NORTHERN AREA HEALTH BOARD

Report No: 6/2004

Services to Ensure Social Inclusion

Introduction

It is recognised that the needs of persons with social inclusion issues are best addressed through a co-ordinated approach, involving Statutory, Voluntary and Community Groups.

Various initiatives in addressing social inclusion and community development, have been developed by Central Government in recent years, including the Area Partnerships, ISP's (Integrated Services Projects), Drugs Task Force, RAPID, City and County Development Boards, which involve Government Departments, Local Authorities, Health Boards, other Statutory Service Providers, Voluntary Service Providers and Organisations and Community Groups in identifying needs in particular areas and developing agreed strategies to meet these specific needs.

Our Board has been involved in each of these initiatives with the lead Agency and have had a significant input into the engagement with all stakeholders in the identification of health needs, the setting of priorities and the development of action plans.

We have experienced considerable social change, in our Board, in particular in the last 5 years. The population in our area has grown, due in no small part to the number of Asylum Seekers / Refugees who now reside in our area.

In addition, there has been major residential developments in our Board's area – particularly in the Dublin 15 and the MI corridor. A considerable percentage of the new housing development was purchased by investors and now accommodates persons in private rented sector – many of whom qualify for rent supplement, payable under the Supplementary Welfare Allowance Scheme, administered by our Board on behalf of the Department of Social and Family Affairs. Expenditure in rent supplement in our Boards area in 2003 amounted to €78m. Of this figure, €18.3m was in respect of clients in Dublin 15, a figure comparable to the total expended on this scheme in the East Coast Area Health Board or Midland Health Board.

It should also be noted that of the 23 RAPID areas identified nationally, 5 of the areas are in our Board's geographical area. RAPID areas are defined as having a high social deprivation index and the RAPID programme aim is to respond to needs in either these areas in a co-ordinated and holistic manner.

Central to addressing these issues is the engagement with other stakeholders, i.e. Statutory and Voluntary Agencies and most importantly with communities. There is on-going contact between staff at all levels within our Board and staff in all other agencies with a view to arriving at agreed approaches to dealing with local issues.

It is imperative that this inter agency approach continues to be taken in order to meet the needs of the socially excluded or marginalised within our society and within our Board.

A significant financial investment has been made by our Board over recent years to deal specifically with persons with social inclusion issues and approximately €14.3m will be spent on providing targeted services in 2004and details of this are contained in Appendix 1. In addition to this investment it should be noted that this cohort of the population because of their multifaceted care needs are significant users of the general health services and utilise a percentage of health services disproportionate to their numbers e.g. acute hospital services, community care services including GP's, maternity, paediatric, addiction, mental health and ambulance services etc.

Overview

Social Inclusion is defined as the integration of all marginalized groups into society by specific and targeted actions that alleviate social inclusion, poverty and deprivation among these groups.

Our Board is committed to providing mainstream and specifically designed health and social services to address the needs of these groups and recognises this is a priority issue.

Marginalized Groups include:

- Adult Homeless
- Ethnic Minorities including Asylum Seekers/Refugees
- Travellers

It is accepted that there are significant cohorts of people in our Board's area who suffer from social deprivation. Our Board's target is to continue to develop services, which are culturally sensitive to meet their needs.

In late 2003 and early 2004 our Board appointed three Managers for Services for Social Inclusion for Community Care Area 6,7 and 8.

Our Board had recognised the need to develop the integration of services for people with social inclusion issues for some time. The appointment of these staff will enhance and proactively target services towards these groups.

Since taking up duty the Social Inclusion Managers have proactively pursued the strengthening of links with all service providers, forming social inclusion committees at area level and dealing with key issues regarding the development and improvement of services for persons with social inclusion needs.

In addition the Manager for Services for Social Inclusion in Community Care Area 6 had prior to her recent appointment, significant experience in the area of homeless services in the greater London area and has prepared a detailed report (Appendix 2) outlining the history of development of services in London in which can be seen clear parallels regarding both the challenges facing our Board's service providers and addressing social inclusion initiatives using this model and others to inform our approach.

1. Adult Homelessness

1.1. Current context for planning of services for Homeless Persons

The Health issues arising from homelessness is recognised as a priority issue in the our Board's area.

A significant percentage of the population suffer from social deprivation and this when associated with physical, mental health and addiction issues leads in some cases to individuals and or families spiralling into homelessness.

The health needs of homeless persons present a major challenge to health service deliverers and it is accepted that only a multi sectoral approach and coordinated response will deliver appropriate services to homeless persons. In this regard it is accepted that it is the Local Authorities role to identify and respond to the needs of homeless persons around housing needs, it is our Board's responsibility to work in an integrated way with the Local Authorities, Voluntary Agencies and the Homeless Agency to deliver a coordinated and flexible response to the health and social needs of these clients.

It is important to recognise that very few people, if any, wish or choose to be homeless. Homelessness is a by product of more prevalent and pertinent issues mainly relating to social care and welfare factors which incessantly drive people into homelessness.

It is only by addressing the underlying causes whether they be alcohol, drugs, physical or mental well being that we will reduce homelessness.

The Health Strategy – Quality & Fairness – A Health System for You published in 2001 set out a number of key points to address the health needs of homeless persons, which in turn endorsed a previous government report – Homelessness – An Integrated Strategy (2000).

Key Elements were:

Action: Local Authorities and Health Boards in partnership with the Voluntary Bodies will draw up action plans on a county by county basis to provide a more coherent and integrated delivery of services to homeless persons by all Agencies dealing with Homelessness.

Response: Shaping the Future – An Action Plan on Homelessness in Dublin 2001 – 2003 was completed under the umbrella of the Homeless Agency as a coordinated response to homelessness by voluntary and statutory partners.

Action: Homeless Fora comprising representatives of the Local Authority, Health Board and Voluntary sector will be established in each county.

Response: The Board of the Homeless Agency which comprises representatives from the Health Boards, Local Authorities, other statutory agencies and voluntary agencies oversee the development of services for homeless persons. In addition a Consultative Forum with an independent chairperson and representative of statutory/voluntary organisations advises the Board of the Agency on policy and developmental issues.

Action: Local Authorities will be responsible for the provision of accommodation, including emergency hostel accommodation for homeless persons and Health Board will be responsible for the provision of their in house care and health needs.

Response: The Local Authorities are responsible for the housing needs of homeless persons while the Homeless Persons Unit under the direction of our Board's Community Welfare Officers manage the emergency placement service on behalf of the Local Authorities. The provision and funding of care and health services in hostels and the wider homeless services is carried out by our Board.

Action: Preventative strategies targeting at risk groups are an essential requirement for those leaving custodial or health related care. Procedures will be developed and implemented to prevent homelessness among those groups.

Response: Proactive discharge policies have been piloted with the Mater Hospital while our Board's Community Welfare Officers provide an inreach advice/placement service to prisons to plan the discharge pathways for prisoners returning to society. Our Board is also planning the further development of a dedicated Consultant led Psychiatrist team, for homeless persons.

The Health Strategy together with "Shaping the Future – An Action Plan on Homelessness in Dublin 2001 – 2003 form the cornerstone of our Board's strategy to develop a range of responsive services to meet the needs of homeless persons.

1.2. Needs Assessment

In identifying the trends in persons who present as being homeless and requiring accommodation a key element is the work of the Homeless Persons Unit which is operated by Health Board Community Welfare Officers.

During 2003 a total of 2998 new cases availed of this service representing 3707 individuals. The breakdown of this caseload and a comparison with 2002 is as follows: -

Cases and People

Year	*Total Cases*	*Adults*	*Children*	*People*
2002	3049	3319	839	4159
2003	2988	3151	556	3707
	98.00%	**94.94%**	**66.27%**	**89.15%**

Case Size

Year	*Cases*	*Single*	*Couple*	*One Parent Families*	*Couple and Children*
2002	3049	2441	124	334	150
2003	2988	2593	86	232	77
	98.00%	**106.23%**	**69.35%**	**69.46%**	**51.33%**

Examination of the data together with implementation of the Action Plan on Homelessness in Dublin 2001 – 2003 and the imminent publication of a new action plan has allowed our Board together with its partners in the Local Authorities and Voluntary Sectors adapt and change hostel and B&B services to allow for a more coherent and planned response to the needs of homeless persons.

In addition our Board is actively involved in co-operation with the Health Information Unit of the ERHA in preparing a social deprivation mapping exercise for Dublin City (North) and Fingal areas, which will inform our Board of the needs of homeless persons.

A more detailed breakdown of the work carried out by the Homeless Persons Unit is contained in Appendix 3.

1.3 Current Service Provision

1.3.1. Interagency Placement Service

It is accepted that a Multi-Agency approach locally and nationally is necessary if the root causes of homelessness are to be addressed and a reduction and ultimately abolition of persons progressing into homelessness is achieved.

While addressing the medium/long term target of reducing/abolishing homelessness an ongoing multidisciplinary approach to meeting the current needs of homeless persons is required.

This is achieved by developing vibrant partnerships between our Board, the Homeless Agency, the Local Authorities, the voluntary sector, the Gardai, the Probation and Welfare Service. Our local managers ensure that our Board's directly managed services and those in the voluntary sector are targeted and co-ordinated as appropriate to meet the needs of homeless persons.

In this regard the Homeless Persons Unit coordinates the assessment and emergency placement service for all homeless persons on behalf of three Area Health Boards. The clinic services available in three locations provide a comprehensive payments, advice, referral and placement service for homeless persons.

Residential places are available in a range of hostels and B&B's mainly in the city centre.

In addition to the placement service the Homeless Persons Unit provides a free phone service for homeless persons seeking placement and advice during and after normal clinic hours.

Dublin City Council and voluntary organisations in our Board's area provide emergency, transitional and extended hostel accommodation. Our Board meets the care costs of the hostels with other costs being met via the Local Authorities. Included among these organisations are: Dublin City Council, Simon Community, Focus Ireland, Sonas Housing Association, Respond Ireland, De-Paul Vincentians, Capuchins, Legion of Mary in particular. In addition our Board directly manages Haven House, Morning Avenue, a hostel for women and families.

Further details of the hostels in our Board's area and type of accommodation is contained in Appendix 4.

1.3.2 Multidisciplinary Outreach Team

It has been long recognised that a key element of improving the health status of those people either homeless or in danger of drifting into homelessness is the provision of a responsive health and welfare system.

Central to this policy is the provision of a multidisciplinary outreach team for homeless persons, which is based at Westward House, Dublin 1.

The main aim of this team, which comprises 7.5 W.T.E. staff, is to provide interim support and thereafter link to people into mainstream health services wherever possible and in so doing to ensure that clients have easy access to GP's, medical cards and other community and welfare services.

Other services provided include nursing, counselling, support and managed pathways towards a range of appropriate health responses.

The multidisciplinary team also links closely with the acute general and psychiatric hospitals around issues of admission and appropriate planned discharge.

Key to facilitating this process has been the provision of dedicated staff in each Community Care Area to fastrack medical card applications for homeless persons.

1.3.3 Community Welfare Service

The Community Welfare Service in addition to managing the Homeless Persons Unit provides the mainstream payments system to homeless persons. Central to this has been the provision of a patch outreach payments service to homeless persons in clusters of hostels/B&B's, which has allowed homeless persons to have relative financial continuity.

The C.W.O service has also forged links with the Probation and Welfare Service by providing inreach visiting services to Mountjoy and Arbour Hill Prisons.

This service allows prisoners whose discharge is imminent to make arrangements for their accommodation needs and to plan for appropriate links to Health Service provision. It is hoped to extend this service to other prisons subject to staff availability.

A joint report by the Probation and Welfare Service and Homeless Persons Unit on the inreach service was prepared and published in January 2004. Feedback from prisoners indicated high satisfaction with the service provided; this was mirrored by feedback from the statutory agencies. It is evident that the positive relationship developed between both services has led to more effective liaison and communication. Both services are committed to ongoing development of this scheme and to sustaining the partnership approach.

1.3.4 Care Support to Hostels

While every effort has been made to link homeless persons in hostels and B&B's to mainstream services, dedicated primary care medical centres have been established at a number of hostels including Cedar House and the Capuchin Day Centre, Church Street. In addition a pilot nursing service has been put in place with the De Paul group of hostels to ascertain if a dedicated nursing service can improve and sustain the health status of hostel dwellers, many of whom live into relative old age with significant health care needs.

1.3.5 Acute General Hospitals

As with other health services it is accepted that homeless persons have an equitable right to access both Accident and Emergency Departments and a range of Outpatient Departments and Inpatient facilities in the various acute general hospitals.

To achieve an effective outcome from acute treatment episodes it is accepted that there is a requirement for ongoing liaison between key personnel in the acute hospital settings e.g. Bed Manager, Discharge Co-ordinator and Social Worker Departments and key Health Board personnel e.g. Multidisciplinary Team, Social Inclusion Managers and Community Welfare Officers to ensure that homeless persons have access to these services and that a planned discharge care plan is effected.

To copper fasten this a multiagency project involving ERHA, Area Boards and the Mater Hospital has agreed protocols to ensure the planned discharge of homeless clients to appropriate care setting. These protocols will be rolled out to Beaumont, JCMH and the hospitals in the other two Board areas.

1.3.6 Psychiatric Services for Homeless Persons

People rarely drift into homelessness by desire or choice but more often because of a significant life event. The small number of homeless persons with an overriding psychiatric illness must have, as outlined in previous services, equity of access to mainstream acute care, rehabilitation and community supports in keeping with the general population.

With the majority of (homeless) hostels and B&B's located close to the city centre there has been an associated increased demand for psychiatric services particularly in the North Strand and Mater sectors. To meet this demand our Board provided additional medical and nursing personnel to these services to meet presenting needs.

In recent years the consultant led homeless multidisciplinary team was further strengthened. The transfer of day services from St. Brendan's to Ushers Island has proven very successful – there is however an overriding need to develop a day service for homeless female clients with mental health problems.

Central to our Boards plans to meet the future needs of this client group will be provision of a second Consultant led multidisciplinary team. The team will work proactively across boundaries and more particularly with the community psychiatric teams to ensure that services are flexible and responsive so that the mental health needs of all homeless persons are met and that a programme is in place to ensure that individual clients have access to acute inpatient rehabilitation and mainstream programmes

The multidisciplinary team will provide assessment and support services to persons in a homeless setting and also to key voluntary organisations who manage the mainstream hostel service.

They will form bridges to services across traditional Health Board boundaries and provide joint care packages where appropriate.

The SWAHB has put in place a consultant led multidisciplinary team in late 2003.

Our Board has also in partnership with the Mater Hospital and St. Vincent's Hospital, Fairview engaged in a review of the impact of homeless persons and ethical minorities on mental health services in the North Inner City. The review, which will be published shortly, will inform our Board's planning and development of services for homeless persons.

1.4 Integration Management of the Service

1.4.1 Current Position

Our Board has appointed a Director for Social Inclusion and three Managers of Services for Social Inclusion. The Director has a developmental and a planning role in relation to social inclusion including services for the homeless.

The Managers of Services for Social Inclusion are based in each of the three Community Care Areas of our Board and their task is to manage the totality of services for homeless people in each Community Care Area, including the development of prevention strategies and to actively pursue the integration of the homeless into the wider care services. The Managers are responsible for the implementation of policies, procedures and processes in relation to the Social Inclusion measures of the National Development Plan at Area level. Key links are being established with Local Authorities and voluntary providers to address the issues that cause homelessness in the first instance, and to reintegrate the homeless back into their local community, where possible.

It is acknowledged that in order to provide an integrated service our Board must link with a number of partners in its role as deliverer of health and personal social services to homeless people. Our Board works in partnership with Local Authorities, Voluntary Housing Agencies, other Area Health Boards, the Homeless Agency, other statutory and voluntary agencies, and across care groups within our Board so as to deliver seamless and accessible services to homeless persons.

1.5 Way Forward – Targets

As referred to earlier the integration of services for homeless persons across the statutory and voluntary sector is central to our efforts in improving the health and social status of homeless persons.

- A new Action Plan on homelessness being drafted by the Homeless Agency in partnership with the statutory and voluntary sector is targeted for presentation in 2004.

A key component of this plan is the vision of Health Professionals working across all care groups and services and with the Local Authorities to provide advice, counselling, short term placement and support the Local Authority in providing long term housing solutions so as to prevent vulnerable persons / families slipping in to homelessness in the City Centre.

This is being done in a variety of ways e.g.

- High level strategic contacts at Assistant Chief Executive and equivalent level with the Local Authorities.
- Senior Management level within Health Board Areas across various services.
- At Community Care level by Senior Area Managers and Local Authority Managers.

The target is to significantly reduce the numbers falling through the net (local) and presenting centrally at the Homeless Persons Unit.

Discussions will take place with the relevant Local Authorities and partners to explore the possibility of piloting local area based responses to homelessness by providing a small number of emergency / transitional units as well as providing information / counselling services to prevent people gravitating to the city centre.

- The Managers for Social Inclusion are developing Area based Social Inclusion Committees which will inform our Boards policy in relation to the planning of services. Key to this will be the forging of concrete linkages with the Multidisciplinary Team, the Acute General Hospitals and Acute Psychiatric Services in our Board's area.

To assist the process, a mapping exercise to detail the incidence and degree of Social Inclusion in Dublin City (Northside) and Fingal will be commenced in 2004 by the Director of Services for Social Inclusion and the newly appointed Managers of Services for Social Inclusion; like wise bilateral service agreements will be developed between our Board and key voluntary agencies.

- A homeless multi-agency initiative which involved Senior Managers from our Board, Representatives from Dublin City Council and the Gardai was piloted in 2003. This involved the putting in place and management of a multidisciplinary team to target a small group of chaotic rough sleepers who had multi-faceted care and social needs with the objective of stabilising their lives and attempting to provide a housing solution. This integrated approach achieves a successful outcome for the majority of all clients targeted and will be expanded in 2004 subject to availability of resources.

Two key pilots will be initiated in 2004 to help inform our Board as we further develop services.

- In conjunction with the voluntary sector and ERHA a Project Co-ordinator will be engaged to ascertain the health and welfare needs of clients in B&B's in Community Care Area 6 and to report on how these needs could best be met.

- A key voluntary housing body which provides a range of accommodation in four hostels in the SWAHB and our Boards area will provide a Nursing service to fast track a response to care needs of clients in the hostels.

  This service will be evaluated to ascertain whether the response brings a level of stability to the client group and obviates an existing pattern of clients endeavouring to access a variety of self directed service options.

  - In latter years the voluntary organisations managing hostels for homeless persons in the city have indicated that there is an increasing number of people living into relative old age in unsuitable accommodation, in cramped conditions, with little recreational or social activation. These people are also experiencing increased frailty and a multiplicity of medical/nursing issues to add to their existing symptoms.

Our Board has piloted nursing and primary care services in selected hostels which has been successful in the provision of preventative and treatment services and it is only in isolated cases that they have to be referred to nursing home type care.

However it is becoming increasingly obvious that despite these interventions that the accommodation of hostels is not conducive to those growing into old age (55 years upwards) any privacy, dignity, day space or social stimulation.

To address this issue has entered our Board has entered into discussions with representatives of a key voluntary agency, a voluntary housing trust and Dublin City Council to scope a way forward. Plans are at a preliminary stage on the development of a sheltered housing model (village style) on a dedicated site so designed that the housing, social and healthcare, rehabilitation / integration programmes can be provided in an unobtrusive manner.

In this way the statutory/voluntary agencies can provide wraparound services to the frail older clients and others as appropriate and also examine the possibility of a joint outreach service to support persons either homeless or in danger of becoming homeless in the locality.

- It is recognised that there will always be a small cohort of people who cannot continue to live in hostels with supports and have to access residential services appropriate to their needs; elderly disabled, elderly psychiatric residential care.

In such cases these homeless persons should have equity of access to long stay residential care settings in facilities managed by or on behalf of our Board. Where this is not possible a small cohort (10 or 12) of fully subvented beds should be contracted in specifically selected nursing homes to meet these needs.

2. Asylum Seekers/Refugees

2.1 Current Context for Planning of Services for Asylum Seekers/Refugees

In recent years Ireland has developed as a Multicultural Society. An increasing number of Asylum Seekers/Refugees enter Ireland from various countries particularly African and Eastern European. Many of these people have suffered mental and physical trauma in their country of origin and often enter Ireland in a fragile and traumatised state.

Adjusting to a new life in a strange country can be problematic and difficult with issues of poverty, discrimination and language to the fore.

Our Board recognises this specific pressure on our Health and Social Service but is committed to providing mainstream services to these people in an equitable manner and also by providing focused services to meet specific needs.

Dublin is the first point of entry to the country for Asylum Seekers/Refugees and our Board provides health and personal social services to: -

- Asylum Seekers newly arrived in the state who are initially accommodated in two reception centres at Balseskin, Finglas and Parnell West, Dublin 1. On average this client group spends approximately 2 weeks in our Boards area prior to being dispersed to Residential Centres throughout the state.

- Asylum Seekers and persons who have achieved refugee status and who reside in private and local authority accommodation within our Board's geographic area.

It is recognised that these client groups have particular health and welfare needs and in particular requiring guidance and support in navigating what can be a complex system. It is our Boards policies to work with partners in the public and voluntary sector towards the development of culturally and linguistically appropriate services for them.

Our Boards strategy is informed by: -

- National Anti-Poverty Strategy 1997
- Health Promotion Strategy 2000 - 2005
- Health Strategy – Quality and Fairness a Health System for Year 2001
- Regional Health Strategy for Ethnic Minorities – ERHA 2004

National Health Strategy Actions/Responses

Action
Commitment to provision of equal, accessible culturally appropriate care to this group, using models of best practice of interculturalism and integration.

Response
Our Board has provided Multidisciplinary Inreach health services to the clients at Balseskin and Parnell West and provided sensitively planned crèche facilities on site and Inreach Obstetric/Gynaecological services provided by the Rotunda Hospital in consultation with the residents. From the outset inhouse Public Health Services (including chest x-ray) has been provided; this service has an uptake rate of approximately 70%.

Action
Acknowledgement of the unique and personal social needs of the Asylum Seeker Group with particular regard to the vulnerable status of women and children. Implicit in the approach is the empowerment of Asylum Seekers to voice and advocate for their own concerns and needs.

Response
Our Board works closely with and funds key voluntary agencies who represent Asylum Seekers/Refugees particularly around upskilling leaders of ethnic groupings to enable them to speak for their community. We are committed to working in the coming year with these groups to provide customer feed back/fora which will help our Board to continue to develop appropriate services.

Action
Adoption of a collaborative, multi-sectoral approval to addressing the needs of Asylum Seekers through utilising partnerships between statutory and voluntary providers.

Response
Our Board has and will continue to develop strategic alliances with key voluntary agencies such as Spirasi, Access Ireland, Cairde, Emigrant Advice, The Vincentians and The Reception and Integration Agency and Local Authorities as well as with Asylum Seekers/Refugees, themselves to plan and develop services.

A new report “Regional Health Strategy for Ethnic Minorities 2004” to be considered by the ERHA in April 2004 is founded on principles set out in the National Health Strategy will assist in forming policy in our Boards area.

A cross Health Board Implementation Team representing the three Area Boards will now examine this strategy when adopted by the Authority and plan for the phased implementation of the Strategy in the coming years.

2.2 Needs Assessment

The numbers of Asylum Seekers who presented at the two main reception centres within our Board at Balseskin and Parnell West in 2003 as compared to 2002 were as follows :-

3589	2003
5868 Est*	2002

*Balseskin became operational in December, 2002 and Parnell West in April, 2000.

On transfer to direct provision centres in the various Board area's a full medical / social assessment on each client including status / outcome of public health screening and relevant health data are referred to public health doctors in the health board where direct provision is being provided for the particular clients.

The Reception Centres are managed by the Reception and Integration Agency (RIA) and our Board's community staff work closely with the RIA to ensure that residents have access to screening an mainstream health services for children and adults as required.

In addition to the above, significant numbers have settled in our Board's area:

- Former Asylum Seekers who have been granted refugee status
- Programme and convention refugees who have been invited by the Government to resettle in Ireland on the basis of recommendations from the UNHCR
- Persons who in the past left direct provision on the basis of having an Irish born child have settled in our Board's area..

These persons with their accompanying mult-cultural issues and language/interpretation difficulties have introduced a unique set of challenges for the health care services. In order to quantify the need it is now be necessary to link with key voluntary organisations working with these people to quantify their care needs and how these needs have impacted on an already oversubscribed service.

Details of accommodation in our Board's area is contained in Appendix 5.

2.3 Current Service Provision

2.3.1 Health/Welfare Screening Service

Our Board provides a range of health care and welfare services at the two main reception centres at Balseskin and Parnell West as well as ongoing Supplementary Welfare Services at the three accommodation centres at Newlight House, Gardiner Place, North Frederick Street and the unaccompanied centres at Blessington Lodge, Chester House and Ashton House.

Services Include:

- Full medical screening including radiology services.
- Psychological Services.
- GP Services.
- Public Health Nursing Services.
- Community Welfare Services.
- In addition, our Board has entered into a joint agreement with the Rotunda Hospital for the provision of an obstetric/gynaecological clinic at Balseskin and has provided a crèche facility there which is managed by peers from within the Asylum Seeker community; this responds to and acknowledges the culturally sensitive issues which pertain.

Details of Asylum Seekers/Refugees entering the reception centres and of the screening and other services supplied is contained in Appendix 6.

2.3.2 Health Promotion

Our Board is represented on a cross Health Board (NAHB, ECAHB, SWAHB) group which examines the health promotion needs of Asylum Seekers/Refugees and targets ways of addressing specific needs of these groups such as access, information and integration.

- A pilot project is being carried out in the SWAHB on reconfiguring a health centre to meet the needs of Asylum Seekers/Refugee clients. This will be concluded in 2004.
- The PHN Request Form is being drafted in 8 languages and piloted in Dun Laoghaire. When evaluated, it will be utilised in all areas.

2.3.3 Partnership with Voluntary Organisations

It is accepted that the voluntary sector plays a vital role in providing a wide range of culturally acceptable information to Asylum Seekers/Refugees and our Board works closely with a number of organisations in this regard, e.g. Cairde, Spirasi, Access Ireland, Emigrant Advice and The Vincentians among others.

Cairde is involved in important work in the general area of educating people in the complexities of the various services including health. Work has also been carried out in the areas of HIV infection in women and in the Healthwise Community Impact Programme.

Similarly Spirasi has a detailed programme of advice and counselling services for Asylum Seekers/Refugees and has specific programmes.

- Health Information Programme (HIP) which includes a specially designed guide to the Irish Health Service.
- Centre for the Survivors of Torture.

Both of these centres extensively utilize peer leaders from within ethnic minorities to provide these services on a paid and/or on a voluntary basis.

2.3.4

The Community Welfare Service provides a dedicated unit to deal with Asylum Seekers needs. This includes payment of SWA; sourcing and payment of accommodation for unaccompanied minors (on behalf of the ECAHB); payment of accommodation for Asylum Seekers/Refugees who become homeless; outreach clinics in the reception and accommodation centres within the three area boards

2.4 Way Forward – Targets

- We are fully aware that our staff need to be upskilled in a sensitive way on the cultural issues and fears and anxieties that beset Asylum Seekers/Refugees as they enter the country. Our Board's Health Promotion Department has and continues to play a vital role in providing antiracism courses/tutorials to our front line staff so as to develop the skills in dealing with language and cultural difficulties and minimise confrontation.

- Key voluntary organisations have made enormous advances in working with and advocating on behalf of Asylum Seekers/Refugees ; all of us at Board level particularly those staff in front line services can learn from this collaboration. Our Board's newly appointed Managers of Services for Social Inclusion will play a major role in forging links with these organisations and this client group.

- A new European initiative to promote health and health literacy for migrant patients and ethnic minorities is being developed across the EU. There are 12 hospitals participating across Europe and James Connolly Memorial Hospital is the representative for Ireland in the Migrant Friendly Hospital project. This project will run over a two and a half year period. The aim of the project is to identify, develop and evaluate models of good practice in the participating members states of the EU. More specifically the objectives are to promote the health and health related knowledge and competence of migrants and ethnic minorities and improve hospital services for these patients groups. A recent report on admissions to JCMH revealed that 17% of admissions were non-national patients.

- Our Board is committed to working cohesively with the Dublin City Development Board and Fingal Development Board around specific actions that will advance the integration of Asylum Seekers/Refugees into mainstream services (Dublin City 2002 – 2012 A City of Responsibilities and A Strategy for Economic, Social and Cultural Development in Fingal 2002 – 2011).

- Our Board will continue to engage at a strategic level on the Reception and Integration Agency and with the E.U. Working Group on the MORE Project around the integration of programme refugees.

3. TRAVELLERS

3.1 Current Context for Planning of Services for Travellers.

It is recognised that the majority of members of the travelling community and particularly traveller children have a level of health which on average falls far short of their counterparts in the traditional settled community. This is particularly evident when we compare life expectancy and other areas such as infant mortality.

Travellers experience social exclusion and marginalisation with attending poverty and reduced health status.

The key challenge for our Board is to link travellers especially those who have settled on fixed sites, with mainstream health and social services for both adults and children, where practical. This is particularly important in the area of antenatal care, immunisation etc.

Where access to mainstream services is not possible our Boards target is to develop outreach services specifically designed for travellers, which respects their culture in a sensitive manner.

Particular importance is the work of the Health Promotion Service in our Boards area which together with the Community Services have been to the forefront in developing training modules for Health Board staff around discrimination issues and in working with Travellers Groups on health promoting issues which will impact on future lifestyles of travellers for the better.

The SWAHB takes the lead in co-operation with our Board and the East Coast Area Health Board in co-ordinating the further development of travellers services in a focused consultation forum in the Traveller Health Unit – which allows representation from the various Traveller Groups.

The development of services for the travelling community is informed by

- The National Anti-Poverty Strategy 1997.
- National Health Promotion Strategy 2000 – 2005.
- Health Strategy – Quality & Fairness – A Health System for You 2001.
- Travellers Health – A National Strategy 2002 – 2008.

National Health Strategy Actions/Responses

Action To ensure that travellers have equal status rights to health services as the settled community.

Response Our Board is committed to encouraging and supporting travellers to avail of mainstream services and to ensure that health professionals offer services to travellers in a sensitive way.

Each Community Care Area has a public health nurse dedicated to travellers who work particularly with women and children on priority areas such as immunisations, pre-natal and post natal care and child developmental clinical and oral health.

Action The implementation of the National Travellers Health Strategy.

Response Our Board continues to work with key stakeholders around implementation of the Strategy in line with resource allocation. Issues that have been progressed include formation of the Travellers Health Unit participation in the National Travellers Health Advisory Group and development of Primary Health Care Projects.

Action To ensure that services are delivered to travellers, which are culturally sensitive and meet the specific needs of travellers.

Response Our Board works closely with Pavee Point, and other organisations representing travellers in our Boards area on issues such as, implementation of actions recommended by the Traveller Health Unit, development of the Primary Health Care Projects, development of Health Promotion initiatives and delivering anti-racism training.

In addition and to emphasise the direction of the National Health Strategy. In this context the Travellers Health Unit selected 5 priorities from the National Travellers Health Strategy e.g.

- Support the Development of Primary Health Care.
- Support the development of local traveller implementation groups at community care area.
- Support the upcoming National Traveller Health Study.
- Improving access to primary care services.
- Develop anti-racism training.

3.2. Needs Assessment

Due to the transient and sometimes nomadic nature of travellers in our Boards area it is sometimes difficult to be specific about the exact numbers who require occasional services at a particular time.

Travellers Health A National Strategy 2002 – 2005 indicated that there were 1353 traveller families in the ERHA area, with the majority in our Board and the SWAHB areas.

Latest figures indicate that there are 298 traveller families in Fingal and 560 traveller families in Dublin City Council North/South. The majority of travellers in our Boards area are based in Community Care Area 6 & 8.

The Strategy also indicated that the population of travellers in Ireland had grown fourfold in the period 1960 – 2000.

Of particular concern as shown in the Strategy is that traveller men and women on average had a reduced life expectancy of ten & twelve years compared to the settled community. Equally, infant mortality among travellers was 18.1 per 1000 births compared to a national figure of 7.4.

3.3. Current Service Provision

The majority of travellers in our Boards are located in Community Care Areas 6 & 8.

In both areas, travellers are encouraged to avail of mainstream community services and pre and antenatal services in line with the settled community. However, in defference to cultural issues our Board attempts to work with the travelling community to develop specific solutions to their care needs.

3.3.1. Primary Care

The Primary Care Project continues to be developed and strengthening in our Boards. Area. This project concentrates on our Boards front line community care staff working with a key travellers organisation in our Boards area on training travellers as primary health care workers, who in turn train travellers within their communities and co-ordinate linkages to various health services in a culturally sensitive way.

There are three Primary Care Projects actioned in our Boards area with a further two due to go live in 2004. To date twenty travellers have been fully trained as peer leaders with a further thirty-four receiving training.

3.3.2. Travellers Health Unit.

The Travellers Health Unit, which is co-ordinated/managed by the South Western Area Health Board on behalf of the three Boards is charged with the development of best practice, implementation of policy and actioning of already social developments in a structured way.

The development of the Travellers Health Unit was a key recommendation of the National Travellers Strategy and gives travellers a real say in how services are developed to meet their needs. Key to this has been the training of Health Board personnel in cultural issues relating to travelling communities, which enhances the partnership concept. The National Health Strategy specified the need to collaborate with user and communication in the planning and delivery of services across all care groups for the entire population.

3.3.3. Health Promotion

The development of an improved health status for travellers continues to be central to all our Boards policies.

To this end, our Boards Health Promotion Service continues to lined with key traveller organisations and our Community Services on specific projects, which will overtime improve the health of travellers by adjusting their lifestyles while simultaneously respecting their culture.

3.4 Way Forward – Targets

- Our Board is committed to the continued implementation of the Travellers Health Strategy in 2004 with the development of 2 further Primary Care Projects and the further training of 34 peer leaders.

- Our Board will play a lead role in the development of a national project to determine the health status of travellers on the island of Ireland with a target start date of late 2004.

Our Boards Health Promotion team will continue to work with travellers organisations to develop, peer-led health promotion training programmes, physical activity initiatives and peer led nutritional programmes.

M. Windle **21st April, 2004**
Chief Executive

APPENDICES

APPENDIX 1

Estimated Costs of Social Inclusion Services for 2004

			€
(i)	General Planning / Management of Service		.400m
	Sub Total		.400m
(ii)	**Homeless Service**		
	(a) Care Costs Hostels		
	Simon	**Sean McDermott Street**	**.318m**
		Dorset Street	.386m
		Abbey Street	.200m
	Salvation Army Granby		.667m
	Dublin City Council	Elm House	.142m
		Maple House	.142m
		Oak House	.142m
	Focus Ireland	Aylward Green	.289m
		Stanhope Green	.204m
		George's Hill	.163
	Haven House Dublin 7		.500m
	Rendu Apartments, North William Street		.219m
	Hail Housing (various)		.126m
	Sonas Housing, Killester		.119m
	Sophia Housing, Ballymun		.023m
	Capuchin Day Centre, Dublin 7		.092m
	Centre Care, Dublin 1		.050m
	Arrupe Society, Whitworth Road		.104m
	Our Lady of Charity, Sean McDermott St. / Beechlawn		.160m
	Aids Fund, Granby House		.025m
	Respond Housing, High Park		.500m
	(b) Section 65 Payments Homeless		
	Anna Liffey Project		**.054m**
	De Paul Trust		.030m
	Bernardo's		.064m
	C.D.V.E.C.		.022m
	Cedar House		.060m

(c)	**Consultant led dedicated Psychiatry Outreach Service for Homeless Persons (2004)**	.720m
(d)	**Current Consultant led Psychiatric Service Located at Ushers Island**	.600m
(e)	**Community Welfare Service, Homeless Persons Unit, including Patch Outreach Service**	2.200m
(f)	**Multidisciplinary Outreach Team**	
	Westwood House	.450m
(g)	**Grant to Fund Homeless Agency**	.150m
(g)	**Fastracking of Medical Card System At Community Care Area level + 12 staff (est) assigned to deal with Homeless (Social Inclusion) Issues**	.500m
	SUB TOTAL	**9.421M**

(iii) Asylum Seekers / Refugees

(a)	**Section 65 Grants**	
	Spirasi, Dublin 7	**.278m**
	Vincentian's, Dublin 7	.074m
	Access Ireland, Dublin 1	.075m
	Cairde, Dublin 1	.363m
	Miscell.	.023m
(b)	**In Reach Medical Screening / Nursing Care Teams to Balseskin / Parnell West Reception Centres**	.671m
(c)	**Community Welfare Service (Asylum Seekers / Refugees) and Outreach Services**	1.480m

SUB TOTAL **2.964m**

(iv) Travellers

(a)	**Development of 5 Primary Care Projects (ongoing) including 54 peer trained health care workers**	.566m
	Dedicated Senior Dental Surgeon Service	.100m
	Admin Support	.040m
	Dedicated Public Health Nurse Service	.130m
	Provision of Family Planning Service (Coolock)	.080m
Health Promotion Activity including		
	Nutrition / Physical Activity	.080m
(b)	**Support to Pavee Point (travellers org.)**	.086m
(c)	**Community Welfare Service (Travellers)**	.400m
	SUB TOTAL	**1.482m**

Overall Costings

(1)	General Costings	€ .400m
(2)	Homeless Service	€9.421m
(3)	Asylum Seekers / Refugees	€2.964m
(4)	Travellers	€1.482m
TOTAL		**€14.267m**

APPENDIX 2

Homelessness in London

Introduction

In development and reengineering of services in Dublin City, through the auspices of the Homeless Agency we were informed by the London Services in the way those services were reorganised and reconfigured. As of now the delivery and range of services provided in Dublin are somewhat similar to those in London albeit on a smaller scale.

The factors that lead to homeless are broadly similar, including substance abuse, alcohol or drug addiction, anti-social behaviour, mental illness, children leaving care, mental breakdown etc.

Similarly, a number of agencies and government department's have responsibility for delivering different aspects of service to homeless persons and specifically to preventing homelessness i.e. Income Support, Education, Accommodation and Housing (including Housing Benefit), Health and Welfare.

The model used in London has demonstrated the benefits of an integrated, multi-agency approach when tackling homelessness. In particular, the focus on preventative measures is shown to provide the best chance of reducing the numbers of vulnerable people who end up homeless.

In Dublin, the "Homeless Agency" have been charged with co-ordinating the responses of various statutory and voluntary agencies in responding to and providing services to homeless persons and have published an action plan on homelessness, setting targets which it regularly reviews. The Homeless Agency is currently devising its second "action plan" based on a review of its previous plan and identification of current needs.

The lessons to be learned from the experiences in London are that a co-ordinated approach provides the best results and focusing on preventative measures i.e. preventing a person becoming homeless is the most effective strategy.

In this context our Board is now working proactively with the Local Authorities in a range of preventative measures; this is a major component of the work of the social inclusion managers. As can be appreciated the fact that the greater proportion of homeless persons present from areas outside the ERHA region this presents its own difficulties.

Background Information

In July 1998 the Social Exclusion Unit (S.E.U.) published a Report setting out the way forward for reducing rough sleeping and homelessness in England. The Prime Minister set the tough target of reducing rough sleeping by two thirds by 2002. The central issue that the government set out to address was prevention. A dedicated Rough Sleepers Unit (R.S.U.) headed by a former Deputy Director of Shelter was created. The Unit with a co-ordinated approach worked to reducing rough sleeping in the capital, and assumed responsibility for the rough sleeping target nationally.

The Government also launched the Homelessness Action Programme to provide £34 million in grants to voluntary organisations tackling rough sleeping outside London. Across the country, the New Deal rules were changed for young people to allow rough sleepers early access to the scheme. It published new arrangements for looking after children leaving care, and for integrating the work of the prison and probation services in resettling ex-offenders.

The SEU Report showed that of the 2,400 people who sleep on the streets of London over the course of a year at least 1,800 are new arrivals and that many of these new arrivals come from particular groups within the community who are at a high risk of becoming homeless. Targeting these groups with preventative measures provides the best chance of reducing the numbers of vulnerable people who end up on the streets.

In the last 18 months, the successes of the Rough Sleepers Unit have demonstrated the benefits of an integrated approach to policy when tackling rough sleeping. The co-ordination of support advisers, with increased first stage accommodation and better central government inter-working, has paid dividends. Recent innovations include Contact and Assessment Teams (CATs) and Tenancy Sustainment Teams (TSTs), both of which are RSU initiatives. CATs are multi-disciplinary teams, run by the voluntary sector but with statutory involvement, which are responsible for making contact with rough sleepers and giving them the help needed to come inside. The role of TSTs is to support tenants in independent accommodation following their move from the street. Take-up of services for rough sleepers has significantly improved over the last number of years.

The Government established a committee, Rough Sleepers Committee, to ensure that plans, not just for housing but also for health, social services, education and training, employment, benefits and welfare, street culture, prison and probation, and those leaving the armed services, would work together in a joined up way. The Committee includes ministers from the Home Office, the Department of Health, the Department for Education and Employment, the Department of Social Security, the Ministry of Defence, and HM Treasury. It has to date:

- agreed the action plan in the SEU Report for delivering the Prime Minister's target;
- agreed the programme for setting up the new Rough Sleepers Unit
- agreed the scope of specific major programmes, such as the Homelessness Action Programme outside London;
- checked and reported on progress; and
- identified new issues, such as street life, and access to benefits.

Establishing a baseline

The Ministerial Committee agreed that its first task was to clearly identify the scale of the rough sleeping problem.

They now have established, and published, a detailed estimate of the number of people sleeping rough against which progress can be measured. This was based principally on street counts, but elsewhere on estimates by local authorities.

It showed that there were 1850 people sleeping rough in England on any single night. This detailed information means that resources can be targeted where they will be most useful such as to seek to address perceptions about the numbers of people on the streets during the day, including beggars, street drinkers and others, many of whom may in fact have somewhere to sleep at night.

The Government are committed to a new approach in London. Therefore, an integrated strategy through the Rough Sleepers Unit has been created. The unit has staff from DSS, the Department of Health, the Housing Corporation, the NHS Executive, local government and the voluntary sector. The key tasks of the Unit are to develop integrated strategies and programmes for achieving the overall target and to develop and co-ordinate policy to prevent people sleeping rough and becoming homeless.

The Unit had an integrated budget of £145 million for London over three years, drawn together from a range of sources across Government. The integrated budget provided more effective and flexible funding arrangements. The Unit also worked with other partners and funder's and organised access to mainstream programmes enabling them to tackle in a joined up way the healthcare, education and training needs and benefit problems that many people sleeping rough have, in addition to their housing needs.

They are currently working with local authorities and the voluntary sector to revise their detailed guidance on how to draw up and implement a successful local strategy. The main steps involve:

- finding out how big the problem is;
- defining what the local community needs to achieve;
- working with others, especially health and social services, the police and the voluntary sector;
- identifying any gaps in services and working up a plan for filling them;
- identifying what resources are available, and what more are needed;
- monitoring results so as to review objectives and
- reporting action locally.

To complement the Homelessness Action Programme the Department of Health has also announced a programme of grants under the Homeless Mentally Ill Initiative, Drug and Alcohol Specific Grants to help rough sleepers with these health problems across the country outside London. They will be allocating a second trance of Homelessness Action Programme grants, totalling some £7m.

Thus better joint working, more effective delivery of services at street level and revised contracting arrangements are required.

The SEU Report estimated that between a quarter and a third of rough sleepers have been in the care of local authorities as children, and other studies have estimated that up to 20% of young care leavers experience some form of homelessness within two years of leaving care.

The Department of Health launched the Quality Protects programme for the reform of children's services. A children's services special grant of £375 million over three years was made available to local authorities in support of the programme which has, as one of its priority areas, the aim of increasing the support offered to care leavers and preventing the inappropriate discharge from care of 16 and 17 year olds.

Guidance to Local Housing Authorities was issued making it clear that with very few exceptions, all care leavers and homeless 16 and 17 year olds without back up support should be regarded as "vulnerable" and have priority rights to be housed in suitable accommodation. The aim is to ensure that young people are looked after until they are ready to leave care. When they do leave care, the local authority will have a duty to assess and meet their needs until they are 18. This includes ensuring that they have suitable accommodation.

Centrepoint and Safe in the City have been commissioned to draft guidance for Local Education Authorities which will highlight: good practice in preventing homelessness; the need to ensure adequate arrangements are in place for young people at risk; and the scope for addressing rough sleeping as part of the national curriculum and as part of youth service provision.

The guidance will make a link between the factors contributing to family crisis and young people leaving home, and the proposed content of the curriculum framework for PSHE. This includes managing relationships, resolving disagreements peacefully, the role of parents and the organisations which support relationships in crisis.

Centrepoint have presented proposals to develop a "peer education" module on homelessness and rough sleeping and will provide groups of young people at high risk with a vivid taste of what homelessness really means. The aim is to discourage them from taking steps which would lead to them becoming homeless.

Around half of rough sleepers have been in prison or a remand centre at some time. 40 % of ex-offenders are homeless on release. The SEU report recommended that the Home Office develop a new focus for prison and probation services on preventing homelessness, and that homelessness should be a key element of the Home Office monitoring regime, with both the prison and probation services having a new performance indicator.

If ex-offenders are to settle easily into civilian life, they need to begin to develop the necessary life skills before they are released. National standards for resettlement have being developed. . There will be a particular focus on resettlement, including housing.

It is recognised that the problems of rough sleeping and social exclusion will not be solved until rough sleepers are brought back into the mainstream of society and equipped with the skills for independent living. This includes supporting them to move into sustainable employment, and break out of the "no home - no job" cycle.

Many rough sleepers have serious problems with drug and alcohol dependency, and both their mental and physical health. These problems can be a barrier to getting work and housing, as well as a threat to life. The SEU report showed that rough sleepers can have real problems in trying to access the mainstream services that can offer them mental and physical health care and treatment for substance abuse.

Mental health is a high priority for both the NHS and social services. The Government's strategy on mental health, Modernising Mental Health Services, describes how mental health services will be modernised to be made safe, sound and supportive. This will provide extra beds, more hostels and supported accommodation, better outreach services, better access to new anti-psychotic drugs, 24 hour crisis team, and more and better trained staff. The challenge ahead will be to ensure that the Strategy on Mental Health means real action on the ground for rough sleepers.

In London, where problems are particularly concentrated, a senior NHS manager has been seconded to the Rough Sleepers Unit. He will ensure that mental health services in London are responsive to the needs of homeless persons.

Also, as part of the arrangements for receiving the Mental Health Grant, all local authorities have been required to nominate a senior manager with clear responsibility and accountability for mental health, who will develop close links with other agencies working to reduce the level of rough sleeping. One of the senior manager's principal responsibilities is to work jointly with housing, including nominated rough sleeping contacts, to address housing and homelessness issues. The aim is to ensure that there is a co-ordinated response to the mental health problems of rough sleepers, focused on the local authority-led rough sleeping strategies.

Also in London the Metropolitan Police Service are working to address the particular needs of street drinkers and to reduce crime and disorder. The Met are working with the Inner London Detoxification Centre and their partners, St Mungos, to set up in Camden a centre to which prisoners could be taken immediately on arrest, instead of a police station.

As well as receiving a high level of care during the sobering up process, the person would be encouraged to embark on a recovery programme as a resident at the centre for up to fourteen days.

Many rough sleepers should also be reached by mainstream drug and alcohol services. The strategy: Tackling Drugs to Build a Better Britain recognises the importance of reaching vulnerable groups such as rough sleepers, and of an integrated approach to helping people with a range of needs, such as housing and employment, as well as substance abuse. The key challenge ahead is to ensure that rough sleepers on the streets gain real access to services which allow them to deal with their drugs problems. The Rough Sleepers Unit will be working with the UK Anti-Drugs Co-ordination Unit to deliver this.

Appendix 4

Hostels/Day Services/Advice Service

Emergency Hostel Accommodation

Salvation Army Marlborough Place, Dublin 1	Emergency Accommodation
Elm House (Dublin City Council) Blessington Street, Dublin 7	Emergency Accommodation
Focus Ireland Alyward Green, Finglas, Dublin 11	Emergency Accommodation
Regina Coeli Morning Star Avenue, Dublin 7	Emergency Accommodation
Morning Star Hostel Morning Star Avenue, Dublin 7	Emergency Accommodation
DePaul Trust Clancy Barracks, Dublin 7	Emergency Accommodation
Haven House, Dublin 7	Emergency Accommodation
Cedar House Malborough Place, Dublin 1	Emergency Accommodation

Transitional Accommodation/Supported Housing

Simon Community Dorset Street, Dublin 7	Transitional Accommodation
Simon Community Sean McDermott Street, Dublin 1	Supported Housing
Simon Community North Circular Road, Dublin 7	Supported Housing
Salvation Army Granby Centre, Dublin 1	Transitional Accommodation
Mapel House (Dublin City Council) North Circular Road, Dublin 7	Transitional Accommodation

Oak House (Dublin City Council) 55 Benburb Street, Dublin 1	Supported Housing
Focus Ireland Stanhope Green, Dublin 1	Transitional/Supported Housing
Focus Ireland Georges Hill, Dublin 1	Transitional/Supported Housing
Vincentians North William Street, Dublin 1	Transitional Housing
Sonas Housing Association Ballymun, Dublin 11	Supported Housing
DePaul (Women Leaving Prison Project) North Circular Road, Dublin 7	Trnsasitional Housing
Sisters of Our Lady Sean McDermott Street and Beechlawn, Dublin 9	Transitional Housing
Arrupe Society Whitworth Road, Drumcondra, Dublin 9	Transitional Housing
Rendu Apartments North William Street, Dublin 1	Supported Housing
Hail Housing (Various Locations)	Supported Housing
Sophia Housing Ballymun, Dublin 11	Supported Housing

Day Centre/Advice Centre

Homeless Persons Unit (Various Locations)	Advice/Placement Service
Centre Care Cathedral Street, Dublin 1	Advice
Capuchin Day Centre Bow Street, Dublin 7	Day Centre
Threshold Mary’s Abbey, Dublin 7	Advice

APPENDIX 5

Accommodation Details.

Accommodation Venues within Northern Area Health Board

Type of Accommodation	Name	Capacity
Reception Centre	Balseskin	381
Reception Centre	Parnell West	90
Accommodation Centre	Gardiner Place	34
Accommodation Centre	North Frederick Street	33
Accommodation Centre	Newlight House	32
Self Catering Accommodation Centre[2]	Montpelier Apartments	69
Unaccompanied Minors Centre[3]	Chester House	48
Unaccompanied Minors Centre	Blessington Lodge	30
Unaccompanied Minors Centre	Ashton House	25
Homeless Accommodation Centre[4]	23 New Cabra Road	15
Homeless Accommodation Centre	129 North Circular Road	21
Homeless Accommodation Centre	29 North Frederick Street	26
Homeless Accommodation Centre	Lismore House – Drumcondra	8

[2]Provided by the Reception and Integration Agency for those asylum seekers who have special medical needs.
[3]Note: all unaccompanied minor centres are the responsibility of the East Coast Area Health Board.
[4]All Homeless Accommodation Centres are provided by Dublin City Council to meet the needs of homeless persons who are refugees, illegals, foreign students etc.

Appendix 6

Balseskin & Parnell Square Reception Centres

Medical Screening Service – 2003

Activity	Balseskin	Parnell	Total
Numbers offered appointments	2072	1076	**3148**
Numbers attended screening	1544	664	**2208**
Percentage attending screening	74.5%	61.7%	**70.1%**
Number of reviews	177	474	**651**
Number of TB Cases	0	2	**2**
TB Cases as % of numbers screened	0	0.3%	**0.1%**
Number of Hepatitis B Cases	18	28	**46**
Hep B Cases as % of numbers screened	1.17%	4.2%	**2.1%**
Number of Hepatitis C Cases	5	10	**15**
Hep C Cases as % of numbers screened	0.32%	1.5%	**0.7%**
HIV positive	14	10	**24**
HIV Cases as % of numbers screened	0.9%	1.5%	**1.1%**
Varicella non-immune rate	18.1%	11.1%	**16.8%**
Rubella non-immune rate	9.8%	11.1%	**10.1%**
Polio Cases	0	0	**0**
Number of pregnant women	573	118	**691**
Pregnant women as % of screened	37.1%	17.8%	**31.3%**
Referrals to Psychologist	120	67	**187**
Referrals to Social Worker	0	7	**7**
Newborns examined by Midwives*	209	-	**209**
Guthrie tests performed on newborns	105	-	**105**

*Balseskin Only

Notes

(1) No screening was undertaken during the 10-week Public Health Doctor strike from April to June 2003

(2) Parnell offered half-week screening only to mid-September – currently offers 4 days per week

(3) Balseskin offered 4 days a week screening throughout the year

(4) Types of client referred to each Reception Centre differs – single males tend to be referred to Parnell, pregnant women to Balseskin

(5) Numbers seeking asylum reduced towards the end of 2003