex workers. For Refugees & Asylum Seekers it was most likely within the asylum system itself. For Homeless people the situation was more random – police, passer-by and outreach services. For Travellers it was mainly within their own community, most likely the Traveller primary care projects.

[16] A Traveller primary health care project consists of Traveller women trained and working as Community Health Workers within their own community.

Q**2. Which services, once informed, would go out and contact him**?

Target Groups

- **Long-term unemployed** would usually have to be taken to a service e.g. a G.P. – there is no form of outreach.
- For **Sex Workers** it is street services once again. These services don't chase people or go out to them, rather they are just positioned.
- For **Homeless** people the ACCES[17] mental health team if contacted would go out to do an assessment on him, or else the generic homeless outreach services would make contact. If arrested by police they could possibly end up in the forensic services, which in not good.
- For **Refugees & Asylum Seekers** it may be a social worker, police or outreach services from Spirasi[18]. If he was in the psychiatric services a community nurse might go out and see him.
- For **Travellers** the only organisations which would possibly go out are the Traveller Primary Care Projects or a Public Health Nurse.
- For **Illegal Immigrants** the options are limited as there is a reluctance to report such cases if the person is undocumented.

Summary

Outreach services (the majority being homeless related services) were the most frequently mentioned in terms of who might go out and contact him, followed by primary care services such as a social worker or a GP.

Once again the type of service which may go out and contact him is different for each group. Many of the services highlighted are group specific, although only one of these is specific to

[17] ACCES Service – An Assertive Community Care Evaluation Services for homeless people aged 18-65 with a severe and enduring mental illness.

[18] Spirasi provides three directly delivered services to asylum seekers, refugees and torture survivors. 1) rehabilitation services for survivors of torture 2) education and integration services for disadvantaged migrants & 3) health information and promotion for newly arrived asylum seekers.

mental health i.e. the ACCES service for homeless people. With LTU there are probably no services which would go out and contact him, so he would have to be taken to a service.

Q3. What care would they provide and how would they refer the person on?

Target Groups

- For **LTU** it is from a GP to the psychiatric services.
- For **Sex Workers** if they engage with the relevant services they are referred to a GP. In one Sex Worker specific service there is a psychiatrist who attends sessionally and who will refer to Trinity Court[19] if necessary. If the engagement with relevant services occurs on the streets then sex workers usually end up going to A/E.
- For **Refugees & Asylum Seekers** it is to a GP or A/E for appropriate referral. There is also the possibility of referral to specialised services e.g. for victims of torture or rape (Spirasi).
- For **Homeless** depending on the GP involved or the severity of the illness they may be referred to relevant catchment area hospital.
- For **Travellers** the Primary Health Care projects would refer to GP's and from there possibly to the psychiatric services. They might also go directly to A/E.

Summary

Most referrals would be to a GP and from there to the psychiatric services. In some cases individuals would be sent to A/E or attend there themselves. Outside of this there seems to be little else. Group specific mental health services were indicated twice (homeless and refugee/asylum seeker specific). Counselling services and groups specific NGO's were mentioned once each.

It seems that the individual involved is likely to go through the same route/procedure as a member of the general population.

[19] Trinity Court - largest addiction treatment (Day) centre in Ireland, providing a broad range of specialist treatments for a variety of drug using populations and those requiring specialist psychiatric, psychological, social and medical interventions.

Q4. What are the further care pathways or treatment options for him?

Target Groups

- For **LTU** it is into educational/rehabilitation services.
- For **Sex Workers** it is the mental health services.
- For **Refugees/Asylum Seekers** there is the HSE Psychological Service at St Brendan's Hospital or services provided by Spirasi.
- For **Homeless** people there is a mental health team for homeless people specifically for the northside of Dublin but there are issues around their criteria for acceptance. The ACCES service (whose main target area is the southside of Dublin) provides specific mental health care for homeless people and they also refer to Community Welfare Officers at the Homeless Persons Unit[20]
- For **Illegal Immigrants** the focus was on the fact that they do not have a medical card and cannot normally afford a GP. They are entitled to emergency care but the possibilities for follow up are minimal.

Summary

The most frequent possible further care pathways mentioned were the generic mental health services. Group specific mental health services were mentioned on four occasions in relation Homeless people and Refugees & Asylum Seekers. Sex Workers and Travellers are usually confined to the generic mental health services. For LTU the further care pathways are related to educational and rehabilitation services. For Illegal Immigrants the further care pathways are minimal or non-existent.

[20] Support service for homeless men around welfare, accommodation and income maintenance – and referrals to other services.

Q5**. What are the barriers for him to receive that care and/or treatment?**

Target groups

- Barriers for **LTU** people include the entry criteria for rehabilitation services in the community; the availability of a place; no history of sustained unemployment; low educational levels and poor personal hygiene.
- Barriers for **Sex Workers** are the inaccessibility of services; the length of time between attending A/E and getting appointment for community mental health services; seeing a different psychiatrist each time they attend; not being take seriously; the stigma attached to prostitution; the lack of multi disciplinary teams within the services which are provided specifically for women in prostitution.
- Barriers for **Refugees & Asylum Seekers** are lack of knowledge regarding the services that are available to them and how the system works e.g. the importance of the GP; lack of time and space in mainstream services; seeing a different psychiatrist every time they attend; lack of appropriate accommodation; language and culture; interpreting services are not always available and the length of time in asylum process.
- The barriers for **Homeless** people are the catchment area system; prejudice towards homeless people in the services; the Homeless health service system itself as it needs to be embedded in place where Homeless people live; lack of communication between services; the individual in question is not seeking help and the individual may end up in the forensic services.
- Barriers for **Travellers** include stigma around mental illness in the travelling community; resistance from services to come and visit him e.g. to a halting site; negative stereotypes within services towards Travellers; openness of services towards Travellers; little information on mental health designed with Travellers in mind; literacy difficulties amongst Travellers and lack of cultural awareness in the services.
- The main barrier for **Illegal Immigrants** is their undocumented status followed by language difficulties. Lack of medical records and confusion within services regarding what level of services illegal immigrants are entitled too are also seen as barriers.

Summary

A wide variety of barriers were described. The most prominent categories were service accessibility and quality/continuity of care, prejudice and stigma. Many of the barriers highlighted were specific to each group. Some were also were related to problems inherent in the health services themselves rather than being specific to the target groups e.g. accessibility, quality of care.

Q6. **Are there any ways to overcome these barriers?**

Target Groups

- **Long-Term Unemployed** - more positive models and approaches to treatment in the services. Programmes for LTU people with mental health problems which include elements on hygiene & diet etc while they gain work experience at the same time.
- **Sex Worker** services need to be more accessible; the clients need to be listened to and see the same psychiatrist each time. There are limited resources available and there is a need for more to be done e.g. the creation of multi-disciplinary teams within sex worker specific services.
- Ways to overcome barriers for **Refugees & Asylum Seekers** are access to training in cross cultural mental health care for service providers; the use of interpreters; psychological services for refugees/asylum seekers; access to private accommodation; early identification of torture survivors and good basic information available in English regarding the mental health services.
- **Homeless** - to reconfigure homeless services so they are concentrated in areas with the biggest homeless problems. To have clearer policies with regard to catchment areas.
- **Travellers** - for individuals to be more proactive in engaging with the services and trying to shape the services the way they want them; for services to acknowledge the differences in culture and be non-judgemental; to raise awareness around mental health issues in the Traveller community; for services to engage with Travellers and traveller community projects; for community project workers to have a link in with the mental health services e.g. a liaison person.
- For **Illegal Immigrants -** more frequent and better translation services; for services to upskill around cultural competencies; training for hospital workers and social workers on how to apply for residency status for an individual and a channel where vulnerable people can be regularised in order to receive the treatment they need.

Vignette 2

A 40-year old female, unemployed (or homeless, sex worker, Traveller etc. depending on target group assessed) for more than 5 years, living alone, depressed, with suicidal ideation. She wants help.

Q1. How would she find information on how to deal with her health problems?

Target Groups

- For **Long Term Unemployed** there are the support organisations like Shine[21], Aware, Citizens Information Centres, the Health Board / Mental Health Services.
- For **Sex Workers** a GP or a Community Welfare Officer.
- For **Homeless** people there are the billboards on the streets; information in homeless hostels; Simon and Focus Ireland; Homeless food centres, Merchants Quay[22] or the Safety Net Service[23].
- For **Refugees & Asylum Seekers** a GP and also sometimes the possibility of getting information in the post office or via solicitors.
- For **Travellers** a GP; a local Traveller Primary Health Care project or possibly a Public Health Nurse or a Social Worker.
- For **Illegal Immigrants** there is word of mouth; the Migrants Rights Centre Ireland (MRCI)[24] and Cairde[25].

[21] Shine is a national organisation dedicated to upholding the rights and addressing the needs of all those affected by enduring mental illness including, but not exclusively, schizophrenia. The Shine Basin Club, which is located in Dublin North Central, is a peer driven community resource centre whose services also include a jobs club and employment support service.

[22] Merchants Quay - an open access Primary Health Care Unit for homeless persons aged 18+ - it is located outside both target areas.

[23] Safety Net Service - A private agency coordinating a set of clinics providing primary health care for homeless people. There are 8 such clinics consisting of nurses and the input of 2 GP practices. The main clinic is in Smithfield, Dublin.

[24] Migrants Rights Centre Ireland (MRCI) is a national organisation concerned with the rights of migrant workers and their families. It includes services for undocumented workers and those in forced labour and irregular migration.

[25] Cairde is a community development organisation working to tackle health inequalities among ethnic minority communities by improving ethnic minority access to health services and ethnic minority participation in health planning and delivery.

Summary

Generally GP's were the most prominent service mentioned in relation to where she might get information on where to get help with her problems. For Homeless people there are variety of homeless services which could provide information. For Sex Workers, Travellers and Refugees & Asylum Seekers) the main focus was on GP's but also a possibility through community welfare officers (sex workers), post office and solicitors (refugees & asylum seekers) and primary health care projects, public health nurse and social workers (travellers).

Q2. Which Organisations could she approach?

Target Groups

- For **Long Term Unemployed** a GP or the Irish Advocacy Network[26].
- For **Sex Workers** a GP – but many don't have a GP. If they are homeless they could receive treatment through Focus Ireland or the drug services.
- For **Homeless** it is a GP or the Safety Net Service.
- For **Refugees & Asylum Seekers** the responses were the same as the previous question.
- For **Travellers** it is Community Health Workers in the Traveller Primary Care Projects; a Public Health Nurse or possibly through the Traveller Counselling Service
- For **Illegal Immigrants** it was once again MRCI and Cairde; and also the Citizens Information Centres (CIC)[27], the Immigrant Council of Ireland and local churches.

Summary

One again the main focus is on GP's. One issue for Sex Workers is that they many don't have a GP. If a Sex Worker is homeless they could receive treatment through the Homeless services. There is a specific primary care service for Homeless people called the Safety Net Service. Travellers once again might link in with the local Traveller primary care projects.

[26] The Irish Advocacy Network is a peer advocacy service whose members give support and information to people with mental health difficulties by befriending them and offering a confidential listening ear or peer advocacy.

[27] The Citizens Information Centres are drop in centres which provide information, advice and advocacy in relation to a variety of services in Ireland.

Q3. What are the further care pathways and/or treatment options for this person?

Summary

The predominant route is from a GP to the mental health services. From there LTU may get referred to employment services, Homeless people may at some stage get referred to specific mental health services for Homeless people (2 services) and Refugees & Asylum Seekers possibly to Spirasi. A lot depends on what the GP actually thinks is the best option and what options are available. Options for Illegal Immigrants are limited or non-existent.

Q4. What are the barriers to receive that care and treatment?

Target Groups

- For **Long Term Unemployed** similar to Vignette 1 but here she is a willing participant, this is important. Also, as an example, if she wants to attend the National Learning Network[28] she has to give permission for medical records to be transferred there - there can be a reluctance to do so. People who are LTU and receiving a disability allowance need an exemption form if they want to start a part-time job. This can take time to get and therefore cause problems.
- For **Sex Workers** there are issues with accessibility; seeing a different psychiatrist each time they attend; the length of time between attending A/E and getting appointment for community mental health services; not being taken seriously; the difficulty/fear of disclosure; working long hours on the streets and drug problems.
- With **Homeless** people if attending A/E they have to wait a long time to be seen. The A/E services sometimes hope they leave before they have to treat them. If sleeping rough it is hard to engage with the services and they are more likely to be a victim of abuse. In such cases females are more vulnerable and many are alcohol dependent.
- Barriers for **Refugees & Asylum Seekers** are lack of knowledge about the services that are available and about the system i.e. the importance of the GP; the lack of time and space in mainstream services; seeing a different psychiatrist every time they attend; appropriate accommodation; gender issues; language and culture; interpreting services are not always available and the length of time in asylum process.
- In the case of **Travellers** she is a woman and maybe has a family so is likely to have children to look after and may not want to leave them. There is a stigma with using the mental health services amongst travellers and a fear of treatment. Also within the services there is a fear of Travellers and a lack of awareness of cultural issues amongst staff.

[28] The National Learning Network assists people at a disadvantage in the labour market to learn the skills they need to build lasting careers in jobs that reflect their interests and abilities. The majority of National Learning Network's student body is made up of people with disabilities.

- For Illegal Immigrants the barriers are literacy, a lack of information available regarding the health services and people who are undocumented being fearful of coming forward to a services due to a fear of deportation. Also undocumented migrants may not want to consider they may be ill as they feel they have to work in order to send money home to their family.

Summary

The barriers are similar to Vignette 1. The main difference in this instance is that the individual is a female and there may also be literacy problems. If sleeping rough a female is more likely to be a victim of abuse and to be more vulnerable. In the case of Travellers she may have children which may make it difficult to attend services. The fear of deportation of a big barrier for illegal immigrants around approaching services.

Q 5 Are there any ways to overcome these barriers?

Target groups

- **For Long Term Unemployed** it depends to what extent are services responsive to her needs, rather than having a pre-determined idea of what someone in her condition needs. If offered part time unemployment people on a disability allowance need to be able to start work straight away rather than waiting for an exemption form as this can take time. The system needs to be changed to allow this.
- For **Sex Workers** services need to be more accessible and sex workers need to be listened to and have the same psychiatrist each time. More resources are needed on the street, more outreach work, more support work and more interdisciplinary teams available.
- **Homeless -** the education of frontline staff and also educating clients as to what happens in the services.
- Ways to overcome barriers in relation to **Refugees & Asylum Seekers** are access to training in cross cultural mental health care; the use of interpreters; psychological services for refugees and asylum seekers; access to private accommodation; early identification of torture survivors and good basic information available in English regarding services.
- For **Traveller**s supports need to be put in place for women who need to attend the services. The services need to be more accessible and supportive and for community health workers to have a liaison person / link with the services.

Section 2: General questions regarding the quality of health care

Q1. How is mental health care for people from the target group co–ordinated in the area?

a) How is it co-ordinated at administrative level?

Long-Term Unemployed

Interview 1

- Rehabilitation guidance service (HSES) – responsible for administering funding and monotoring the quality of community rehabilitation services in North Dublin.

Interview 2

- No co-ordination at all – we don't sit down together.

Sex Workers

Interview 1

- It is very much hit and miss.

Interview 2

- There is none – I don't see anything.

Refugees & Aylum Seekers

Interview 1

- No real co-ordination at administrative level.

Interview 2

- Care fits in with other services. There is no particular co-ordination.

Homeless

Interview 1

- For Dublin North Central it is done by St Brendans (which looks after all North Dublin). It is not a decent service.

- There are things going on but it can be a struggle to get invited to them.

Interview 2

- Social inclusion Managers in HSE co-ordinate services – they have a remit for homelessness and other socially marginalised groups.

Travellers

Interview 1

- There is a Traveller mental health sub group of the Traveller Health Unit (all-Ireland initiative). It is a recent initiative, I'm not sure if it is having much of an impact.

Interview 2

- I dont think that there is. There is a Traveller Health Unit for the Eastern Region. Here projects meet together but there is no mental health subgroup in that.

Illegal Immigrants

Interview 1

- No co-ordination.

Interview 2

- None.

b) How is it co-ordinated at the level of individual patients?

Long-term unemployed

Interview 1

- It is not co-ordinated at all.
- Individual may be accessing lots of services but there is no one central to it. Co-ordination is badly needed.
- There is a Central Assessment and Referral Service but they do not have enough personel.

Interview 2

- Sometimes by contacts within different services but it is very splintered.

Sex Workers

Interview 1

- Never hear from other services – only contact is with social worker. No case conferences etc.

Interview 2

- There are some (referrals) between psychiatrist who attends here and Trinity Court in relation to drug using women.

Refugees & Asylum Seekers

Interview 1

- We will contact other services which the client may be attending to try and ensure no overstepping. There is little working together across clients – seems to be a deliberate effort to avoid duplication.

Interview 2

- There is little co-ordination at this level. Unfortunate, espescially the lack of integration with social providers.

Homeless

Interview 1

- It is add hoc.

Interview 2

- The Homeless Agency[29] have a care and case management pilot programme. (30 to 40 patients). I haven't seen any success yet.

[29] The Homeless Agency is responsible for the planning, co-ordination and administration of funding in relation to the provision of quality services to people who are homeless in the Dublin area and for the development of responses to prevent homelessness.

Travellers

Interview 1

- Not that I know off.

Interview 2

- Dont know. In my opinion services don't link in.

Summary

There is little co-ordination of services at either an administrative level or at an individual level.

Q2. In your opinion, what are the strenghts of mental health services for the target group in the area?

Long-term Unemployed

Interview 1

- Mental health care providers i.e. the community services. It depends on the team – some are well resourced, some not.
- The HSE community rehabilitation teams when they are in place, although none are specific to this area.

Interview 2

- There fact that there are many relevant services in this area e.g. OBAIR[30], GP's, Mental Health Centre, National Learning Network, EVE Westpoint[31].

Sex Workers

Interview 1

- I don't know because I haven't seen any. The Community Psychiatric services can be supportive, but they see a different psychiatrist each time.

Interview 2

- I don't think I can answer that question.

[30] Obair – a local employment service for the Ballyfermot area consisting of
1. A Mediation service to Long Term Unemployed (6 months)
2. Jobs Club
3. Enterprise Service – start your own business
4. Jobs Plan – addictions. An 18 week course including detox and one to one counselling
5. Jobs initiative
6. A high support jobs coach for people with disabilities

[31] EVE Holdings are a subsidiary of the Health Services Executive and provide a range of community based services in the Dublin Area including Training Centres, Clubhouses and Rehabilitative Occupational Services. The majority of people who participate in EVE's services experience mental health difficulties.

Refugees & Asylum Seekers

Interview 1

- The Cultural Mental Health Clinic[32] at the Mater hospita offers more focussed, more appropriate assessment, more time and in some cases clienets are fast tracked onto other services.

Interview 2

- Medical card with the ability to access ordinary medical care/services, including all services in hospitals.

Homeless

Interview 1

- There are lots of resorces that could be used – don't know if they are being used for the people who need them the most.
- The team at St Brendans is well resorced in terms of buildings etc.

Interview 2

- Communication – we communicate as best we can.
- There are a large number of relevant services in this building – you get to know people.

Travellers

Interview 1

- I don't see too many strengths, even in terms of the Traveller Counselling Service.

Interview 2

- If there are any.

[32] A Cultural Psychiatric Clinic for migrants, refugees and asylum seekers at the Mater Hospital in Dublin North Central. Clients are referred to this service from the Hospital itself and the Hospital Outpatient Services.

Illegal Immigrants

Interview 1

- The good thing is that emergency care services to date haven't prevented people from accessing the services initially.

Interview 2

- I don't know.

Summary

No strengths were reported for Sex Workers or Travellers. For LTU the community based mental health services and community rehabilitation teams can be beneficial when they are well resourced. In Dublin West there are quite a number of relevant services available for LTU people with mental health problems. For Refugees & Asylum Seekers the ability to get a medical card and the access to services that allows and the Cultural Psychiatric Clinic at the Mater hospital are seen as strengths. For Homeless there seems to be resources available but are they being used in an effective manner?

3. In your opinion, what are the weaknesses of mental health care provided for the target group in this area?

Long-Term Unemployed

Interview 1

- The HSE services rely too much on the medical model, are over dependent on drug treatment and hugely under resourced. Change is happening towards a recovery model but it is slow.
- The community based services (non HSE) are mostly failing to respond to the individual needs of people. People are being pulled into services that simply don't meet their needs because of the need for the services to maintain funding.
- There is a lack of co-ordination between the HSE services and the community rehabilitation services.

Interview 2

- There is no collective. Also, there is a large number of people who don't know about the relevant services.

Sex Workers

Interview 1

- The closed nature of the mental health services (inaccessibility), but this is across the board and not just in relation to prostitution.

Interview 2

- The long waiting lists for services, the limited resources, accessibility, not knowing people in the services and not very good interagency work.

Refugee & Asylum Seekers

Interview 1

- Lack of trained professional interpreters
- Communication - a lack of coordinated holistic care based on holistic assessment and a lack of cohesion among mainstream services in dealing with refugees and asylum seekers.

- A lack of understanding of cultural issues e.g. woman might not want to talk to a male officer at airport which creates unnecessary suspicion amongst services.
- Not enough provision for families - a need for family accommodation.

Interview 2

- General mental health care is weak so it is not just for Refugees. Mental health care is weak in this area. There is not the same level of advocacy. Mental health need is relevant to socio-economic levels of the area and this area is of a low level.

Homeless

Interview 1

- The team that is there doesn't look after the people they are supposed to look after.
- No definition of homelessness that everyone agrees on – a huge weakness.
- If 80% of homeless are in one catchment area then surely it is that catchment area that the team needs to be based from and shaping what the homeless services do.
- Not clear cut in terms of catchment areas and getting people in and out of hospital.

Interview 2

- An Assertive Community Outreach Team is supposed to be 24/7, you have to have a full multi-disciplinary team, you have to have movement in and out. The team in Dublin only has three staff members from Monday to Friday 8–4, this is a big weakness. There is no crises contact point.

Travellers

Interview 1

- Accessibility – in terms of information, in terms of targeting the traveller population, in terms of tailoring services for travellers, in terms of understanding the mental health issues travellers might suffer with. Previouly it has been mostly about giving out medication – just to get people out of surgery as fast as possible.

Interview 2

- Services are not inclusive, they don't actively seek out Travellers. There is a presumption that if Travellers don't go to the services then.....

Illegal Immigrants

Interview 1

- Lack of follow up, recovery plan is limited – it is emergency treatment only.

Interview 2

- No specific services for undocumented workers, no specific services for ethnic minorities, general mental health services are weak

Summary

Weaknesses are mainly specific to each group and are mostly relevant to the situations an individual from a specific group is likely to encounter. For example, for Refugees & Asylum Seekers it is a lack of trained interpreters, cultural issues and accommodation provision.

Some of the comments were relevant at a general service level such as 'general mental health is weak', inaccessibility and the fact that most people don't know much about the general services which are available.

Q4. What are the two things (in terms of changes in practice) that would most improve the quality of mental health care provided for the target group in this area?

Long-Term Unemployed

Interview 1

1. Focus on the **model of intervention** and moving towards a recovery model.
2. Look at **employment and occupational services and supports**. People need to have something to do and the sense of self that it brings.

Interview 2

1. **Self-referral** – even if it was only a preliminary assessment. Lack of option to self refer is a barrier.
2. **Information** – informing people about the services that are available and what they are entitled too e.g. medical card.

Sex Workers

Interview 1

1. For the mental health services and services for sex workers to work together. For sex worker services to have a contact point/route in to the services for their clients.
2. For the services to be more open with knowledge and information in terms of the geography of the mental health services.

Interview 2

1. For the mental health services to be as visible as possible and for the relevant information to be visible for other service providers.
2. More interagency work/collaboration at both a management and worker level.

Refugee & Asylum Seekers

Interview 1

1. More time for initial assessment of asylum seekers on arrival.
2. Early identification of torture survivors and those who have survived severe trauma and referral for appropriate therapeutic intervention.

Interview 2

1. To have more time with clients – this is particularly relevant to refugees and asylum seekers.
2. More information and increasing the awareness of refugees regarding what to expect from the health services.

Homeless

Interview 1

1. A dedicated service for homeless people located within the area or at least responsive to the needs of the people in the area.
2. Defined beds – with responsibility for homeless teams to admit and discharge into these beds. But not having them segregated from rest of population.

Interview 2

1. Having the assertive community treatment model properly resourced etc.
2. Crises beds for homeless people who are not sick enough for inpatient units but who feel they couldn't return to a hostel. A maximum 2-3 weeks stay. Ten to 12 beds in the unit with a continuous move on.

Travellers

Interview 1

1. To raise awareness amongst Travellers of the issues around mental health and the relevant services using appropriate materials, and awareness training around culture for people working in the services.
2. Accessibility – to make services more accessible.

Interview 2

1. Awareness raising for both Travellers and the relevant services.
2. Training for both GP' and for Travellers themselves to be able to deliver information. Training at all levels.

Illegal Immigrants

Interview 1

1. More outreach services and training for health care staff in terms of what it means to be undocumented, how people get into that situation and the implications of what that means to peoples well-being.
2. Clear medical channels with which to regularise individuals who had a mental health issue i.e. to regularise someone's status. The Department of Immigration need to make it clear to hospitals and other organisations regarding its working with the target group.

Interview 2

1. Remove the G.P's reign over referrals to all services. For people to be able to access specific services (e.g. psychologist) directly. We have had cases where people with mental health problems did not want to go to their G.P. Also, people have to pay an additional 60 Euros in GP fees.
2. Over use of medication. The ease of which people are given medication without looking at other ways of getting results.

Summary

The issue which cropped up most often was related to information/knowledge regarding the services (six times), mostly in relation provision for the target groups but also for service providers who may be in contact with the mental health services e.g. Sex Worker outreach services.

The experts concurred across the following groups:

- For Refugees & Asylum Seekers both experts highlighted more time with clients (for initial assessment after arrival & time within the services) as something which would improve care.
- In relation to Homeless people both experts highlighted either crises or defined beds for homeless people with mental health problems as something which would improve care.

- In relation to Travellers both experts highlighted awareness raising for both Travellers and services providers as something which would improve care.
- In relation to Sex Workers both experts mentioned the provision of more knowledge and information for non-statutory service providers regarding the mental health services as something which would improve care.

Section 4: Discussion

In total, eighty services were assessed across both Irish target areas. This was the second highest number assessed across all 14 participating EU countries. The average number of services assessed across all countries was 43. The highest number was 116 and the lowest number was 5 (2 countries). When we remove these two countries from the analyses the average number of services assessed across all countries was 49.5.

There was a large variation in the number of services assessed in both Irish target areas - 54 in Dublin North Central and 18 in Dublin West. This difference is related to the fact that a large number of group specific social care services are located in the Dublin North Inner City area, which is part of Dublin North Central. These services are located here mainly because (1) the North Inner City is part of the city centre and for this reason services are more likely to be located here; (2) there is a large cohort of homeless people and refugees and asylum seekers residing in the North Inner City. It is important to note that many of these group specific social care services are not specifically aimed at the population of Dublin North Central, but rather at the population of Dublin as a whole. Although most of the respondents from these services felt that the majority of their clients reside in the Dublin North Central area, they were unable to give a specific breakdown of the numbers.

Significantly higher levels of active outreach were reported across the Irish target areas (51.3%) compared to the other European countries (30.7%). However, certain issues should be taken into consideration when interpreting this finding. It is difficult to determine whether the term 'active outreach' was defined in the same manner in all participating countries i.e. on a continuum from simply providing a service at a different location once in a while to providing a more structured assertive outreach service. In an Irish context some of the outreach reported was related to the practice of community mental health nurses visiting patients in their homes. Local Employment Services and Traveller services also reported high levels of outreach. Also, a high level of variability in outreach provision was reported across all counties. For example, the United Kingdom target areas had the highest level of outreach provision at 63.6% with Austria the lowest at 6.7%.

Only two of the six group specific mental health services assessed in the Irish target areas provide active outreach (both are homeless mental health services). This low level of

outreach provision amongst the group specific mental health services is also present in the European target areas. One reason for this may be that group specific mental health services are usually small and may not have adequate staff levels to provide outreach services. None of the group specific mental health services in the Irish target areas engage in case finding. Overall, the majority of services providing case finding in the Irish target areas are homeless and LTE social care type services.

Significantly lower levels of exclusion criteria were reported amongst services in the Irish target areas compared to other European countries. Irish services were significantly less likely to view 'aggressive behaviour' and 'criminal history' as reasons for exclusion from their service. It should be noted, however, that there was some confusion amongst respondents in relation to the term 'aggressive behaviour' i.e. does it mean current aggressive behaviour or previous aggressive behaviour as a reason for exclusion.

In comparison with the other European services included in the PROMO study, the service providers in Ireland reported that they were significantly less likely to offer the possibility of self referral. Services assessed in Ireland are significantly more likely to be provided by the state in comparison to European services assessed which are predominately provided by NGO's. There may be a link here. Do the Irish services assessed provide a lower level of self referral in comparison to their European counterparts because they are more likely to be provided by the state? In the Irish target areas the NGO's assessed are significantly more likely to offer the possibility of self-referral compared to the statutory services assessed. In Ireland it is difficult if not impossible to access the statutory mental health services without first going through primary care, predominately a GP, or A/E. This is not generally the case with NGO's where the possibility of self-referral is usually greater.

The Irish services assessed reported lower levels of routine monitoring and evaluation of services. The Irish service providers were significantly less likely to report collecting information on the socio-demographic characteristics of clients, data on input and attendance and outcome data on client satisfaction and experience. Irish services assessed reported that they are significantly less likely to engage in routine meetings at least once a month concerning the care of clients and significantly less likely to provide external supervision for staff.

Regarding staffing, the services assessed in the other European countries have on average significantly higher numbers of Whole Time Equivalent staff in comparison to the services assessed in the Irish target areas. Services assessed in the other European countries estimated contact with a significantly higher number of clients in the previous 12 months than the Irish services. The services assessed in Ireland report a significantly lower number of mental health staff compared to other European services assessed. The Irish services reported on average lower levels of psychiatrists, counsellors and nurses and significantly lower levels of psychologists/psychotherapists. In terms of therapy provision the Irish services reported significantly lower levels of counselling and group psychotherapy provision. They also reported lower levels of social care staff, in particular lower levels of social workers.

In terms of accessing the care provided for the target groups, family and friends are reported as being the most likely to notice problems and initiate contact with the services. They are followed by the police and street outreach services, which are provided for homeless people and sex workers. The most prominent pathway to treatment is initially via a GP and then to the generic mental health services if necessary. There is also the possibility of referral for homeless people and refugees/asylum seekers to group specific mental health services. In essence, the pathways to care are the same as those provided for the general population, with no specific model of access for socially marginalised and vulnerable groups.

A variety of barriers to receiving care and treatment were highlighted. The most prominent categories were continuity of care (e.g. seeing a different psychiatrist at each appointment); accessibility of services; prejudice in the services towards the target groups and the effects of stigma (both related to the effects of being marginalised e.g. being a sex worker, and the stigma surrounding mental health problems). Many of the barriers highlighted were specific to each group.

Respondents reported very little, if any, co-ordination of services in both Dublin areas at either an administrative level or at the level of the individual client. A limited number of service strengths were reported for LTE, homeless and refugees & asylum seekers. No service strengths were reported for sex workers, illegal immigrants or travellers. The weaknesses reported, as with barriers, are mainly specific to each group. It is important to highlight that the differing needs amongst each of the target groups was a reoccurring theme

through the interviews. This relative specificity in relation to each target groups suggests that specific services or training of service staff relative to the needs of the target groups are necessary. When asked what two things (in terms of changes in practice) would most improve the quality of mental health care provided for the target group, the most common response was more information/knowledge regarding the mental health services, mostly in relation to provision for the target groups but also for service providers e.g. sex worker service providers.

In relation to the Quality Index of Service Organisation scores the Irish services assessed scored significantly lower than the services assessed in the other European countries. When we look at each component of the index individually we see that the Irish services scored significantly lower on accessibility, co-ordination, provision of multi-disciplinary teams and evaluation. There are some limitations regarding the Quality Index score which need to be taken into consideration. Firstly, different components account for different proportions of the quality score. In particular, 'Accessibility' accounts for eight (out of 15), programmes provided and evaluation account for two, and the other indicators account for one. The different weights of each domain might mean that some services score higher on the quality score because of being more accessible (e.g., A&E and main hospitals). Another limitation of the quality score regards its lack of empirical evidence to support it. Although the quality score was defined among experts in mental health with a wide range of both clinical and research experience, it was not based on previous research.

In interpreting the findings from this study, it must be borne in mind that the assessment of service provision is based on reports from service staff in the target areas. Validation of responses, in terms of access to actual service data or the views of service users from the target groups, was beyond the remit of this study. Some of the questions in the assessment of services questionnaire were open to interpretation which made it difficult to verify the response. For example, in some cases 'does the service have routine meetings at least once a month' proved difficult for respondents as they were unable to specify exactly if a meeting occurred once a month or at longer intervals. Issues with questions assessing 'is aggressive behaviour or addiction an exclusion criteria' and 'active outreach' have already been discussed.

The results from the PROMO study suggest that, in comparison to the other assessed capital city areas in Europe, there is a high level of fragmentation in the services for socially marginalised groups across both geographic areas assessed in Dublin. The variability across countries in terms of numbers of services assessed is likely due to services in some countries being quite centralised and services in other countries being more fragmentised. However, it may also be an effect of which services each individual country choose to interview and the demographic profile of each target area. For example, as already mentioned one of the reasons for the variability in services assessed across both Irish target areas is that there is a higher number of homeless people, sex workers and refugees and asylum seekers in Dublin North Central. Services will, therefore, most likely choose to locate in that area rather than in another deprived area with lower numbers of these groups e.g. Dublin West. If an area had been selected in an Irish context which did not include the North Inner City then the number of services assessed may have been lower. However, in that case it would have been difficult to get an accurate overview of service provision in Dublin.

The PROMO study has highlighted a number of issues in relation to mental health and social care provision for socially marginalised groups in Ireland. There is a need for specific training of mental health staff in dealing with socially marginalised groups along with the development of more positive attitudes towards socially marginalised groups within the services. A greater level of provision of informational material in relation to the mental health services is needed for marginalised groups and also for those working marginalised groups in other settings. More specific pathways to care for vulnerable groups with higher levels of need should be developed along with more options for self-referral and the provision of active outreach services with a mental health component targeted to specific groups. Greater provision of generic support services is necessary (including translation and culturally competent services) and there is a need to strengthen the level of routine monitoring and evaluation of the overall quality of service provision. Finally, greater coordination of services should be developed.

Appendix A: Service Assessment Questionnaire

1. About your service/institution

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

2. Provider and funding information

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

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

2.3 What was the total annual budget of your service/institution in the last budget year? **Please state approximate amount in local currency**

2.4 What was the system of funding for your service/institution in the last budget year? **Please state percentages - they should add up to approximately 100%**		
2.4.01	Lump sum for the budget	%
2.4.02	Payment related to number of clients served	%
2.4.03	Payment related to specific activities with clients	%
2.4.04	Other, please specify	%

3. Staffing

3.1 Staffing levels **Please state numbers as Whole Time Equivalents (WTE)**

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

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

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

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

Type of supervision		**Yes**	**No**
3.3.01	Internal supervision		
3.3.02	External supervision		

4. Accessibility

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

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

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

☐ Yes ☐ No

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

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

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

Please tick.

☐ Yes ☐ No

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

Please state time in minutes

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

Please tick one option.

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

☐ They can do so if needed

5. Clients

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

Please state number and/or tick option that applies

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

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

Inclusion criteria:		**Yes**	**No**	If Yes, please specify			**Yes**	**No**	If Yes, please specify
5.2.01	Age				5.2.05	Gender			

5.2.02	Location (*i.e.* catchment area)				5.2.06	Diagnosis			
5.2.03	Specific social problem				5.2.07	Ethnic group			
5.2.04	Manifest mental health problem (which type ands degree?)				5.2.08	Other, please specify			

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

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

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

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

6. Services provided to target groups

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

Please state number and/or tick option that applies.

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

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

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

Type of service		**Yes**	**No**	**Clients helped to access these programmes elsewhere**	**Type of service**		**Yes**	**No**	**Clients helped to access these programmes elsewhere**
6.2.01	Active outreach				6.2.12	Alcohol addiction treatment			
6.2.02	Case finding				6.2.13	Direct practical help in clients' homes			
6.2.03	Home visits				6.2.14	Befriending			
6.2.04	Counselling				6.2.15	Leisure activities support			
6.2.05	Psychotherapy Individual				6.2.16	Mental health advocacy			
6.2.06	Psychotherapy Group				6.2.17	Social welfare support			

6.2.07	Self – help support				6.2.18	Housing /accommodation advice and support			
6.2.08	Occupational (work) therapy				6.2.19	Legal advice and support			
6.2.09	Medication				6.2.20	Job coaching / finding			
6.2.10	Detoxification and acute withdrawal treatments				6.2.21	Mental health promotion measures			
6.2.11	Drug addiction treatment				6.2.22	Other, please specify			

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

Please tick.

☐ Yes ☐ No

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

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

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

☐ Yes ☐ No

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

	Yes	No	If YES, please specify what the programme is

6.4a.01	Long-term unemployed			
6.4a.02	Sex workers/Prostitutes			
6.4a.03	Homeless			
6.4a.04	Refugees/Asylum seekers			
6.4a.05	Illegal immigrants			
6.4a.06	Travelling population			

7. Coordination with other services/institutions

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

☐ Yes ☐ No

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

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

		Yes	No	If YES, please specify the names and the types of the services/institutions the meetings are held with
7.1a.01	Long-term unemployed			

7.1a.02	Sex workers/Prostitutes			
7.1a.03	Homeless			
7.1a.04	Refugees/Asylum seekers			
7.1a.05	Illegal immigrants			
7.1a.06	Travelling population			

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

☐ Yes ☐ No ☐ Not known

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

☐ Yes ☐ No ☐ Not known

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

	Yes	No	Not known	If YES, please specify the names and the types of services/institutions which were the main sources (FROM) and main destinations (TO) of referrals for clients from the specific target group. Please indicate the number of referrals for each.

7.2a.01	Long-term unemployed				**FROM:**
7.4a.01					**TO:**
7.2a.02	Sex workers/ Prostitutes				**FROM:**
7.4a.02					**TO:**
7.2a.03	Homeless				**FROM:**
7.4a.03					**TO:**
7.2a.04	Refugees/Asylum seekers				**FROM:**
7.4a.04					**TO:**
7.2a.05	Illegal immigrants				**FROM:**
7.4a.05					**TO:**
7.2a.06	Travelling population				**FROM:**
7.4a.06					**TO:**

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

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

7.3 Does your service/institution accept self-referrals?
Please tick.

☐ Yes ☐ No

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

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

8. Evaluation

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

	Types of data	Yes	No	If YES, please specify the type of data collected

8.1.01	Socio-demographic characteristics			
8.1.02	Data on input and attendance			
8.1.03	Outcome data on satisfaction and experience			
8.1.04	Other outcome data			

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

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

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

☐ Yes ☐ No

9. Further general comments

Appendix B: Semi Structured Interview (homeless version)

Vignette 1

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

1. Who would be likely to notice his problems and initiate help?

2. Which services/organisations would, once informed, go out and contact him?

3. What care would they provide, or how would they refer the person on?

4. What are the further care pathways and/or treatment options for him?

5. What are the barriers for him to receive that care and/or treatment?

6. Are there any ways to overcome these barriers?

    a) Are there any ways for the *client* to overcome these barriers?

    b) Are there any ways for the *service* to overcome these barriers?

Vignette 2

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

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

2. Which services/organisations could she approach?

3. What are the further care pathways and/or treatment options for this person?

4. What are the barriers for her to receive that care and/or treatment?

5. Are there any ways to overcome these barriers?

   a) Are there any ways for the *client* to overcome these barriers?

   b) Are there any ways for the *service* to overcome these barriers?

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

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

1. How is mental health care for homeless people co-ordinated in the area?

a) How is it co-ordinated at administrative level?

b) How is it co-ordinated at the level of individual patients?

2. In your opinion, what are the strengths of mental health care provided for homeless people in this area?

3. In your opinion, what are the weaknesses of mental health care provided for homeless people in this area?

4. What are the two things (in terms of changes in practice) that would most improve the quality of mental health care provided for homeless people in this area?

Appendix C(i): Policies and legislation with relevance to Homeless people

Legislation

Housing Act, 1988 sets out the legal definition of homeless persons to include those for whom no accommodation exists, which they could be reasonably expected to use, or those who could not be expected to remain in existing accommodation and are incapable of providing suitable accommodation for themselves.

Strategies and Policies

Homelessness: An integrated strategy (2006b)
A Key to the Door: A Homeless Agency Partnership Action Plan on Homelessness in Dublin 2007-2010

Vision of Change (2006): Report of the Expert Group on Mental Health Policy

15.2 Mental health services for homeless people

The most recent official government figures state that there are over 5,000 people currently experiencing homelessness in Ireland, out of an estimated total population of 4.34 million.

15.2.2 The mental health needs of Homeless People

Recommendations

15.2.1: A data base should be established to refine the dimension and characteristics of homelessness and analyse how services are currently dealing with it.

15.2.2: In the light of this information, scientifically acquired and analysed, make recommendations as to requirements and implement them.

15.2.3: *The Action Plan on Homelessness* (The Homeless Agency) should be fully implemented and the statutory responsibility of housing authorities in this area should be reinforced.

15.2.4: A range of suitable, affordable housing options should be available to prevent the mentally ill becoming homeless.

15.2.5 Delivering mental health services to homeless people

Recommendations
15.2.5: The CMHT team with responsibility and accountability for the homeless population in each catchment area should be clearly identified. Ideally this CMHT should be equipped to offer assertive outreach. Two multidisciplinary, community-based teams should be provided, one in North Dublin and one in South Dublin, to provide a mental health service to the homeless population.

15.2.6: Community mental health teams should adopt practices to help prevent service users becoming homeless, such as guidelines for the discharge of people from psychiatric in-patient care and an assessment of housing need/living circumstances for all people referred to mental health services. This should be primarily an outreach service provided on an extended hours basis (08.00 to 23.00 daily). Governance should be in accordance with the leadership model described for multidisciplinary teams (see Chapter Nine); each team should have a clearly identified clinical leader, team coordinator and practice manager.

15.2.7: Integration and coordination between statutory and voluntary housing bodies and mental health services at catchment area level should be encouraged.

4.7 Housing

Recommendation 4.7: The provision of social housing is the responsibility of the Local Authority. Mental health services should work in liaison with Local Authorities to ensure housing is provided for people with mental health problems who require it.

12.10 Accommodation needs of people with severe mental illness

Recommendations
12.4: Opportunities for independent housing should be provided by appropriate authorities with flexible tenancy agreements being drawn up in accordance with each service user's needs. Arrangements that best enable service users to move from high support to low support and independent accommodation need to be considered.

12.5: Rehabilitation and recovery mental health services should develop local connections through linking with local statutory and voluntary service providers and support networks for people with a mental illness is required to support community integration.

12.6: All current staff within the mental health system who are appointed to rehabilitation and recovery services should receive training in recovery-oriented competencies and principles.

National Economic and Social Forum: Mental Health and Social Inclusion (2007)

Homelessness

8.39 *A Key to the Door, the Homeless Agency Partnership's Action Plan 2007-2019,* argues that "it is imperative that society's most vulnerable groups, such as people experiencing homelessness, are well and truly accounted for in any future service developments, including those related to community based services in mental health care and drug and alcohol addictions" (The Homeless Agency, 2007:16).

8.41 However, according to *A Key in the Door* (The Homeless Agency, 2007),the situation will improve as the recommendations from *A Vision for Change*, relating to the homeless population are implemented. *A Key in the Door*(p.51) also states that "the Health Service Executive will implement its plans to provide respite beds for people who are homeless to prevent inappropriate use of Accident and Emergency services as well as to support people to recuperate following acute hospital stay."

However, other areas of concern remain such as the suitability of emergency accommodation for those with mental ill-health and the lack of move-on accommodation with appropriate supports. The forthcoming *Health Impact Assessment of the Homelessness Strategy* is welcomed by the Project Team (NESF).

8.51 The Department of the Environment, Heritage and Local Government's *(2006) Homeless Strategy* wants all psychiatric hospitals to develop a formal and written discharge policy, communicated to all staff involved in the discharge of patients. The *Strategy* also calls for psychiatric teams to have a nominated professional to act as Discharge Officer and ensure that discharge policy is followed. However, this is not currently happening. As Focus Ireland reported, service users arrive on a regular basis to them, with Focus Ireland written on their discharge papers, rather than an appropriate accommodation.

Nation
5.6.4. Housing and Accommodation.
A national housing strategy for people with disabilities will be developed by end 2009, as recommended in the National Economic and Social Council *Housing in Ireland* report. This will have particular regard to adults with significant disabilities and people who experience mental illness. It will be progressed through the establishment of a national group, under the aegis of the Housing Forum.

Chapter 6 relates to Communities:
Goal 10: Housing
Deliver high quality housing for those who cannot afford to meet their own housing needs and to underpin the building of sustainable communities. The planned enhanced housing output (2007 to 2009) will embrace meeting special housing needs (the homeless, Travellers, older people and people with disabilities).

National Action Plan for Social Inclusion (2007-2016)

5.6.4. Housing and Accommodation.
A national housing strategy for people with disabilities will be developed by end 2009, as recommended in the National Economic and Social Council *Housing in Ireland* report. This will have particular regard to adults with significant disabilities and people who experience mental illness. It will be progressed through the establishment of a national group, under the aegis of the Housing Forum.

Chapter 6 relates to Communities:
Goal 10: Housing
Deliver high quality housing for those who cannot afford to meet their own housing needs and to underpin the building of sustainable communities. The planned enhanced housing output (2007 to 2009) will embrace meeting special housing needs (the homeless, Travellers, older people and people with disabilities).

Appendix C(ii): Policies for mental health care with relevance to marginalised groups in general

Vision of Change (2006): Report of the Expert Group on Mental Health Policy

Chapter 4 Belonging and participating: Social Inclusion

Chapter 4 deals with social inclusion of marginalised people and makes the following recommendations:

4.8.1 Responding to the mental health needs of minority groups includes people from other countries and cultures and also travellers.

4.8: Mental health services should be provided in a culturally sensitive manner. Training should be made available for professionals, and resources provided for services to other ethnic groups, including provision for interpreters.

4.5.1 Actions to tackle poverty
Long-term unemployment is specifically referred to in relation to urban disadvantage.

4.5: Mental health services should take account of local deprivation patterns in planning and delivering mental health care.

4.1: Access to employment, housing and education for individuals with mental health problems should be on the same basis as every other citizen.

4.6: Evidence-based approaches to training and employment for people with mental health problems should be adopted.

4.10: The National Mental Health Service Directorate should be specifically represented in the institutional arrangements which implement the National Action Plan against Poverty and Social Exclusion, with specific targets to monitor action in achieving greater social inclusion for those with mental health problems.

Fostering well-being: Mental Health Promotion

In Chapter 5 the following points and key recommendations are made:

5.6 Priority issues in mental health promotion: A *Vision for Change* adopts a lifespan approach across various settings, which facilitates the inter-sectoral, multidisciplinary and inter-agency requirements for successful mental health promotion. While this model takes a 'cradle to the grave' approach, it is also intended to address the mental health needs of specific populations. The needs of groups such as travellers, the refugee and asylum-seeking population, and other immigrant populations will be addressed by the provision of comprehensive mental health services that are based

on care planning taking all the needs of the individual into account. Appropriate programmes need to be developed to promote greater integration of these distinct groups at every stage in the lifespan.

National Economic and Social Forum: Mental Health and Social Inclusion (2007)

10.4 Mental ill-health is included under the grounds of disability and is, therefore, protected under our equality legislation.

> 10.6 (c) The report supports the full and timely implementation of the recommendations in *A Vision for Change* and seeks to complement and deepen the focus on social inclusion through the recommendations set out in this report. In addition, the report recommends that " bodies with responsibility for vulnerable groups should prioritise policy and action to address their numerous and complex health needs".

10.6 (d) Given the significant links between poverty and mental ill-health, responsibility at national level for promoting vocational and social (non-health) outcomes, as detailed in this report and in *A Vision for Change*, should be vested at strategic level with the Senior Officials Group under the *National Action Plan for Social Inclusion (NAPinclusion.* for active cross-departmental involvement and participation. Particular attention should be given to strengthening the working relationship and services provision at local operationa **Integrated Services**
10.12 Provision of integrated services can be more effective and is key to tackling social exclusion and mental ill-health. At present, there is no coordinated strategy at the individual, social and structural level to link together employment, housing and mental health services. Vocational services need to be more closely integrated with mental health services. To this end, key Departments and agencies should take greater responsibility for the non-health aspects of mental health prevention.

10.12 (b) Person-centered and integrated services with appropriate interdisciplinary input, including counseling; social work; nursing; vocational expertise; and occupational therapy should be provided at primary care level, with the development of 'one-stop-points of contact' and simpler forms and less bureaucracy.

Integrated Supports
8.15 Greater co-ordination and designated vocational, housing and welfare advisors and advocacy services within and between existing and future Community Mental Health Teams and Primary Care Teams, are called for. To ensure a continuum of care from early intervention to recovery, the links to non-health sectors should be included at every point. The Mental Health Commission (2006a) presents a useful model for multi-disciplinary team working which places the service user at the centre and works outwards to the community level.

10.12 (c) These services should be underpinned with case management approaches, action plans, mapping, targeting of disadvantaged groups, along the lines advocated in the recent NESF report on *Improving the Delivery of Quality Public Services* (NESF Report No. 34, *2007a*).

10.13 (c) Further development of community support services such as volunteering, befriending, mentoring programmes and peer groups should be supported and encouraged in local communities in tandem with the community and voluntary sector and official bodies. These support services should also include targeted initiatives for vulnerable groups in the community.

National Action Plan for Social Inclusion (2007-2016)

3.5 Services.

3.5.1. Employment and Employability
To provide targeted training and supports to groups outside the labour market such as the unemployed, people with disabilities and Travellers. Special projects will be provided to support personal development, intensive training, counselling and other supports for those who are most marginalised.

3.5.4. Health
Working to improve the health status of all, and particularly vulnerable groups such as people with disabilities, including those with mental illness, drug users, the homeless and Travellers, is an essential element of social inclusion. Achieving positive outcomes will contribute to their greater participation in education, training and employment, thus helping to break the cycle of disadvantage and poor health over the long-term.

Chapter 5 has recommendations pertaining to People with Disabilities:
Goal 9: Employment and Participation
Increase the employment of people with disabilities who do not have a difficulty in retaining a job. The immediate objective is to have an additional 7,000 of that cohort in employment by 2010. The longer term target is to raise the employment rate of people with disabilities from 37% to 45% by 2016, as measured by the Quarterly National Household Survey. The overall participation rate in education, training and employment will be increased to 50% by 2016. These targets will be reviewed in the light of experience and the availability of better data.

5.6.4. Housing and Accommodation.
A national housing strategy for people with disabilities will be developed by end 2009, as recommended in the National Economic and Social Council *Housing in Ireland* report. This will have particular regard to adults with significant disabilities and people who experience mental illness. It will be progressed through the establishment of a national group, under the aegis of the Housing Forum .

Chapter 6 relates to Communities:
Goal 10: Housing
Deliver high quality housing for those who cannot afford to meet their own housing needs and to underpin the building of sustainable communities. The planned enhanced housing output (2007 to 2009) will embrace meeting special housing needs (the homeless, Travellers, older people and people with disabilities).

6.5.5 Community Development

> A revised CDP will be prepared to cover the period 2007-2013 to support local people in improving their own communities. Local Resource Centres and Community Development Projects will support a wide range of self-help activities designed to improve quality of life for individuals and groups in disadvantaged communities. Projects are managed by local voluntary boards from the target groups - people with disabilities, lone parent families, young people, the elderly, Travellers and other disadvantaged groups.

6.5.7 Community Services Programme

The objective of the Programme is to support local community activity to address disadvantage, while providing employment opportunities for people from the following priority target groups: people with disabilities; the long-term unemployed, Travellers, lone parents and stabilised drug addicts. Currently 274 projects are funded which provide services to their local communities with an additional 125 projects approved for funding from 2007.

Appendix D: Quality Index of Service Organisation – Indicators

1. Accessibility

Key Indicator	Value	Definition
1.Days open	0	Open less than 5 days/week
	1	Open every day Mon-Fri
2.Opening hours		
a. Open outside normal office hours	0	Open within normal office hours only (Mon-Fri)
	1	Open anytime outside the normal office hours (Mon-Fri)
b. Open at weekend	0	Not open at weekend (anytime)
	1	Open at weekend (anytime)
3. Exclusion criteria		
a. Lack of motivation	0	Yes to 'lack of motivation'
	1	No to 'lack of motivation'
b. Command of language	0	Yes to "command of language of the host country"
	1	No to "command of language of the host country"
c. Addictions	1	No to "addictions"
	0	Yes to "addictions"
5. Self-referrals	0	No to self-referrals
	2	Yes to self – referrals
TOTAL		**Out of 8**

2. Staff supervision

Key Indicator	Value	Definition
Any supervision internal/external	0	No to any supervision (internal/external)
	1	Yes to any supervision (internal/external)
TOTAL		**Out of 1**

3. Multidisciplinary team

Key Indicator	Value	Definition
Presence of multidisciplinary team	0	No to any combination of mental health and social care professionals (one or the other only)
	1	Yes to any combination of mental health and social care professionals (at least on mental

		health and one social care professional)
TOTAL		**Out of 1**

4. Programmes provided

Key Indicator	Value	Definition
1. Active outreach/home visits	0	No to active outreach and home visits
	1	Yes to active outreach or home visits
2. Case finding	0	No to case finding
	1	Yes to case finding
TOTAL		**Out of 2**

5. Coordination

Key Indicator	Value	Definition
Routine meetings with other services	0	No to routine meetings
	1	Yes to routine meetings
TOTAL		**Out of 1**

6. Evaluation

Quality indicators for individual services			
Key Indicator	**Value**	**Definition**	Question #
1. Recording data on input and attendance	0	No to recording data on input and attendance	8.1.02
	1	Yes to recording data on input and attendance	
2. Recording outcome data on satisfaction and experience	0	No to recording outcome data on satisfaction and experience	8.103
	1	Yes to recording outcome data on satisfaction and experience	

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