

Having Choices

An Evaluation of the Home Focus Project in West Cork

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Table of Contents

Executive Summary.....	5
Chapter One: The Home Focus Project in Context.....	11
1.1 Introduction and Background to the Evaluation Study.....	13
1.2 The Operational Context	14
1.3 An Overview of the Home Focus Project	23
1.4 The Evaluation Process.....	33
Recovery and evidence-based practice.....	38
Chapter Two: Developing Community, Recovery-Oriented Practice.....	43
2.1 Mental Health and the ‘Community’	45
2.2 Recovery-Oriented Practice	50
2.3 Assertive Outreach	54
2.4 An Emerging Identity for the Home Focus Project.....	59
Chapter Three: The 3-dimensional Impact of Home Focus; Evaluation Findings.....	65
Introduction.....	67
3.1 Micro-level; Impact on service users	67
3.2 Mezzo-level: Impact on service provision.....	96
3.3 Macro-level: Impact on the community	105
Chapter Four: Conclusions and Recommendations	110
The wider implications of the evaluation study.....	112
Strengths of the project	112
Challenges	114
Recommendations.....	115
Bibliography.....	118
Appendices.....	124

Executive Summary

Policy and Practice Context

The need for comprehensive, accessible, community-based mental health services has been identified by key Irish policies and in particular the Mental Health Strategy *A Vision for Change* (DoH&C, 2006), the *Vision for a Recovery Model in Irish Mental Health Services* (MHC, 2008) and the *Primary Care Strategy* (DoH&C, 2001). *Vision for Change* proposes a fundamental shift in the location of mental health services and the philosophy underpinning their provision. The strategy advocates the promotion of a holistic, person-centred, recovery-oriented, community-based service.

This evaluation study explores the achievements and challenges of the Home Focus project and puts them in the context of a literature and policy review on mental health, community and recovery. This will allow a consideration of the wider implications of this innovative approach which, it is hoped, will contribute to a debate on how (a) to achieve the changes recommended by *Vision for Change*, and (b) to evaluate innovative services for people suffering with mental health difficulties.

The Home Focus Project

Home Focus is a pilot project funded under the *Enhancing Disability Services Project Funding* (EDS) of the Department of Justice, Equality and Law Reform. The funding is administered by Pobal, a not-for-profit company with charitable status that manages programmes on behalf of the Irish Government and the EU. The project is based on a collaborative approach between National Learning Network West Cork, West Cork Mental Health Services, the Irish Advocacy Network, HSE Disability Guidance Services, Work Start West Cork and West Cork Community Partnership.

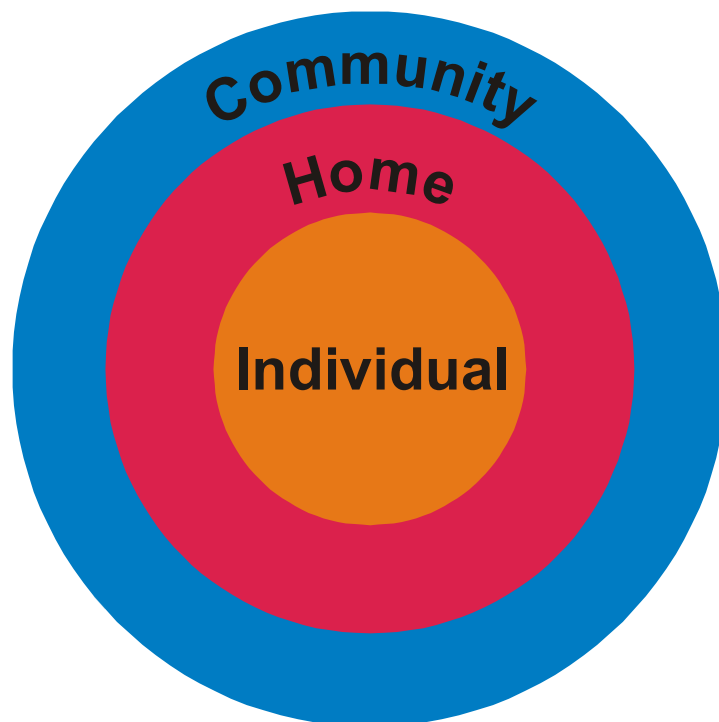
Home Focus provides outreach, individualised support to people with mental health difficulties who are isolated because of their inability or unwillingness to access traditional, centre-based models of service delivery.

The aim of the project is to deliver a service to this group of people in their own homes and communities in the West Cork area, enabling them to enhance their mental health and wellbeing, independent living skills, levels of connection to their own communities, access to training, education and employment opportunities, improved quality of life and future planning.

The Home Focus programme is delivered by a team combining diverse service-user and professional expertise. The staff team includes a rehabilitative training instructor, an outreach nurse, a recovery support worker and a recovery resource worker.

The participants were primarily those identified by the West Cork Mental Health Services. Between September 2006 and March 2008 the Home Focus team worked with 35 individuals for an approximate duration of between 3 and 18 months, depending on the needs of each participant.

Based on the individual participant's needs, the project was delivered at three levels:



Underpinning Philosophy

This innovative model of service delivery is based on community, outreach and home-based interventions, combined with the involvement of users of mental health services in programme design and delivery. Throughout its formation and delivery, the Home Focus project has developed its own unique identity. This identity is a constellation of variables including the philosophy informing mental health provision in West Cork, the diversity of the staff and management teams, and the geographical and social characteristics of the target area. This distinct identity is evidenced in:

- The application of creative, strength-based engagement strategies
- The provision of a holistic, non-medically-driven service
- The provision of a service in a rural context where issues of isolation and limited access to services are pertinent to the experience of service users.

The Evaluation Study

An evaluation process was put in place from the onset of the project. The design of the study was informed by the philosophy underpinning (a) current developments in mental health and (b) the development and delivery of the Home Focus project. In this philosophy, service-users play key roles in defining and taking charge of the changes they want to bring about in their lives. The approach to the evaluation needs to reflect the ethos of the project, which is user-centred and recovery-oriented. In a period where evidence-based practice is central to service development and delivery, this evaluation study highlights the significance of evidence constructed by the narratives of people who have direct experience of mental health services.

Key Findings

The broad range of experience and expertise pooled by the Home Focus project ensured a holistic approach to participants' needs and a high-quality, flexible and balanced programme. Key findings of this study include:

- ***A significant reduction in hospital days*** (47%), over a period of 12 months for participants who engaged with the Home Focus project. This also represents significant savings on hospital admissions.

- ***Specific gains achieved by participants*** include health and social gain; improved social engagement; linking with community groups and support organisations; improved mental health; improved independent living skills; employment; further training and certification.

- ***A new unique experience of service provision.*** Participants spoke extensively about how the project provided them with a hopeful vision for their future, how they felt respected, listened to and were treated 'as a person rather than a symptom'. They appreciated being met in their own environment, having choices and the time and availability of the staff team. They also identified striking differences between this and previous, predominantly negative, experiences of services. As many of the participants experience social isolation, they valued the social contact and relationship-building opportunities offered through the project. Many participants also talked about their improved mental health and their increasing sense of control over their mental health difficulties.

- ***A contribution to new approaches in service provision.*** The Home Focus project demonstrated the possibility for/viability of a flexible, user-centred service which is community-based and recovery-oriented. The project also provided a valuable additional resource to West Cork and, as it is based on a partnership, it contributed to improved relationships between various services and community organisations. Furthermore, the partnership demonstrated a positive way forwards for service provision to people who suffer from mental health problems, shifting the responsibility of care from mental health services to the community.

➤ ***Articulating a community development approach to mental health.***

Through the partnership and the engagement with community groups, the project demonstrated a commitment to a community development approach. Through this approach it is possible to address the broader contextual factors contributing to mental distress, normalise mental distress by providing support within mainstream community services, and develop an educational component which will help the reduction of stigma associated with mental health difficulties.

Recommendations

The Home Focus project provided a unique resource in enabling the provision of a quality, flexible service to people with mental health difficulties in West Cork. In order to continue and maximise its contribution, the project needs to be (a) mainstreamed and (b) part of a broader network system of community-based resources.

Chapter One: The Home Focus Project in Context

1.1 Introduction and Background to the Evaluation Study

Home Focus is a pilot project funded under the *Enhancing Disability Services Project Funding* (EDS) of the Department of Justice, Equality and Law Reform. The funding is administered by Pobal, a not-for-profit company with charitable status that manages programmes on behalf of the Irish Government and the EU. The project provides outreach, individualised support to people with mental health difficulties in their own environment. *Home Focus* is based on a collaborative approach between National Learning Network West Cork, West Cork Mental Health Services, the Irish Advocacy Network, HSE Disability Guidance Services, Work Start West Cork and West Cork Community Partnership. The project started in May 2006 and direct work with participants began in September 2006. The project's funding through Pobal came to an end in March 2008, however *Home Focus* will be supported through internal funding until June 2008.

The group of clients for this project are people with mental health difficulties who are isolated because of their inability or unwillingness to access traditional, centre-based models of service delivery. The aim of the project is to deliver a service to this group of people in their own homes and communities in the West Cork area, enabling them to enhance their mental health and wellbeing, independent living skills, level of connection to their own communities, access to training, education and employment opportunities, improved quality of life and future planning.

The evaluation process was established from the beginning of the project. Early in 2006 the Department of Applied Social Studies, University College Cork was commissioned by the project's management board to carry out this task. This report is based on the research carried out as part of the evaluation of the *Home Focus* project. This evaluation study is concerned, in the first instance, with establishing the extent to which the original objectives of the *Home Focus* project have been achieved, and the implications for future development. Furthermore, this study considers the broader operational context of the project and therefore provides a conceptual and policy analysis of community-based, recovery-oriented practice in mental health.

Finally, as the main objective of the study is the consideration of 'evidence of recovery', the question of 'what constitutes valid evidence' is central in the design of the evaluation. The author proposes an evaluation framework which reflects the innovative approach of the Home Focus project through the development of participative methodologies, and the generation of outcome indicators based on service-user experiences.

1.2 The Operational Context

1.2.1 Local Context

Partner organisations

The design, delivery and management of the project are based on a partnership approach, which is one of the unique aspects of Home Focus as it provides the basis for a holistic and comprehensive community-based mental health service provision.

The partner organisations to the Home Focus project are:

- Health Service Executive (HSE) South:
 - West Cork Mental Health Services: A multidisciplinary team provides acute hospital-based and community-based services. This includes residential services, out-patient services respite care and elements of primary care. The West Cork Catchment area has a population of 53,445 (CSO, 2006) which is divided into three sectors: (a) Skibbereen/Schull, (b) Bantry/Castletownbere and (c) Clonakilty/Dunmanway (see map on page 31). The overall ethos of West Cork Mental Health Services is to create an empowered partnership with the client through promoting good mental health and to provide a high quality service which is equitable, empathetic and respectful.

- Disability Guidance Services: This service is composed of three main elements: (a) Guidance and Advice, (b) Monitoring and Rehabilitative Training, and (c) New Developments. The service is applicable to all people with physical and sensory, intellectual and mental health disabilities from the ages of 16 to 65.
- National Learning Network (NLN): A non-Governmental training organisation, part of the REHAB Group. NLN offers vocational and rehabilitative training programmes which carry nationally and internationally recognised certification and are designed to lead directly to jobs or progression to further education.
- Irish Advocacy Network: A user-led organisation aiming to provide information and support to fellow mental health service users and to empower them to speak up and take control of their lives.
- West Cork Community Partnership (WCCP): A community development organisation with a mission statement to “develop the social, economic, environmental and cultural resources of West Cork for the purpose of improving quality of life and creating full and equal participation of all sections in the community”.
- Work Start West Cork: A FAS-funded Supported Employment organisation which helps people with learning, mental health, physical and sensory disabilities find work in the open labour market. Work Start West Cork covers the whole of West Cork with offices in Bantry, Skibbereen, Clonakilty and Bandon and services from Castletownbere through to Kinsale.

Needs identification

Following a broad and inclusive consultative process including service providers and service users and informal discussions between the partner organisations, the need for a programme that would address the needs of a particular group of individuals who have mental health difficulties became apparent. This is a group of people who have severe and enduring mental health issues and who do not effectively engage with the traditional or current services provided by the partnership organisations or

other community services. These people will not utilise the traditional service models of training and support, which are predominantly centre-based. As a result of their disengagement from services and community activities, these individuals have little or no social, occupational or leisure outlets.

The following extract from the Southern Health Board (now HSE) “*Focussing Minds*” report (2002) indicates that statistics for levels of mental illness in the West Cork area are as follows:

Prevalence of Mental Health Difficulties in West Cork Population		
	<i>Prevalence</i>	<i>No. of Population</i>
Adult Population >= 16 yrs		36,341
All Mental Disorders	20%	7,268
Depression: (Any Week)	10%	3,634
(Lifetime)	55%	19,988
Anxiety Disorders	5%	1,817
Alcohol Dependence	5%	1,817
Drug Dependence	2%	727
Schizophrenia	1%	363
Bipolar Affective Disorder	1%	363
Source: Focussing Minds 2002 Note: Total Population 2006: 53,445		

The combined experience of the partner organisations in this project has led to a realisation that the group of individuals with the highest level of need (i.e. people with enduring mental health difficulties) is currently the group in receipt of the lowest level of support and intervention. In particular, four of the six organisations have had direct experience of seeing the emerging need that is being addressed by this project. The following is a description of this experience.

The National Learning Network (NLN) has been providing services to people with mental health difficulties in the West Cork area for over 20 years. Traditionally NLN training programmes have been partly or wholly delivered in Centre. In the past number of years NLN has also developed employer-based and home-based training programmes as well as delivering training programmes in outreach locations within communities. Much of this experience has resulted in the successful engagement of individuals with mental health difficulties with NLN services, and as a consequence, it has also resulted in high levels of community integration and successful outcomes for these individuals. However, it has become apparent over a period of time that there are a substantial number of individuals with mental health difficulties who would benefit from engagement with NLN services, yet their degree of mental health difficulties makes it extremely difficult for them to engage in a consistent and meaningful way with existing programmes. For example, some individuals say that although they would be interested in attending training programmes and feel that such programmes would be of benefit to them, they would find it awkward and difficult to participate for a variety of reasons, as follows:

- Fear of change in daily routine
- Reluctance to leave the security of the home environment
- Inability to be part of a group
- Not accustomed to using means of transport, necessary to travel to a training centre
- Inability to get up in the mornings
- Lack of motivation

- Lack of confidence needed to interact with other course participants or staff.
- Would prefer a service in familiar surroundings – home or local community.

There are a number of students who commence training programmes but who subsequently discontinue for many of the reasons listed above. In nearly all cases, these individuals, who have high levels of need, return to their homes and do not have access to any further rehabilitative training service.

West Cork Mental Health Services have identified a group of their clients whom they find are difficult to engage, reluctant to attend current services, some of whom may be socially isolated and with significant disability. These people have been identified by Mental Health Services through Mental Health teams. They require a more intensive, tailor-made, individualised and home-based intervention than currently available. This intervention would be best delivered utilising the team-approach. Mental Health Services believe that this approach will result in improved mental health for the individuals, thus enabling them to engage with existing community projects and services.

HSE – Disability Guidance Services – West Cork would have very similar experiences to that of National Learning Network and Mental Health Services – West Cork, insofar as identifying a group of people with mental health difficulties who have extra needs. On an ongoing basis, they meet people in guidance interviews who are then referred to a particular service, but who then never engage with that service for many of the reasons mentioned above.

The Irish Advocacy Network (IAN) was commissioned by the then Southern Health Board to carry out a survey on the needs of users of mental health services in Cork and Kerry. Through 163 in-depth interviews held with service users in Cork and Kerry, it became increasingly obvious that a change of approach towards community, home-based services was called for. This is evidenced by the following extracts from service user comments:

"A move in the right direction would be treatment at home".

"Need more information on alternative treatments".

"Lack of support, such as Welfare Officers or Community Psychiatric nurse to keep in touch with you".

"Would prefer if I had proper care in the community and did not have to come into hospital. I work 3 days a week and find it very difficult to go back to the community and work after a spell in hospital. I feel as if I have psychotic patient written all over my forehead and everyone knows".

"Do not know what is available in services. Better information needed on illnesses".

"Activities needed to relieve boredom, computer to work with, visits maybe once a week to cinema".

"Would like more support after discharge from hospital".

"Would like the doctors to go through drugs with me to get a drug to help with the problem and to involve me in that decision".

Contributions from voluntary groups were also included in the same study, and a sample of these comments are included here:

"Additional staffing required, together with more training".

"Need to develop improved links between hospitals, GPs and voluntary groups".

"7 –day services needed on a 24 hour basis".

"Multi-disciplinary teams needed".

"Counselling services required".

"Home-based services".

"Alternative treatments – not just medical model".

1.2.2 National Context; Mental Health and Primary Care Policy

The Home Focus project clearly echoes the recommendations of national guidelines for primary and mental health care.

Primary Care

The need to work with individuals and communities to improve their health and social well-being through a primary care approach is advocated by the 2001 Health Strategy on Primary Care. The strategy sets out a new direction for primary care as the central focus of health and social services in Ireland. The aims of the proposed developments are: to provide (a) a strengthened primary care system which will play a more central role as the first and ongoing point of contact for people with the health-care system, (b) an integrated, inter-disciplinary, high quality, team-based and user-friendly set of services for the public, and (c) enhanced capacity for primary care in the areas of disease prevention, rehabilitation and personal social services to complement the existing diagnosis and treatment focus.

“The primary care team will work with local populations and other agencies to identify health and social needs” (DoH&C, 2001:26). Broadening the focus of primary care means the shift of responsibility to primary care teams for services which are currently provided in specialist care settings but which may require less extensive specialist input (ibid). This has significant implications for the re-allocation of mental health care within broader community-based services. This approach is consistent with the current directions in mental health policy and service delivery.

Mental Health Policy

The need for comprehensive, accessible, community-based mental health services has also been identified by key Irish policies and in particular the new Mental Health Strategy *“A Vision for Change”* (2006). This policy builds on previous community care policies to advocate a person-centred, holistic, community-based, recovery-oriented

mental health service. Overall, “*A Vision for Change*” proposes significant changes and improvements in mental health, with increased reliance on community-based services.

“The vision embodied in this policy is to create a mental health system that addresses the needs of the population through a focus on the requirements of the individual. This mental health system should deliver a range of activities to promote positive mental health in the community; it should intervene early when problems develop, and it should enhance inclusion and optimal functioning of people who have severe mental health problems. Service providers should work in partnership with service users and their families, and facilitate recovery and reintegration through the provision of accessible, comprehensive and community-based mental health services” (DoH&C, 2006:14).

The Home Focus project is based on principles of assertive outreach and home-based care, two of the four community-based intervention programs proposed for the effective delivery of community-based care.

Proposed Community-Based Intervention Programmes

1. Home-base care
2. Crisis intervention
3. Early intervention
4. Assertive outreach

Vision for Change 2006

Home Focus is also underpinned by a recovery philosophy, discussed in chapter two, which is a key recommendation of *Vision for Change*. The Mental Health Commission’s Discussion Paper “*A Vision for a Recovery Model in Irish Mental Health Services*” also provides a foundation for the development of a recovery approach in mental health care. The principles informing the delivery of the Home Focus project are also identified in the “*Quality Framework*”, another key document by the Mental Health Commission (2007). The “*Quality Framework*” is based on a broad consultation with stakeholders and identifies the following fundamental eight themes to mental health service provision:

1. Provision of a holistic seamless service and the full continuum of care provided by a multidisciplinary team.
2. Respectful, empathetic relationships are required between people using the mental health service and those providing them.
3. An empowering approach to service delivery is beneficial to both people using the service and those providing it.
4. A quality physical environment that promotes good health and upholds the security and safety of service users.
5. Access to services.
6. Family-chosen advocate involvement and support.
7. Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service.
8. Systematic evaluation and review of mental health services underpinned by best practice will enable providers to deliver quality services.

It must be noted however, that while "*A Vision for Change*" has been a welcome development in promoting long-awaited changes in mental health care, there are serious concerns about the process of 'making it happen'. Over two years after its publication, the pace of its implementation has received heavy criticism from user groups, doctors, psychiatrists, health professionals and mental health campaigners.

The Irish Mental Health Coalition (IMHC), a coalition of NGOs working in mental health, outlined some of these concerns at a press conference on 23 January 2008. The IMHC highlighted a number of recommendations of "*A Vision for Change*" which have not been acted upon, including the abandonment of the promised National Directorate for Mental Health; the fact that catchment areas have not yet been finalised; delays between the allocation of resources and recruitment of staff, and the fact that the implementation plan for "*A Vision for Change*" has not been published two years after the launch of the policy.

Of particular concern is the redirection of assets deriving from the sale of mental hospitals as these assets were ring-fenced for community-based developments in the

mental health sector. According to "*The Lie of the Land*", a report by the Irish Psychiatric Association (IPA, 2008) there was a "*systematic shredding of assets ...with both lands and buildings in mental health services either being given away or sold for under the market cost without any benefit to mental health services...The political system is clearly complicit in this process, either directly or more often, by silence and indifference*".

These concerns make the contribution of the Home Focus project even more significant as it is one of the few initiatives, after "A Vision for Change", providing evidence of a recovery, community-oriented, person-centred mental health service.

1.3 An Overview of the Home Focus Project

Participant profile

The Home Focus team was set up to work with people who have severe and enduring mental health issues and who typically do not effectively engage with the traditional or current services provided by the partnership organisations or other community services. The participants were primarily those identified by the West Cork Mental Health Services. The Home Focus team received a total of 49 referrals between September 2006 and March 2008. Out of these referrals, 35 individuals were suitable for and willing to engage with the programme. The following table presents the gender and age profile of the project's participants.

Home Focus Participants – Gender and Age details		
	Male	Female
16-20	2	0
20-40	11	1
40-60	12	3
60+	5	1
Total	30	5

Project's aims and objectives

The programme aimed to enable participants to enhance their mental health, independent living skills, level of connection to their own communities, quality of life, access to training, education and employment options and future planning.

Specific objectives of the home focus project included:

- The delivery of a high-quality, intensive service to 30 - 35 people with mental health difficulties.
- The involvement of users of Mental Health Services in the design and delivery of the programme.
- Assimilation of learning from the project to inform future design and delivery of services for people with mental health difficulties
- Reduced admission to Mental Health Acute Services.
- The expectation that as participants will progress to training and employment, they will become net contributors to the State and this will result in a reduction in the burden on Social Welfare payments.
- The hope that that the project will have a positive influence on service users' expectations of Mental Health services.

Stakeholders' expectations

During the evaluation research, members of the partner organisations and the Home Focus team had the opportunity to expand on the project's objectives and to articulate their expectations of the project on three different levels: (a) service-users (micro-level), (b) service provision (mezzo-level), and (c) the community (macro-level).

(a) For service users

"That for people who have been isolated or have experienced difficulties with relationships it [Home Focus] will open up ways that they can experience positive encounters and that in some way that will help them to move on in their lives; perhaps help them to stay out of hospital, perhaps help them to get involved in a meaningful activity with other people that they couldn't access prior to the service" (member of management board, June 2006).

A central expectation of the project was the provision of a service that is client-centred rather than service-centred. Stakeholders from management and staff viewed that as a way to meaningful empowerment of service users, who are considered as active participants in their care plan.

The issue of a bottom-up approach to making choices is also very important. Many interviewees stressed that both 'the need to change' and 'the kind of changes to be brought about' have to be identified by the participants themselves rather than the professionals working with them, which has been the traditional way of working in mental health. The need to recognise that expectations for every individual participant were different was also stressed.

Stakeholders also identified the contribution of the project to breaking social isolation, forming new relationships and making informed choices about use of available help and resources.

(b) For service providers

The opportunity for the Home Focus project to impact on service provision in the West Cork area was also identified. The project is considered as an opportunity to develop a holistic approach to mental health, by learning to support users to make their own choices, and by having greater co-ordination and respect between service providers. Home Focus can provide a different model of service provision, shifting the focus from hospital care. *“The service idea is that intensive work takes place at the hospital, that the hospital is at the centre of the activity of the service. What needs to happen is that we move away from that, that the community is the area of high activity and intensive working and that hospitals are places for respite care”* (management board member, June 2006).

Home Focus was also seen as an additional resource, providing intensive service to clients who have disengaged from existing services. The contribution of the project to assisting the development of knowledge at a local level and of policy at a national level was also recognised.

(c) For the community

Home Focus was considered as an opportunity to bring the community to the centre of mental health care provision. This can be done by recognising the role of the social environment in mental distress, reducing stigma and normalising the process of seeking help. The role of the recovery support worker, outlined in the next section, was seen as particularly important in engaging with the community, promoting awareness and therefore ensuring that the community is more likely to be supportive of people with mental health difficulties.

The Home Focus Team

A multidisciplinary team including a Rehabilitative Training Instructor, a Recovery Support Worker and an Outreach Mental Health Nurse deliver the programme directly to the service users. A Recovery Resource Worker is also a member of the team and works with the community, raising awareness and supporting community

development initiatives. A broad range of staff from all the partner organisations including psychiatrists, psychologists, managers, administrators and programme development officers support the Home Focus staff team.

The Home Focus Team

- Rehabilitative training instructor
- Outreach mental health nurse
- Recovery support worker
- Recovery resource worker

A partnership approach

The programme is based on a collaborative approach between the partner organisations listed in section 1.2.1. The broad range of experience and expertise pooled by this approach ensured a holistic approach to participants' needs and a high-quality, balanced programme. The catalyst for programme development was the organisations' experiences of the needs on the ground and an examination of best practice approaches that have been adopted internationally to address similar needs. This innovative model of service delivery is based on community and home-based interventions, combined with the involvement of users of mental health services in programme design and delivery.

Referrals system

For the duration of the pilot project all the referrals have come from the Mental Health Services through the Team Coordinator. These referrals originate with the Multidisciplinary Mental Health Team (Community Mental Health Nurses, Psychiatric Social Workers, Psychiatrists, Occupational Therapists, In-Patient Staff). The Home Focus Team then assesses the referrals and appropriate actions are taken.

Engagement and project delivery

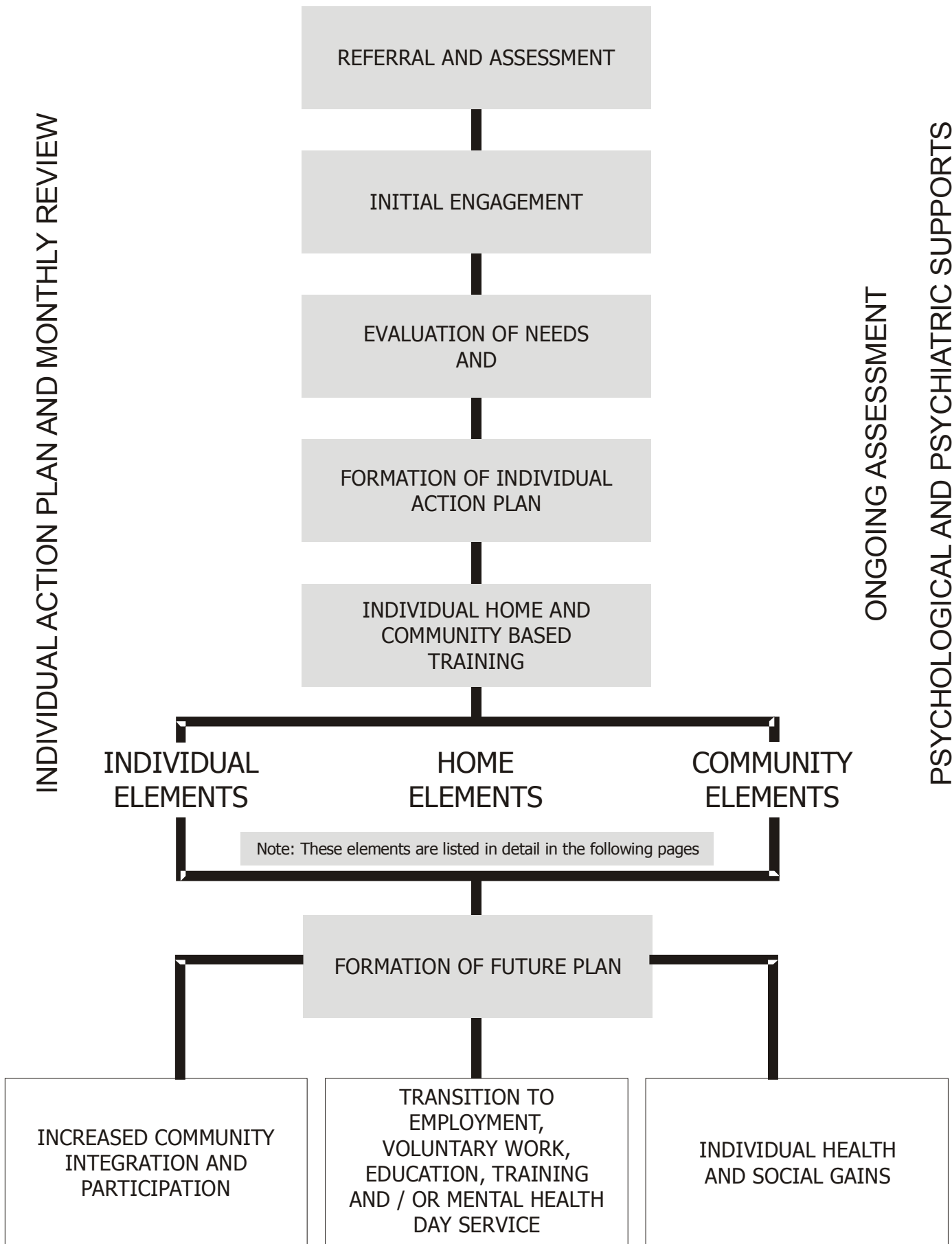
The service delivered consists of a home and community-based intervention, which has an approximate duration of between 3 and 18 months, depending on the needs of

each participant. Following referral of individuals to the programme, there is a period of engagement between the staff team and the individual, during which trust and relationships are established. During this initial stage of the programme, there is an identification of the individual's needs, strengths, supports, goals, desires, interests and barriers to achieving their future plans. Also, there is an assessment of areas such as access, transport, health, support and opportunities with a view to enhancing the success of engaging the individual in their community. Following this evaluation of needs, an Individual Action Plan is drawn up collaboratively between the individual and the staff team. The participant will then begin to work on the elements (Individual, Home, and Community) of their Individual Action Plan with the team. A continual and systematic review and revision of the plan ensures that each individual's changing needs and hopes are met (see Project Delivery Flow Diagram on following page).

A key part in the implementation of the Individual Action Plan is supporting the individual in accessing community services, supports and facilities. Examples of these include:

- Community Organisations, e.g. Rural Transport Initiative, MABS, Community Resource Centre, West Cork Community Partnership, NALA
- Support Groups, e.g. GROW, Irish Advocacy Network, Aware, Schizophrenia Ireland
- Health Services, e.g. GP, Mental Health Day Activity Services
- Community leisure facilities, e.g. Swimming Pools, Sports Centres, Libraries
- Employment Supports - FAS, Work Start
- Training and Education Supports: V.E.C., NALA, National Learning Network, Post-Leaving Cert courses, and evening courses.

PROJECT DELIVERY (FLOW DIAGRAM)



Elements of Home Focus

Based on individual participants’ needs, relevant elements from the following categories are delivered:

Individual Elements	Home Elements	Community Elements
Personal Hygiene and Appearance	Independent Living Skills	Access to:
Mental Health and Wellbeing	Health and Safety	Mental Health Services – e.g. Clinic, Day-Centre
Mental Health Management	Home Management	Medical Services – e.g. GP
Physical Wellbeing	Money Management	Support Groups – e.g. GROW, IAN, Aware, Schizophrenia Ireland, AA
Lifestyle – Diet, Nutrition, Exercise etc.	Healthy Lifestyles	Alternative Therapies
Personal Development	Familial Relationships	Employment Supports – FAS, Work Start
Confidence Building	Home Improvements	Voluntary Work – e.g. Tidy Towns, Charity Shops
Coping Skills	Access to County Council Supported Housing	Work Experience
Stress Management	Support for Change in Accommodation (if appropriate)	Training – e.g. FAS, VEC, National Learning Network
Motivation	Home-Based Leisure Activities and Hobbies	Education – e.g. VEC, NALA, IT, Night and Day Classes
Communication Skills	Home-Based IT	Leisure Activities – e.g. Gym, Swimming
Assertiveness	Home-Study Courses	Community Facilities – e.g. Banks, Library
Knowledge of Rights and Entitlements		Community Services – e.g. CWO, MABS
Self-Advocacy		Community Activities – e.g. ICA, IFA, Church Activities
Peer Support		Transport (Public and/or Personal)
Spirituality		Creative and Cultural Activities e.g. Drama, Art, Music
Individual Routine		
Time Management		
Relationships and Sexuality		
Job Seeking Skills – Application Forms, Interview Skills, etc.		
Clarification of Vocational Goals and Preferences		

Target area

The coverage area for this project is the Health Service Executive West Cork Community catchment area. It stretches from the towns of Clonakilty to Castletownbere. In 2006 the population of this catchment area was 53,445. There were 4,982 (9.32%) people with disabilities living in the area. Figures for the prevalence of mental health problems as outlined in the Southern Health Board's "Focussing Minds" Report (2002) indicate that there are 7,268 adults with mental health problems in West Cork. The difference between the two figures above can be explained by the fact that many people with mental health difficulties would not be willing to divulge this in the Census of Population form.

West Cork Mental Health Services Catchment Map & Consultants



This rural area is one of the most isolated parts of Ireland, extending over 100 miles from Clonakilty to Allihies. In general terms, economic disadvantage in West Cork closely correlates with topography and access. In this context, large swathes of land to the west and north of Dunmanway, as well as on the extremities of the region's peninsulas, represent significant challenges in achieving balanced regional development. With a fragmented settlement pattern, low population densities, poor public transport and a high dependence on car usage, the road network represents the principal means of access and transport in the region. An extensive network of roads of variable quality links for the most part the West Cork region. Outlined here is a demographic analysis of the area.

Statistics	West Cork	National	WC as a % of national stats
Population Statistics			
Total Population 2002	53,445	4,239,848	1.26%
Population Density per sq. mile (urban & rural)	42.11	60.56	69.53%
Population Density per sq. mile (rural)	27	60.56	44.58%
Household Statistics			
Total Households	18,918	1,469,521	1.28%
Household Statistics living alone			
All people 45+	3,534	344,272	
% Of Households with people 45+ living alone	18.68%	23%	
(Gender balance not available for 2006 but 2002 statistics show an even balance between males and females)			
Household Statistics retired			
Retired population	6,713	467,926	1.43%
% Of population retired	12.56%	11.03%	
Affluence and Deprivation			
Overall affluence & deprivation score 2002	16.1	17.4	
Relative affluence & deprivation score 2002	0.9	2.2	
Disability Statistics			
Persons with a Disability	4,982	393,785	1.26%
% Of total population Persons with disability	9.83%	9.28%	

The broad conclusion for the area is one of significant peripheral and rural make-up. Overall the area is more deprived than the national average, with significant deprivation existing on the peninsulas and isolated rural areas. The sparse population density and lack of services result in both rural and social isolation, which are contributing factors to mental health difficulties. The implications of the rural nature of the target area on the work of the Home Focus team are further discussed in chapter 2. 4.

1.4 The Evaluation Process

The Home Focus project was evaluated from the outset. The evaluation is concerned, in the first instance, with establishing the extent to which the original objectives of Home Focus have been achieved, how, and with what implications for future development. *“Evaluation research, as its name implies, is concerned with the evaluation of such occurrences as social and organisational programmes and interventions. The essential question that is typically asked by such studies is: Has the intervention (e.g. a new policy initiative or an organisational change) achieved its anticipated goals?”* (Bryman, 2001:40).

The design of the study was informed by the philosophy underpinning (a) current developments in mental health, and (b) the development and delivery of the Home Focus project. Echoing the recommendations of Vision for Change (2006), Home Focus provides a community-based, user-centred, recovery-oriented outreach service. In this process, service-users play key roles in defining and taking charge of the changes they want to bring in their lives. The author proposes an approach to evaluation which reflects this ethos of such a project. In a period where evidence-based practice is central to service development and delivery, this evaluation study highlights the significance of evidence constructed by the narratives of people who have direct experience of mental health services.

1.4.1 Objectives of the evaluation

The basis of this evaluation and the data collection were determined by the original objectives of the Home Focus project, outlined in section 1.3. The study was designed with the intention of focusing on both the *process* and the *outcomes* of the project, in order to provide a comprehensive evaluation of:

- (1) the impact of the project on (i) service users, (ii) service providers, (iii) community resources, and (iv) policy-making
and
- (2) the broader context in which the project was set up

It is hoped that the evaluation process will also help to:

- a. achieve clarity regarding progress, assess the strengths and weaknesses of the approach taken
- b. plan the future development of the project
- c. foster a capacity for ongoing self-evaluation
- d. address some broader policy issues permeating the administration of recovery approaches through 'home-focused interventions'
- e. contribute to a discussion on the relationship of a recovery approach and evidence-based practice.

1.4.2 Methodology: Capturing evidence of recovery

The main methodological tool employed was *qualitative* in nature. Participant observation (with *ethnographic* elements) and semi-structured interviews were employed to examine all individual components of the project. *Quantitative* approaches have also been utilised to consider demographics; participant profiles; hospital admission trends; and health and social gains measures and outcomes.

Qualitative evaluation research

Applying a qualitative approach in the evaluation of the Home Focus project was considered appropriate and compatible with the ethos of the project for a number of reasons. Firstly, qualitative research provides an “*immersion in situations of everyday life*” (Shaw & Gould, 2001: 6). In this case it allowed an examination of the participants’ experiences in the context of their everyday life, in their own environment. Secondly, a qualitative study is concerned with how people understand a given topic - in this case, ‘recovery’, ‘assertive outreach’ and ‘partnership’/ ‘community development’ approaches to responding to mental distress. Thirdly, a qualitative enquiry aims to understand beliefs and events within their social context. The term ‘holistic’ is often used to describe a commitment to examining social entities as wholes (see Bryman, 1988:44). This is consistent with the holistic nature of the service delivered by the Home Focus team.

Strengths of Qualitative Research:

- Researching people in natural settings
- Achieving a greater understanding of the respondent’s world
- Emphasising interpretations and meanings
- Humanising research processes by raising the role of the researched, allowing higher flexibility
- Presenting a more realistic view of the world.

(Sarantakos 1998:53)

As data was collected from the standpoint of the participants, an *interpretive* framework was employed to consider the service users’ subjective experiences. This subjective dimension was particularly useful in exploring how project participants defined (i) their own recovery and (ii) a positive service intervention. Furthermore, as the evaluator has been actively involved with various aspects of the Home Focus project, the evaluation is also informed by elements of *ethnographic research* and

participant observation. This is “a distinctive qualitative research strategy which enquires into social life and behaviour through first-hand intensive observation in naturally occurring settings; such research is also participant insofar as the researcher ...constitutes the primary research tool, participating in social activity in order to gain a close and unforced understanding of people’s lived experience” (Hall in Shaw & Gould, 2001:51). In the case of the Home Focus evaluation these settings included the participants’ own homes, community- based facilities and services used by the project participants, and Home Focus management and planning meetings.

Evidence

Considering the need for an evaluation framework consistent with the collaborative, strength-based philosophy of the project, the study was also informed by the principles of *participatory* research. “*Participatory research, like empowerment practice, is a strongly value-based attempt to built on strengths and to work with people who are taking control of their lives by understanding and tackling oppression and injustice*” (Dullea & Mullender, in Shaw & Lishman, 1999:82). A significant contribution of participatory research is that it can inform evaluation practice by “*placing in a wider range of hands the right to say what counts as effective, successful and desirable outcomes*” (ibid:93).

Too often, evaluation is regarded as an exercise by outside experts to measure practice interventions against ‘value for money’ and efficiency criteria instead of as a debate about interventions which might be valued by users and practitioners (*ibid*). This evaluation is primarily concerned with the impact of the Home Focus project on individual lives. Measurements developed outside this experience fail to fully capture this impact as such indicators are not connected with the lived experience of the participants.

Furthermore, the Home Focus project is underpinned by a recovery philosophy. A discussion on recovery as a individual journey of re-gaining control and meaning over one’s life, regardless of the presence of symptoms, is provided in chapter 2. However, at this point, it is important to emphasise that the meaning of recovery is closely

related to “*the struggle of survivors to have the right to tell their own stories in their own way*” (Bracken & Thomas, 2005:227). This has significant implications for an evaluation process which aims to capture ‘evidence of recovery’.

Evidence-based practice is central to service provision. Evidence-based practice relies on empirical evidence of the effectiveness of treatments, interventions or services, as such evidence is used to endorse interventions, and to provide grounds to sanction or refute new developments. This has obvious implications for service evaluation, where the questions of ‘what constitutes valid evidence of recovery’ and ‘how can it be measured’ are central. It is argued that a difficulty arises in fitting recovery-oriented services into an evidence-based culture. What constitutes acceptable evidence depends on the framework within which practice and outcomes are evaluated. When practice is primarily based on a medical model of mental health difficulties, outcomes are almost exclusively defined in medical terms e.g. symptom or hospital admissions reduction, resource utilisation and so on (see Anthony, 2001). As a result, the outcomes described do not necessarily reflect the key concepts and new meaning of recovery identified mainly in service user literature, including recovering lost potential, or regaining some degree of control, however great or small, over personal and social life (see Ramon, 2007).

As individual stories have been the main body of evidence in the re-discovery of the concept of recovery, the evaluation needs to capture the stories and claim them as valid evidence. This form of evidence, however, can often be marginalised or even discredited in a wider research community where positivist approaches assume superior status (see Ramon 2007, Mancini *et al.* 2005). However, the fact remains that personal accounts of recovery journeys over the last two decades have had a significant impact not only on service users, their families and carers but also on the formation of mental health policies. This impact is evident in the Discussion Document on Recovery produced by the Mental Health Commission (MHC, 2005) and in the consultation process informing the mental health strategy ‘A Vision for Change’ (2006).

In order to overcome the difficulties of accepting such qualitative approaches in an era where credible evidence is primarily based on positivist enquiries, Anthony et al. (2003) suggest that the notion of evidence needs to be broadened:

Recovery and evidence-based practice

"The notion of evidence-based practices and recovery-oriented services can work well together. However, if evidence-based practice research is to inform the development of recovery-based services, then the concept of evidence-based practice must be broadened. ... Recovery-oriented system designers, programme planners and clinicians must be aware that their current efforts remain guided by the best available evidence, while we accumulate the best evidence possible" (Anthony, 2003: 112).

Broadening the concept of evidence-based practice was a key aim in the design of this evaluation study. The evaluation also aimed to create space for continuing input by service users, project staff and management in the evaluation process. Claiming that the research was user-led or carried by service users would certainly be inaccurate. However, the methodology employed aimed to ensure that participants were not merely the 'respondents' to questions posed from outside but those who, by articulating and constructing the meaning of 'positive outcomes', also formed the relevant questions to capture their own experiences. This was done by building trust between the evaluator and the interviewees, by using a combination of semi-structured interviews and open-ended questions¹, and by using the service-users' narratives as the basis for identifying the key outcomes of the evaluation. In that sense, service users' input was central in deciding (a) what should be evaluated, (b) how it should be done, and (c) what the evaluation findings mean.

The evaluation data

The data for this evaluation consist of:

- (1) Documentation and literature pertaining to the project's aims and objectives.

This includes:

¹ The construction of the questions was also informed by an independent user evaluation of a model of assertive outreach in Norwich. U.K. (Graley-Wetherell & Morgan 2001).

- a. a broad review of relevant policy relating to the 'operational environment' (e.g. 'A Vision for Change', 'A Vision for a Recovery Model in Mental Health Services'), in order to locate the project in the broader context of service provision trends.
 - b. a literature review on recovery, community-based, assertive outreach and evidence-based practice.
- (2) Individual interviews with participant service-users. The questions and the schedule for the interviews are included in Appendices 1-3.
- (3) Individual and/or group interviews with the staff team. The interview questions are included in Appendices 4 & 5.
- (4) Individual and/ or group interviews with the project's management board and the partners involved. The interview questions are included in Appendices 6 & 7.
- (5) Individual interviews with two consultant psychiatrists /members of the project's management board whose clients have participated in the project (see appendix 9).
- (6) Questionnaire to the mental health team co-ordinator and management board members who were not available for interviews (questions as in Appendices 6 & 7).
- (7) Participation at management and strategic meetings where the progress of the project was discussed.
- (8) Third-party information on participants who did not agree to be interviewed by the evaluator (including interviews with staff team and management, the 'Pen Picture' reports by the staff team, and informal discussions with the staff team). Examples of 'Pen Picture' reports for five Home Focus participants are included in Appendix 8.

A chronology of the data collection process

The initial phase of the evaluation provided the baseline data against which the progress of the Home Focus project could be measured. The purpose of the baseline was to develop a profile of the Home Focus initiative with reference to the overall objectives (as outlined in section 1.3) and considered:

- The operational context of the project (mental health policy, community profile, demographics, identified needs)
- The profile/needs/ expectations /of individual service users
- The expectations of the staff team
- The expectations of the management committee

The first part of the baseline data was collected in June 2006 and involved:

- documentary analysis
- individual and/or group semi-structured interviews with the project's management committee and the partners involved
- individual interviews with the staff team

Baseline on participants could not be collected until the beginning of their engagement with the Home Focus staff team. This work started in September 2006. The question of 'the appropriate timing' to interview participants and the ethical issues regarding consent were crucial in the process. The issue was discussed in two management meetings and the evaluator had ongoing discussions with the staff team in relation to the readiness and willingness of participants to be interviewed.

Due to the nature of the relationship of the service user group with the mental health services, the priority was for the staff team to establish a trusting relationship with participants and *then* introduce the evaluator. As a result, most interviews with participants took place three to four weeks after their engagement with the project at the earliest. Therefore, all first interviews with participants collected both baseline and interim evaluation data. These interviews were largely focused on the way participants described (a) their own needs and expectations at the initial point of engagement with the project and (b) their experience of their participation in the project (see Appendices 1 & 2).

As new referrals were received throughout the course of the project, the collection baseline was an ongoing process. Overall, the evaluator interviewed 14 active participants. Some of these participants were initially unwilling to be interviewed but agreed to do so at a later stage of their involvement with the project. The remaining active participants were unwilling to be interviewed and data on their progress was collected through third-party information outlined in the previous section. Baseline interviews started in October 2006. Review interviews took place between April 2007 and February 2008. In the case of two participants who agreed to be interviewed at an early stage of the project, an interim review also took place.

Interim and final interviews were held with the staff team and members of the management board. As the first progress report on the project was produced in December 2006, interim interviews took place between October and November 2006. The final interviews with staff and management took place between November 2007 and March 2008. Both individual and group interviews were utilised, depending on availability of interviewees and interview content. In the case of the staff team, interim and final interviews took place in a group format as this stimulated a better discussion on their experience of the project.

Ethical Considerations; Informed Consent

The engagement of the evaluator with the service users-interviewees in order to establish a trusting relationship has been of crucial importance. To ensure that the evaluation would be an integral part of the project, the Home Focus management committee decided that the evaluator would be introduced to the client group as part of the project's team. At the beginning of their engagement with the project, all participants signed a form in which they consented to partake in the Home Focus evaluation.

The consent was a continuous process. An explanation of the evaluation was given to each interviewee, outlining the reasons for the evaluation and consulting them on the process. Recording methods and confidentiality in relation to data presentation were

explained. All interviewees except for one agreed for the interview to be recorded with the use of a Dictaphone. Permission was given for inclusion of the Participants' profiles in Appendix 8. Participants' consent was also sought for the evaluator to attend meetings where individual cases were discussed. To protect confidentiality, data generated from the interviews with participants is presented using anonymous direct quotes to illustrate themes such as 'training', 'leisure', 'involvement in the community' etc.

Chapter Two: Developing Community, Recovery-Oriented Practice

Developing Community, Recovery-Oriented Practice

The philosophy and practice of the Home Focus project involve a community-based, recovery-oriented outreach service in line with the recommendations of the National Mental Health Strategy Vision for Change (2006). This policy considers assertive outreach as one of the four community-based intervention programmes employed in the effective delivery of community-based care.

This chapter outlines the conceptual, policy and practice frameworks within which the Home Focus Project evolved and developed. For this purpose an examination of (a) 'community care' and 'community development' approaches; (b) recovery-oriented practice, and (c) assertive outreach as key elements of mental health care is provided. The discussion will then progress to describe how the Home Focus project developed its unique identity on the basis of these elements.

2.1 Mental Health and the 'Community'

There are different ways in which the concept of 'community' has manifested itself in the area of mental health care. The development of community-based alternatives to service provision originates in the process of de-institutionalisation and the recognition of the importance of treating people with mental health problems in their own environment. Over the past four decades, community care has become the official term to describe changing policies and practices in mental health care and to indicate a commitment to social inclusion.

In Ireland, the framework for community mental health is outlined in *Planning for the Future*, a policy document published in 1984 following a major review of psychiatric services which was carried out between 1981 and 1984. In summary, the report set out guidelines for future development as far as possible in a community setting, with the emphasis on resources being transferred from large psychiatric hospitals to a large range of alternative community-based services and to acute units in general hospitals. However, while the service was intended to engage patients with the

context of their own lives, families and communities, "the operational system of mental health services has continued to be predominantly hospital based" (DoH&C, 2006: 93).

Community care is considered to be a core principle of the new mental health policy *Vision for Change* (2006). "People with mental health problems should be cared for where they live and if inpatient care is necessary it is to be provided in the least restrictive setting" (DoH&C, 2006:15). The strategy envisages that care in the community will be delivered through Community Mental Health Teams offering "multidisciplinary home-based treatment and assertive outreach, and a comprehensive range of medical, psychological and social therapies relevant to the need of service users and their families" (DoH&C, 2006: 79).

While community-care is a popular and broadly adopted term, it is not an unproblematic one. Ife (2002:13) argues that a fundamental weakness of this approach is that "it assumes that there is an entity called 'community' in which human services can be based...This assumption is problematic as community in the traditional sense is not a significant element of contemporary industrial society...given the lack of strong community structures in contemporary western society...The central issue can be expressed as follows: How can there be community-based services if there is no community in which to base them?" However it is not just a concern about the existence or lack of communities. Assuming that community is a caring place is also problematic as the community can in itself be a mechanism of social exclusion of people who are considered to be 'different' (see Symonds & Kelly, 1998).

In recognising the importance of these social factors for people experiencing poor mental health, a community development approach has been advocated as a 'missing ingredient' to complement community-care (see Ife 2002, Henderson & Thomas 2002, Gilchrist 2004).

2.1.1 Taking a step further: A community development approach to mental health

"Community development models of mental health are particularly useful in the provision of mental health services...Services need to reach out actively to communities to find alternative paths to channel supports to individuals and families" (DoH&C, 2006:40).

The formation and delivery of the Home Focus Project is informed by a community development model. This involves an integrated approach to mental health care based on a partnership between statutory agencies, voluntary agencies and service user groups. Such a process allows for a holistic approach to care, recognising the broader context within which mental health problems arise and within which a recovery process can be facilitated.

As mentioned earlier, 'community care' is a popular though ambiguous term in mental health care. However, a community development approach is a somewhat unfamiliar area to mental health professionals. In order to fully appreciate its contribution, it may be useful to highlight some key differences between the two frameworks.

In general terms, community care aims to provide support at a community level from service providers or informal support networks. The focus of the intervention is on the individual receiving treatment. The shift of services from institutional to community settings does not necessarily lead to addressing the broader factors which contribute to mental distress. In other words, community mental health can be interpreted as 'medical care in the community', an approach that was broadly adopted in Irish mental health care. In this case change occurs in the location of care but not in the prevailing paradigm, which interprets and treats mental distress through predominantly medical/pharmacological interventions.

On the other hand, the process of change in community development is brought about by people working together to design and implement their own solutions to shared problems. *"Community development is distinguished from social work and allied welfare professions through its commitment to collective ways of addressing problems. Community development helps community members to identify unmet needs, to undertake research on the problems and present possible solutions"* (Gilchrist, 2004 in Seeboth et al. 2005:24).

A community development approach to health is *"...the process of organising and/or supporting community groups in identifying their health issues, planning and acting upon their strategies for social action/change, and gaining increased self-reliance and decision-making power as a result of their activities"* (Labonte, 1993).

A community development approach to mental health is informed by the social determinants of health models. This recognises the wide range of economic, social, physical and psychological factors that impact on the mental health of individuals and communities. It recognises that experiences of poverty, discrimination, unemployment, racism, family difficulties, sexual abuse, domestic violence and spiritual conflict have a profound impact on mental health (see Bracken and Thomas, 2005).

The Combat Poverty Agency (2007) identifies the following key principles of community development:

- **Empowerment:** Working with people to enable them to take control of decisions that affect them and their communities.
- **Working Collectively:** Supporting people to come together to identify the things they want to change in their community and to work together with others to achieve that change.
- **Participation:** People have the right to participate in decisions and structures

that affect their lives.

- **Social Justice and Equality:** Community development is concerned with achieving social change that enables individuals, groups and communities to realise their full potential, uninhibited by unfair or discriminatory social structures and systems.

Benefits of applying community development approaches to mental health

(adopted by Lynan, 2007):

- **Ensuring a genuine involvement of currently marginalised groups such as service users and carers:** Community development facilitates the inclusion of people experiencing "*inequality and exclusion in the decision-making process, not as target groups, but as strategic partners with their own specific concerns, insights and objectives*" (Lynan, 2007:14). The practice of the Home Focus project provides evidence of commitment to service-user involvement in planning their care and other areas that affect their quality of life.
- **Adopting a social model of mental health:** Recognising the contextual factors contributing to mental distress and facilitating recovery. A community development approach challenges the dominance of the medical model by engaging with the multiple dimensions of people's lives rather than focusing on symptom management. This was evident in the work of the Home Focus team by:
 - Working in people's own environments
 - Building relationships and social networks
 - Breaking down geographical and social isolation
 - Developing life skills
 - Facilitating engagement with services
 - Enabling participants to become part of the community
 - Addressing practical problems of everyday living which can hold back

recovery

- **Promoting integrated approaches:** Recognising the complex interactions between environmental factors and health leads to the promotion of integrated approaches to address the well-being of individuals and communities. The Home Focus project is a prime example of this approach, as a diverse range of expertise at both management and front-line levels allow for a holistic mental health practice.

Adopting this broader perspective of mental distress allows a deeper understanding of the process of recovery and the conditions that facilitate this process.

2.2 Recovery-Oriented Practice

"A recovery approach to mental health should be adopted as a cornerstone of this policy" (DoH&C Policy, 2006:15).

2.2.1 Recovery as a philosophy

Historically, mental health systems were based on a tradition of diagnosing and treating people with life-long psychiatric conditions with no hope of recovery and meaningful social life. The underpinning principle of this practice was that people with severe mental illness did not recover, and that the course of their illness was a deteriorative, or at best a maintenance course (Anthony, 2000).

While the concept of recovery in mental health is not a new one, during the past two decades there has been a redefinition of recovery which is of particular relevance to the Home Focus Project. This involves a shift from the literal understanding of recovery as 'absence of symptoms' or 'recovery to normality' to a process of 'recovering what was lost': citizenship, rights, meaningful roles, responsibilities, decisions, potential and support (see Curtis 1997, Crowe and Taylor 2006, Bracken

and Thomas 2005). As Roberts and Wolfson argue, the current *"redefinition of recovery as process of personal discovery, of how to live (and to live well) with enduring symptoms and vulnerabilities opens the possibility of recovery to all"* (2004:37).

This conceptualisation of recovery is primarily associated with Anthony's 1993 paper in the U.S. in which he argued that *"a person with mental illness can recover even though the illness is not 'cured'. Recovery is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness"* (Anthony, 1993:15). On a similar note, Deegan (1988) suggested that recovery is a process of taking control of one's life. This focus on the journey rather than on reaching its end is a metaphor which many users prefer (see Ramon *et al.*, 2007). This view has been adopted as a Recovery Competency by New Zealand's Mental Health Commission (2001). *"Recovery is a journey as much as a destination. It is different for everyone. For some people with mental illness recovery is a road they travel on once or twice, to a destination that is easy to find. For others recovery is more like a maze with an elusive destination, a maze that takes a lifetime to navigate"*.

While acknowledging the uniqueness of this journey it is important to be aware of the common themes in recovery stories. Such themes include a sense of hope, a vision of the life people want to live, seeing and changing patterns, finding new ways and reasons, and being in charge of wellness (see Crowe and Taylor, 2006). A further dimension of the recovery approach is its organic link with the service user/survivor movement. For the survivor movement, recovery is about having a voice. As Bracken and Thomas argue, *"through social action, the survivor movement has created safe spaces in which individuals can start the process of telling their own stories...the meaning of recovery is very closely tied to the struggle of survivors to have the right to tell their own stories in their own way"* (Bracken & Thomas, 2005:227). A recovery approach does not involve the implementation of technical measures. It is a

philosophy requiring a fundamental shift in understanding, responding to, and being with mental distress. In this shift, the voice of the service users in defining their own recovery is central.

The Home Focus Project has provided a safe space for the participants to tell their stories and more importantly to realise that they do have desires and hopes for their lives. As discussed in the methodology section, the voice of the project participants in constructing the meaning of their recovery has been central to the evaluation of the project. Chapter three presents these stories and voices as the main evidence of the project's positive contribution to the lives of the participants.

2.2.2 Policy developments

Strong interest in incorporating the recovery philosophy into mental health care and service provision is evident in the United States, New Zealand, and more recently in the U.K. In the U.S., public policy has embraced the concept of recovery, and the President's New Freedom Commission on Mental Health (2003) places the concept of recovery at the centre of a transformed mental health system (cited in MHC, 2005). In New Zealand the Mental Health Commission defined the principles of recovery in their *Blueprint for Mental Health Services in New Zealand* in 1998, and further elaborated this approach with the publication of the *Mental Health Commission Recovery Competencies* (2001). The U.K. developments in recovery have been linked to disability and anti-discrimination legislation, the social inclusion agenda, the emergence of the service user movement, and broad initiatives in support of the Department of Health's Expert Patients programme. In 2001 the Department of Health issued the National Service Framework for Adult Mental Health entitled *The Journey to Recovery - The Government's Vision for Mental Healthcare*.

In Ireland, the consultation process leading to the new Mental Health Strategy *Vision for Change* (2006) identified the need to adopt a recovery perspective at all levels of service delivery. As already discussed, *Vision for Change* promotes a community-based service whereby Community Mental Health Teams (CMHT) would adopt a

recovery model and involve users and carers at every level of care planning and delivery. Momentum for change is also evidenced in the Mental Health Commission's discussion paper *A Vision for a Recovery Model in Irish Mental Health Services* (2005). This paper provides a comprehensive review of recovery literature and provides a foundation to consider how mental health services in Ireland could incorporate the recovery approach.

However, as already discussed, the process of change in the Irish mental health system is slow. Partners to the Home Focus Project expressed their concerns about the resistance to change, the lack of co-ordination between various services dealing with mental health, and the stigma attached to mental illness. "*Evidence that mental health services on the ground are actually willing to take up the radical agenda is very patchy. There is actually evidence of substantial resistance to change. It is very positive that...the Mental Health Commission adopted a recovery model and that senior people in the Department of Health and the HSE endorse radical changes. It will be a challenge to make that happen*" (member of management board). Two years after the publication of *Vision for Change*, interest groups of service users, professionals, and mental health campaigners have expressed their concern about the lack of progress in implementing the policy recommendations (see IPA 2008, IMHC 2008). These concerns are outlined in chapter one.

The most significant contribution to recovery initiatives in Ireland emerges from service user groups and organisations such as the Irish Advocacy Network and voluntary organisations such as Schizophrenia Ireland. Evidence of change towards recovery-oriented practice can be found in participatory research projects such as the *Pathways Project*, the first user-led research on people's experience of the mental health system in Galway (see Brosnan *et al.* 2002); *The Views of Service Users* Report (Making Minds Matter, 2004); *What we Heard* (Crowe, 2004) and *Talking about Choice* (Schizophrenia Ireland, 2006). A review of further projects incorporating a recovery ethos is provided by the Mental Health Commission's discussion paper on recovery (MHC, 2005).

The Home Focus project is clearly based on a recovery philosophy, engaging with people in the context of their lives, facilitating them to decide how they want to move on with their lives. As the staff team has 'reached out' to meet people 'where they were at' in their own communities, an assertive outreach approach has also informed the formation and delivery of the project.

2.3 Assertive Outreach

"...Assertive outreach teams providing community based interventions should be the principal modality through which these teams work" (DoH&C, 2006: 195).

2.3.1 Background and International Developments

Assertive (Active) Outreach (AO) originated from the U.S.A. de-institutionalisation project in the 1970s and was initially designed to help mental health patients develop the skills necessary for independent living in the community. The routes of the approach can be traced in Stein and Test's model of home-based treatment in the U.S., an alternative approach to psychiatric hospitalisation (see Stein & Test 1980, in Killaspy *et al.* 2006). Treatment was tailored to individuals' needs, focused on helping them to develop independent living skills, and took place in the community rather than the hospital (see Test & Stein 1978, Sainsbury Centre for Mental Health 2001). This gradually evolved into two specific models - assertive community treatment and crisis resolution. Assertive community treatment has gained popularity amongst those working with service users who have problems engaging with services but for whom mental health care is essential. Systematic reviews concluded that when targeted at high users of inpatient services, assertive community treatment reduces the costs of care by decreasing frequency and length of admissions. Other positive outcomes include increased engagement with services, more stability in accommodation and improved satisfaction for service users and their carers (Killaspy *et al.* 2006).

Assertive outreach was further researched in Australia in the 1980s and was then introduced in the U.K. in the early 1990s. In 2002 the U.K. Department of Health,

Social Services and Public Safety (DHSSPS) identified the introduction of assertive outreach as one of its priorities for action.

In Ireland, the new mental health policy 'Vision for Change' considers assertive outreach as one of the four community-based intervention programmes employed in the effective delivery of community-based care, and a key principle underpinning the rehabilitation and recovery mental health team. Vision for Change defines the central principle of assertive outreach as "*the provision of individualised, focused and proactive care to service users to minimise the risk of disengagement and to maximise the recovery process*" (DoH&C, 2006: 108).

Definition

Assertive (Active) Outreach is a "*way of working with an identified client group of severely mentally ill adults who do not effectively engage with mental health services. The approach is characterised by work with clients in their own environment, wherever that may be*" (Sainsbury Centre for Mental Health, 2001:2). It is a flexible and creative team-based approach to working with the complex needs and wishes of service users in their own environment (see Graley-Wetherell & Morgan 2001).

The flexibility of the approach allows for services to be provided to people who may not otherwise receive them, in a place where they feel most comfortable. Staff may also visit or accompany service users when they use other services in the country. This encourages a two-way engagement that helps to develop trust and rapport and to establish links with other agencies (Sainsbury Centre for Mental Health, *ibid*).

The relationship between staff and users is central in this process, and assertive outreach staff expect to have regular contact with the client group, however difficult that may be. Assertive outreach workers aim to build a trusting relationship with clients in a flexible, creative and needs-focused way that enables the delivery of a care package which fits each client's individual needs (*ibid*).

Aims

Assertive outreach services aim to help clients to:

- reduce the frequency and duration of hospital admissions (especially for social rather than psychiatric reasons)
- find and keep sustainable accommodation
- sustain family relationships
- increase social network and relationships
- improve their money management
- increase co-operation with treatment
- improve their daily living skills
- undertake satisfying daily activities (including employment)
- improve their general health
- improve their general quality of life
- stabilise symptoms
- prevent relapse
- receive help an early stage.

(adopted from The Sainsbury Centre for Mental Health, 2001).

Core Characteristics

- It is multidisciplinary, comprising a range of professional disciplines (nurses, psychiatrists, social workers at a minimum; also, depending on user-needs, support workers, workers who have also been service users, psychologists, occupational therapists, housing workers, substance misuse specialists and vocational specialists)
- Improved client functioning (in employment, social relations, and activities of daily living) is a primary goal
- There is a low ratio of service users to workers (usually ten clients per case load)
- There is more frequent and more intensive client contact compared to that of standard community mental health teams
- An emphasis on engaging with clients and developing a therapeutic relationship

- Treatment is individualised
- Offers or links to evidence-based interventions
- Work with people in their own environment, often their own home; engagement with the users support system of family friends and others
- A team approach that provides flexible and creative support to the individual case co-ordinators

(adopted from The Sainsbury Centre for Mental Health, 2001 and Burns & Finn, 2002)

2.3.2 The Effectiveness of Assertive Outreach - the International Experience

Assertive outreach is one of the most widely researched models of mental health provision, with a strong evidence base for its effectiveness.

Systematic reviews in the U.S.A., Australia and the U.K. concluded that when targeted at high users of inpatient services, assertive outreach reduces the costs of care by decreasing the frequency and length of admissions (see Marshal *et al*, 2000, Mueser *et al*. 1998). Other positive outcomes include increased engagement with services in the community, more stability in accommodation, and improved satisfaction for service users and their carers (see Marshall *et al*. 2000, Killapsy *et al*. 2006).

The following table is adopted by Stein & Santos (1998) and Davidson (2007) and summarises the key findings on the effectiveness of assertive outreach programs from various international studies.

Table 1: International Research on Assertive Outreach (AO)

(adopted by Davidson, 2007)

Year	Site	Investigators	Psychosocial and Clinical Outcomes
1973	Madison, Wisconsin	Marx, Test and Stein	AO more effective (5 month trial) in reducing use of hospitals and ER's, in improving residential status, and in preserving occupational status
1980	Madison, Wisconsin	Stein, Test and Weisbrod	AO more effective (12 month trial) in reducing use of hospitals, nursing homes, and law enforcement services; in improving residential status, socialization, instrumental functioning, and symptom profiles
1983	Sydney, Australia	Hoult and Reynolds	AO more effective (12 month trial) in reducing use of hospitals and ER's; in improving instrumental functioning, symptom profile, residential status, and occupational activity
1992	London, England	Marks, Muijen, Connolly et al.	AO more effective (20 month trial) for symptoms, social functioning, patient and family satisfaction, and reduced use of hospitals
1994	London, England	Audini, Marks, Laurence, et al.	AO treated subjects in study above randomized into AO or standard services with only significant difference at 45 months being increased family and patient satisfaction
1992	London, England	Merson, Tyrer and Onyett	AO more effective than usual hospital aftercare (3 month trial) regarding symptoms, satisfaction with services, and reducing use of hospitals
1992	St Louis, Missouri	Morse et al.	For homeless sample, AO more effective for satisfaction with program, number of days homeless, and use of community resources
1992	New York, New York	McFarlane et al.	AO plus family psychoeducation more effective in reducing use of hospitals and facilitating and maintaining client employment
1996	Australia	Sanderson et al	More users maintained in treatment longer than in routine case management; Fewer admissions involving the police; Fewer involuntary admissions; Significant improvement in functioning over 12 months in Living Skills Profile cases
1998	Australia	Hambridge & Rosen	35% decrease in hospital admissions; 62% reduction in number of bed days; Increase in number of users in stable accommodation
1999	Bradford Home Treatment Service, UK	Cohen, B.	81% surveyed preferred home treatment to in-patient care; 79% felt they were better able to cope with their problems; in the first 12 months –25% reduction in hospital admissions
2006	REACT London	Killaspy et. Al.	Satisfaction with services, symptoms, social functioning, needs, quality of life, engagement, medication and alcohol/drug misuse
2007	Belfast, Northern Ireland	Davidson, G.	51% reduction in hospital use; improved engagement with services; reducing perceived coercion; minimising risk for coercive services; engaging high-risk clients

2.4 An Emerging Identity for the Home Focus Project

Home Focus has been set up on a model of an assertive outreach team providing individualised treatment to service users who have disengaged from services in their own environment. While Home Focus has moulded ideas of assertive outreach (as implemented in the U.S. and the U.K.) into its philosophy and practice, it has also developed its own unique identity. This identity is a constellation of variables including the philosophy informing mental health provision in West Cork, the diversity of the staff and management teams, and the geographical and social characteristics of the target area. This distinct identity is evidenced in:

- The application of creative, strength-based engagement strategies
- The provision of a holistic, non-medically driven service
- The provision of a service in a rural context where issues of isolation and limited access to services is pertinent to the experience of service users.

2.4.1 Creative, strength-based engagement

The term 'assertive' can be interpreted in different ways, which may also imply various degrees of involuntary treatment and coercion in the community. While this discussion goes beyond the purpose of this report, it is important to be aware of some critiques of AO, particularly in relation to coercion in the community, which can be more subtle than in institutional settings. Assertive Outreach has been criticised as being a quite coercive form of intervention (see Diamond, 1996; Gomory, 1999; Spindel & Nugent, 2000) which could be potentially damaging in terms of human rights and self-determination (see Spindel & Nugent 2000, Davidson & Campbell 2007). These concerns are particularly relevant to practice contexts where Community Treatment Orders (CTOs) are in operation. On a more positive note, a recent study in Northern Ireland showed that AO appeared to be more successful than community mental health teams in reducing perceived coercion among service users (Davidson & Campbell, 2007).

Burns and Firn (2002) argue that assertive outreach can be divided into constructive, informative and restrictive approaches. Constructive approaches include befriending and strengths-focused interventions; informative approaches involve persistent efforts to acquire information about the clients, and restrictive approaches include the use of statutory powers such as involuntary admissions and community treatment orders.

In the case of the Home Focus project, 'assertive' manifested itself as a constructive approach, employing persistent and creative engagement without violating the rights of users 'to say no'. This was evident in the practice of the team who showed remarkable perseverance in their engagement, particularly in cases of participants who would not answer the door or wouldn't would not feel like talking to them. Rather than interpreting this as rudeness or rejection "*the staff team would go back to try to find something that the person identifies as, something that can help them - can be housing, leisure, advice on benefits or help them to get their house done up - whatever it is and establish a trusting relationship*" (management board member, December 2007). Examples of such practice are provided in chapter three. The participants also said very clearly that the engagement was positive and respectful of their wishes, choices and pace.

2.4.2 Non medically-based, holistic interventions

Participants, staff and management of the Home Focus project articulated the holistic nature of the approach taken. During the baseline interviews, a clear distinction was made between Home Focus and the U.S. model of AO which is mainly used "*as pharmacotherapy giving depo [injections] at home*" (management board member). As another management member put it "*a lot of assertive outreach is over-medical...just moving the medical [care] out in the community rather than having a fresh look at things*".

On a similar note, it was stressed that considering a reduction in admissions as a primary goal of the project represents a narrow medical view of AO. "*Our primary goal is to improve participants' quality of life... reduction of bed occupancy may be a*

result of this improvement. Already ... admissions have been significantly reduced in the Bantry hospital” (management board member).

Another important point is the distinction made between Assertive Outreach and Home Based Treatment. “... [AO is] *a multifaceted approach to working with individuals in their homes and in their communities, but ... there is a clear distinction particularly for assertive outreach work that’s based in the home and home-based treatment which is what mental health services mainly provide....home-based treatment...is literally moving the location in which treatment is being delivered from a hospital setting to a home setting, where that the nature of the work involved in assertive outreach is a much broader... and multifaceted approach to the individual, and working with the individual on a broad range of areas” (management board member).*

This multifaceted approach was evident in the testimonies of participants and staff who engaged in activities ranging from counselling and home study courses to social activities in the community and home restoration projects. Taking such an approach was facilitated by the diversity of the staff team and their willingness to work creatively beyond the confines of their job descriptions.

2.4.3 The rural nature of the project

“Rural disadvantage may take the form of poor households in rural areas but there are several problems that can disadvantage a rural community, including a lack of services or a threat to services, because of declining population or dispersed population, a lack of employment opportunities, relatively poor transport, and high incidence of isolation and loneliness” (DoH&C, 2006:38).

The Home Focus project covers large rural areas with low population densities, in one of the most isolated parts of Ireland. As discussed in chapter one, economic disadvantage in West Cork closely correlates with topography and access. Key characteristics contributing to social disadvantage in the area include:

- Fragmented settlement pattern
- Weak urban structure
- Low population densities
- Poor public transport
- High dependence on car usage
- Poor road network
- Lack of community services and facilities
- Poor access to services

The rural nature of the target area has significant implications for the work of the Home Focus team, as access to people living in isolated areas is poor. Furthermore, linking participants to community resources may be difficult due to the lack or the inaccessibility of such resources. In addition, the Home Focus project is delivered by a small team covering a large geographical area. This means that there is significant travel time involved, with an average of 637 kilometres weekly. This has implications for the team's workload and the availability of space to accommodate new referrals.

Rural mental health

The broader theme of mental health in a rural setting has been of particular interest to academic researchers. Philo *et al.* (2003) identify three thematic concerns in the literature of rural mental health. The first tackles *rural incidence*, enquiring about the prevailing types of mentally ill health in rural populations, tracing causes, considering the risks associated with rural areas and the variety of stress factors such as isolation. Such studies also broaden the focus on incidence to consider the "*possible influences on the manifestations on mentally ill health within given rural areas*" (Philo *et al.*, 2003).

The second thematic concern tackles *rural services*. Such studies focus on how rural populations are under-serviced with an unequal distribution of resources. The enquiry targets issues of (in)accessibility, distances of travel, transport costs and related matters. Of particular interest are the resultant stresses on mental health staff and

users, which rarely affect those involved in urban mental health systems (Philo, 2003, Bachrach, 1983, 1985 in Philo 2003).

The third thematic concern tackles *rural lifeworlds*. Such studies enquire more closely into the everyday life of people with developing and diagnosed mental health problems as they struggle to cope with everyday living in rural areas (Philo, 2003). One remarkable contribution in Ireland is Nancy Scheper-Hughes' (1979) ethnographic study in a village in the West of Ireland. She identifies impaired family communication, child-rearing practices (particularly the mother-son relationship), religious scrupulosity and fear of sexuality as keys to understanding the experience of 'madness' in rural Ireland. Furthermore, Scheper-Hughes (1979) proposes the social construction of 'madness' suggesting that "*there were appropriate and inappropriate ways of 'going' and 'being' mad in rural Ireland*" (Scheper-Hughes, 2000:122). As a result she argued that "[e]xtreme eccentricity was allowable, even coddled, if it could pass as harmless 'foolery' or if it came wrapped in the mantle of Irish spirituality" (*ibid*), yet there were certain boundaries of "*speech and action whose transgression would lead to the attribution of madness and the possible interventions of local social control agencies, including removal to the nearest mental hospital*" (Scheper-Hughes 2000, in Philo 2003). In the context of a disintegrating 'subsistence-based peasant economy' in rural Ireland, Scheper-Hughes' account is usefully complemented by Saris' (1996, 2000) insights into how elements of a pre-modern culture in rural Ireland could merge with distinctly modern and rational calculations based on utility, money and the bureaucracy of psychiatric institutions (see Philo *et al.* 2003).

The incidence of mental health problems, accessibility and availability of services, and lifeworlds in West Cork Communities are key contextual factors in the life of Home Focus participants. The next chapter examines the impact of the Home Focus project at individual, local and service levels.

Chapter Three: The 3-dimensional Impact of Home Focus; Evaluation Findings

Introduction

This chapter constitutes the main body of the Home Focus evaluation and is based on the fieldwork undertaken as part of the study. This part of the evaluation is designed to examine the impact of the Home Focus project at three different levels: (a) service users (micro-level); (b) services providers (mezzo-level); and (c) the community (macro-level).

This chapter discusses experiences of the project (at the three levels) from the point of view of service users, Home Focus staff and management. Furthermore, feedback on operational and administrative issues is considered.

3.1 Micro-level; Impact on service users

This part of the report discusses service-users' experiences of their participation in the Home Focus project. The first section outlines the participants' expectations from the project as articulated in (i) the interviews with them and (ii) the feedback of the staff team. This is followed by a summary of the gains achieved by participants since their engagement with the project. Then the views of service users, staff and management are considered.

3.1.1 Service users' expectations of the project

A significant factor that needs to be taken into account, when considering participants' expectations of the project, is that many of them have had a history of enduring mental health problems. It is well documented that through such history people's lives are primarily defined in terms of their 'illness', which leads to a lack of hope of living a life where they can make plans and have choices.

The Home Focus project provided a space where most participants could articulate desires and make some plans for the future. Through the interviews all participants expressed a sense of hope for the future. Studying the 'Pen Picture' report also showed that most participants indicated their aspirations for the future. On some

occasions, while participants did not articulate aspirations, they expressed an openness to learn about the potential benefits from their involvement with the project. A number of participants were clearer about their expectations a few months after their engagement with the staff team.

A vision for recovery

All interviewees indicated a hopeful vision for the future. This was expressed through plans to become more independent, improve the social aspect of their lives, get/feel better, link with services, or simply do something they are interested in.

It is important to note that through the interviews, they communicated that they experience a *sense of possibility*; in other words, things they consider important are possible to happen. Participants identified a diverse range of interests and a desire 'to have a go' at things such as art, going to the gym, joining an interest group, further education and training, and getting a computer.

Developing skills for independence and self-care

Specific expectations of participants included skills development and training as an avenue to becoming more independent and planning for the future. Such plans could involve a career, employment, or just better self-care and a better sense of self. People expressed a desire to be able to look after themselves; for example, one participant joined a home management course, hoping to address some of the difficulties he has with tasks such as using the washing machine or the frying pan. Another participant was hoping to get their own place, while other plans included doing specific courses in areas such as computers, maths and horticulture.

A better lifestyle

Also, while not explicitly articulated by all participants, a plan for improvement in lifestyle was underpinning all interviews. Some participants had concrete plans about such improvements; for example, one participant was hoping to lease his land as cattle caused him difficulties and he was not able to work outside the farm or get a job: "*I suppose to have a better lifestyle, and lease the whole lot of the land, and*

get some class of a handy jobeen, I'd have a better lifestyle then, I'd have my wage every week then". Another participant talked about plans for home improvements, which would also improve his quality of life by having bathroom facilities in his house. Others described aims such as starting to go for a walk, going out on their own, moving out of the house more and linking with the community through activities such as going to the gym or to a local football match.

But also questions about 'quality of life' indicators

It is interesting to note, however, that some clients challenged the concept of 'quality of life' in their initial interaction with staff, as they did not see any problems in this area. This issue highlights how professional perceptions and definitions may misrepresent the way that service users perceive their lives. It also highlights the importance of user-defined rather than professional-defined plans and outcomes.

Employment

A number of people expressed a wish to find employment, mostly part-time. Some participants also indicated the need for support in seeking employment. Not all participants considered working or starting to go out of the house as an immediate possibility; however, some of the interviewees reviewed this position during the course of their engagement with the project and as their confidence grew they were in a position to consider either full-time or part-time employment. Overall, most participants seemed to appreciate the social aspect of the project and the possibilities this opened to them, including the possibility of employment.

Social and community contact

A significant number of participants articulated a desire for more social contact, such as 'going out more', socialise more, find new interests, going to the library, going to a local football match, going to the cinema, accessing public transport, or simply by going out for a walk. Participants also expressed hopes to find and pursue new interests. A number of people also look forward to the contact with the staff-team, as it is for them a significant, and in some cases the only, personal and social relationship.

When evaluating 'community engagement' it is important to make a distinction between 'engaging with the community' and 'being part of the community'. While many people do not engage with community groups and services, they can still be part of the community. In that sense, plans for more socialising, getting a driving licence or accessing public transport are valid indicators of a willingness to be 'part of a community'.

Engaging in the process of identifying tasks and personal development

Articulating a concrete plan for the future, however, is not the only way to evidence a sense of hope and possibility. While some participants articulated expectations of achieving concrete tasks, others focused more on issues of personal development and learning how to cope with 'mental illness', symptoms and medication. One person made reference to anxiety management, while another participant said they would like to 'get their mind working again'.

One of the participant interviewees provided an interesting insight by saying that at the moment he is primarily interested in himself and while he is aware that '*maybe that's bad thing*', he also indicated that he is now learning about himself in a way that can help him improve his life. Further on, the same person articulated that part of an inability or unwillingness to express hopes is that "*this [expression of hopes] can accelerate my stress... by expecting too much too soon. Well maybe that's part of the problem too, looking for everything at the same time... you know... maybe that's part of my make-up, I kind of look for too much at the one time, maybe most people are like that, but well [staff member] was saying to take it in small bits you know, and work towards a goal or whatever like you know. Try to achieve something small first*".

Awareness that change is a slow process

It is also important to stress that people showed an awareness that their plans and expectations may be slow to materialise. Awareness that change takes time was well articulated by one participant who described himself as '*lethargic*', and while he wants to move out of that state, he is clear that it is a slow process and that he needs time.

"Well I suppose in time maybe, maybe things like getting out of the house more, and trying to get out of my comfort zone... So maybe to try to get out of that you know and, in time kind of what you're looking at is in the end is to get a bit of part-time work or something, maybe that, down the line, kind of after a while like, work towards that you know".

Two of the interviewees were very vocal about the need to pace changes in their life and recognised that it will take time to change patterns in their everyday lifestyle.

3.1.2 Gains achieved by participants

The following table provides a summary of the gains achieved by the project's participants since their engagement with the Home Focus team. The figures are presented as a percentage of the total numbers on the programme

**Gains Achieved by Participants
(as % of total numbers who participated in the programme [35])**

<p>Health & Social Gain: (e.g. improved decision-making, better daily routine, improved sleep patterns, increased social interaction with family, friends and professionals, improved social skills)</p>	89%
<p>Improved Social Engagement: (e.g. established means of transport – car, taxi, bicycle, public transport - allowing increased community access to shops, services and businesses; developed routine in the community – hairdresser appointments etc.; playing indoor soccer)</p>	72%
<p>Links with Community Groups and Support Organisations: (e.g. GROW, Aware, Rental Accommodation Scheme, Drop-in centres, involvement in fundraising for local hospital)</p>	40%
<p>Improved Mental Health: (e.g. Marked reduction in paranoia and suicidal ideation, better understanding of medication and own mental health, improved ability to communicate re. mental health, enhanced awareness of mental health issues such as stressors, highs and lows, etc., improved ability to seek help and support, reduced incidence of crises)</p>	69%
<p>Improved Independent Living Skills: (e.g. Buying and driving a car, taking the driving test, using taxi & public transport, using a bicycle, moving to independent accommodation, shopping, dealing with government bodies, increased awareness of rights and benefits, increased telephone use, improved functional literacy in social settings e.g. restaurants)</p>	71%
<p>Employment: (e.g. starting full-time or part-time employment)</p>	11%
<p>Further Training: (e.g. attending a full-time or part-time training course)</p>	14%
<p>Certification: (e.g. working towards an accredited award, such as FETAC, ECDL)</p>	6%

3.1.3 Stakeholders' views on the project

All participant interviewees stressed that they felt more comfortable working in their own environment. They also felt respected and supported by the staff team. The time afforded to them was a new but welcome experience.

A flexible individualised service beyond psychiatric labels

Participants and project staff described Home Focus as a flexible individualised service, which met people 'where they were at' with no pre-conceived ideas about diagnostic categories "...*that's one of the strengths of the project – that we do approach the individuals as individuals first and foremost, and everything comes from that then afterwards. It's not... this person has been diagnosed as schizophrenic so we'll do this, this and this, it's always about the individual first and then from there on*" (staff).

"When people with the same diagnosis on paper will have totally different recovery journeys, and want totally different recovery journeys, and for some people it may be appropriate for them to address past issues whereas for other people that could be the absolute worst thing for them to do, and I think it's again the nature and flexibility of the project is that we can address some of that" (staff). Participants also spoke extensively about how they felt the staff team met them as human beings first and foremost.

"From a service user point I think that they [participants] did receive a more intensive input which was sustained, it was over and above what the ordinary service could provide, it was tailor-made to them, it was highly individualised and considerate of their own particular needs in the ways that the ordinary service couldn't quite extend to in a sustained way" (consultant psychiatrist & member of management team).

Inspiring hope

"[The project] helped me to be positive about certain aspects of my life, and certain directions... to reappraise things" (project participant)

As said in the previous section, while not directly mentioning the word 'hope', participants made reference to future plans and articulated a hopeful vision for the future. All service user interviewees expressed a desire 'to do things' that are meaningful to them.

Being treated with respect

Service users felt that they were treated with respect, particularly when comparing their experience of the Home Focus project to previous experiences of mental health services. They particularly appreciated that their relationship with staff allowed them the space to start working things out for themselves. Participants reported a sense of control over their choices and plans for the future, and they appreciated that plans were not made *for them* by staff.

"..with other people in the [mental health] service, ... they might be a bit pushy or they might tell you do this, or do that or, where I think it's better to work it out for yourself - kind of, because it's kind of you that knows your own mind you know".

Participants also felt that while staff encouraged them to move on, they also respected 'the way they were at the moment'. As one person put it *"... they [staff] always ask me why don't I go out more and I don't [feel I have to] give them any legitimate excuse"*.

Participants also recognised that respectful engagement is about genuine relationships and about being real. *"I could be told what I don't really want to hear, but I would still come away from that feeling positive to some degree, not humiliated, not belittled, not patronised"*.

Being listened to; being valued; having choices

On a similar note, being listened to and being valued was a new experience for many participants. Most participants stressed that they set the agenda during their meetings with the staff team.

"They kind of let you do the talking you know, they listen to you instead of you listening to the mental health services people, which most people are fed up of listening to...(laugh) being told what to do you know".

"... it's people listening, you know that is the biggest thing because I felt up until seeing [staff names] that nobody really listened. You'd talk to them [other professionals] and you'd say my arm is hurting and right ok – well fine see you next week."

Participants overall felt that staff met them 'where they were at' and started working with participants' own interests and expectations. The staff and management teams also confirmed that project participants are being empowered through a new experience with staff where their opinion is valued; staff said that initially some service users were fearful that staff would "go and tell them what to do" but "we [staff] would have said, well that's not really how it works, we're interested in your opinion and what you would like to do different, and how it might be achieved together, and that was a new perspective for them, and ...one or two of them kind of said they felt the whole thing was to empower [them]. That was different for them, the first time that their opinion might have been asked about their situation".

Time and availability of staff

"I never met anyone with so much patience in all my life" (participant about staff member).

Service users, staff and management said that the amount of time staff spent with participants was a big asset. It was possible for staff to get to know participants in the context of their lives, as opposed to traditional services where 'you get 5-10 minutes

[with your psychiatrist] *in the most*' or 'a maximum of *20 minutes with the CPN once or twice a month*'. Participants stressed the significance of time in building a relationship.

... "definitely you have to give people more time anyway, you're not going to get to know somebody in five minutes, you're not going to know how they are feeling ... you know".

" [staff member] was here for about two hours and it's good in a way because you get to know the person. It's more friendly kind of thing".

"And I always know that I have [staff member] to call on, you know, and it's different from the mainstream psychiatry services, you know [staff member] is more of a friend you know".

"I think what they're doing at the moment is spot on, you know they are there for you when you need them, like I can text them, I can phone them if I want to, and ... they come back every week, a lot of the other people don't and they've certainly proved to me that they don't".

"I just can't stress how important that is, to know that I have that connection there you know, and to know that they are good to their word and they will be up and they will talk to you, and they'll spend two or three hours if necessary and things get sorted out... So the issues I had on Monday when I wanted to speak to the psychiatrist, I don't feel it's so urgent today..."

The importance of time available to participants was also recognised by the staff team: *"I suppose the strength we have is that we have time – we can give somebody time, and when somebody is given time they feel valued, and that in itself then, if somebody feels valued they feel better about themselves, they feel more motivated, and continue on their journey towards recovery, but if somebody is watching the*

clock and gives somebody 5 or 10 minutes, it's very demoralising for the person, so we have that strength in that we have the time available".

A number of participants described the availability of staff as surprising. As one person put it *"it's very surprising – 2 hours like and they didn't seem to mind like – I hope they're getting well paid for it".* Staff also talked about participants' responses to their availability. *"At the start there would have been several occasions where we would have been in a house and somebody would say to us, your hour is up, assuming that we had only an hour to spend with them – but we'd say look we're here as long as you need us to be here".*

Intense support was not the rule for all participants. Home Focus participants had various degrees and forms of contact with the team depending on their needs. Some kept in touch by texting and by meetings on a needs-led basis, rather than a regular basis, which is also very important. In many cases participants talked about appreciating the responsiveness of the team when they expressed the need for a meeting.

Another angle of this is the persistent engagement of the staff team with participants, while also respecting people's choice not to engage. As one participant put it *"...[staff name] religiously phones me several times a week... sometimes she doesn't catch me, but keeps in contact until she makes contact, and then makes an appointment to come and see me – she is always there, and says she will be. And you know sometimes she stays an hour, and I can just tell her any of my problems, and I do get on with her, so you know you never feel totally alone".* People also appreciated that they were in charge in terms of meeting the team. As one participant said *"saying 'I don't feel I need you now' is a perfectly acceptable thing to say".*

Consistency of staff and continuity of care

Participants talked about the importance of their consistent contact with same staff in comparison with the mainstream mental health system where there is a regular change of psychiatrists in the outpatient clinics and hospitals. As one participant said, *"inside in hospital you're kind of caged in...and they change their doctors, you get to know one doctor, and just about when you're getting to know the guy, you know because I have to go and see a psychiatrist every month, you get to know him and what do they do - they go and change him"*.

Continuity of care was also identified as a strength by participants *"I think it's a brilliant service really because a lot of people leave hospital and [while] they might have some contact with the psychiatrist sources for a short period of time but then that fizzles out and then, [staff] just keeps on coming you know, and there's just no limitation, so if I feel suicidal I can phone [staff], if I felt anything I can phone..."*.

Time to work at individuals' own pace

Participants appreciated the way their pace of 'working things out' was respected.

"Well I think people with mental illness...need time to work out things for themselves and I suppose you don't want to be treated like a school kid you know..."

"They didn't - they never put any pressure on me to do anything, they left it up to myself you know. A gentle push like you know (laugh)".

An interesting point was made by one individual who said that while he appreciates that no pressure is put on him at present, *"maybe they might apply some pressure after a while maybe, and maybe I might be able to deal with it better now that I'm stable you know"*. This confirms the fact that people experience a sense of the possibility of changing their own attitudes and patterns of behaviour and that they feel stronger to take such risks in the future.

Social contact and relationship building

"I suppose people with mental illness or people that have gone through mental illness tend to isolate themselves to a certain degree anyway, and they tend to kind of keep to themselves a bit you know, and it's a great help for someone to call to the house and see how things are going..."

All service user interviewees appreciated the openings for more social contact offered through the project. One person who, as a result of his work with Home Focus, started attending an NLN course, said *"The one thing is that you're in an environment with people and they're much the same as yourself, kind of that way. And you've company all day and you have your hours and.... you are into something you are interested in"*.

Participants also welcomed the personal relationship with Home Focus staff. This contact was seen as an opportunity to get more support and, as one individual said, to deal with possible concerns and feel safer. *'...If there were people that were living kind of isolated within the community.... And things might happen over the week, so it was good to have somebody to call around to make sure I was OK in that sense... I suppose the expression would be – a couple of paid friends"*.

The opportunity to do things outside the home, in the community, was also appreciated by participants. *"And we've been down in the café twice just for a break from the house, and we have a cup of coffee and a chat then and that feels good."*

On a similar note, another participant who suffers from agoraphobia appreciates the opportunity to go out with the staff to her local coffee shop, an activity she enjoys but has no confidence to do on her own. The same participant said that she is looking forward to the staff's visits and wished they would visit her more regularly. *"It's nice to see them coming"* she said *"they look after me good...they minds me"*.

A participant who lives on a farm and does not meet people regularly said that he likes the social contact provided through the project because *"you get to meet people... that's the main thing anyway..."*.

Another person talked about becoming more confident in social situations *"...I was in a soccer tournament... over Christmas, just up the street here, so that was a start, it was only on for one day like, I got out and I met old friends and people that I used to know, they were all there, we played a bit of soccer and it was a good day..."*

As another participant put it *"I mean it's a lifeline really. It's – ya, I mean I'm lucky, I've got a lot of friends but when I'm depressed I shut myself away from them, so if it wasn't for organisations like this I would be pretty much alone you know"*.

People also appreciated being given the space to talk. One person who finds it *'difficult to talk to people'* views the contact with the staff as an opportunity to *'practise'* talking to people. She said that she has gradually become more comfortable talking with the staff team and also more comfortable *'being with people'*.

This was also recognised by the staff team *"...but when you just talk to people they would say that they find they have built trusting relationship with us, that they've learned to open up a little bit more, it's easier for them to have a conversation then with a neighbour or family or a friend or whoever, and that's what makes a difference to their every day life really"*.

A further participant stressed that *"...it's crucial that people like these guys [home focus team] are available for people like me, because you know without that kind of attention or without that kind of help, you know I got to the point ...I'd given up... but if the guys hadn't been here... I'd still be in the position wondering what am I going to do, what am I going to do with my life. I'm 53 and I feel like I'm 103, I haven't had social contact, you know mixing with people"*.

"Firstly Home Focus gave me the belief in myself and the confidence in myself to actually get up and get out, and I remember saying to [staff names] after the first week [of joining a training programme],...I realised I wasn't as bad as I thought I was. You know that I actually could get out, I could communicate with people and I could, you know I was scared, you know, I didn't know how I'd cope, honestly...if [staff] hadn't brought me down here [training centre] first of all, and if they hadn't in their own unique way given me the push I needed to try at least... I wouldn't be here, it's as simple as that. So ya, again they gave me a bit of self-belief, a bit of confidence, and everything took off from there you know".

Another participant who has led an isolated life for the past 15 years talked about how, through the contact with the project and the possibility to discuss things, he was encouraged to pursue his interests. For example, he is now hoping to join to Green Party. The same person talked about how new skills, such as computer skills, will help him to *"discuss things"* with other people so *"it will affect my relationship with other people"*. A further participant, who also had minimal contact with the community, bought a car and talked about the possibility of getting employment and making contact with the outside world.

Again, the issues of choice and control (in this case over the regularity of contact with the staff team) came up in the interviews with service users. For example, a person with minimal social contact other than the staff team acknowledged that *'[meeting with staff] it's slightly intensive, but it's something to do kind of thing'*. He said that *'maybe once a week [contact with staff], maybe twice a week would be enough really'* and he is happy with the way he can decide how often the meetings are held.

Staff also talked about how, in some cases, achieving basic contact with participants was an important step. *"...Realising that we were achieving something by just actually visiting the person and it was never going to get past just the physical social contact of the visit, ...that was as high as it was going to go, but that was an achievement in itself (staff member)"*. Overall, the staff team described the experience of engaging with participants as *"very fulfilling"*.

Progress and change can also be frightening

Two participants made an interesting point about the unsettling impact of progress in their lives. One participant said that while his "*movement forward, education and social contact*" were positive, the changes achieved, like getting a computer at home, undergoing training and getting a car, have been "*quite drastic, dramatic and scary in a way*". Another participant who suffers from panic attacks appreciates the visits of the staff team at home but found that moving out of the house with the team "*made it [her attacks] worse*". Despite that, both participants appreciated that their fears were respected by the staff team.

Creative and flexible engagement with service users

The staff team demonstrated remarkable creativity and flexibility in their engagement with service users. This was particularly evident in their work with 'difficult clients'. For example, on one occasion staff brought copies of National Geographic magazines to a person, consistently unwilling to engage, who had however mentioned that he had enjoyed reading the magazine in the past. The participant was 'pleasantly surprised' by this gesture. Similarly, in situations where clients presented as unwilling to engage, staff would ask '*Are you OK when we are here?*' or say '*See you next week*', rather than asking '*Do you want to engage with us?*'. It is evident that the staff team showed an ability to gently persist in establishing a relationship and 'leave a door open' while respecting people's choices not to engage, a balance which is indeed hard to strike.

Creativity was also evident in other methods of engagement, particularly in identifying participants' meaningful interests. One participant talked about his interest in writing poetry and how through the project he was able to plan to get a new computer to type his poems. Another participant talked enthusiastically about being invited by a staff member to go to a photographic exhibition "*... I had to decline because I had a headache anyway, but for somebody to turn around, who doesn't even know me to say, do you fancy coming and seeing this photographic exhibition and they've invited me out for lunch... to suddenly have that contact with people it's kind of like overwhelming...to do normal things...I don't do that, I can't remember the last time I*

went out to dinner, or culture - I can't remember the last time I had any contact with any type of culture at all, because let's face it - I'm isolated aren't I. I can't just jump in a car and drive to a museum, or and those things excite me, museums and art galleries, and photographic exhibitions and all that kind of stuff".

A number of participants mentioned the value of talking with the staff about various things outside their mental health. Things like sharing a joke, talking about football and current affairs were valued as they were viewed as a way of being in touch with the world around them. And, it is the simple small things that appear to make a big difference in one's life. For example, one participant said *"they [staff] are helping me in ways that you wouldn't dream about"*. When asked to expand, he said that staff brought him two newspapers and *"I read it because interesting stuff because it helps, but I mean reading is an outlet, you get rid of everything"*.

Staff and management stressed that employing these diverse approaches was supported by the wealth of expertise and resources from partner organisations (training, employment, mental health, advocacy, community development).

Diversity of interventions and the value of practical help

The diversity of the expertise brought to the project by the staff team was greatly appreciated by the participants. As mentioned in the previous section, this diversity was evident in the creativity of engagement methods.

Participants appreciated the variety of staff interventions, such as going for walks or to the local café or clinic. *"[staff] offered to take me down the shop... I didn't go down the shop, my home-help is very good, and she brings me in things that I need... But they did take me to the clinic - that was good because my home-help couldn't take me that day..."* Another participant talked about how during her depression she did not get out of the house and *"[staff] bought me some food one day when I wasn't able to get out to buy some food, and it's just knowing that someone is going to come around when you feel like that"*.

Participants also appreciated the practical help which contributed to the improvement of their quality of life. For example, one participant who had fallen twice down the stairs in his house talked about how he now feels safer and happier in his house as the team put a bar at the end of his staircase. *"...So that was good and unless they'd been in the house they [staff] couldn't do it, which I couldn't get otherwise".* The same participant said how much he appreciated the positive attitude of staff and the help he received in planning home improvements and in getting planning permission for an extension to his house. *"...If it hadn't been for the team and talking I wouldn't have probably bothered to get this extension and this and that and the other, because I don't like change but this is a good change, and they are going to help me with it."* He also spoke about how this will improve his quality of life. *"I think it might be a lot better when I've got a bed downstairs, and I've got a toilet and a bathroom, it will be more convenient to live in, I'll be able to live like an ordinary person then, because people take those things for granted but if you haven't got them they are very important and you miss them – and hot water, I've only cold water now unless I boil it".*

What is of particular importance is that the staff team were open to transcend traditional professional roles and to consider 'valid' all kinds of interventions aiming to improve service users' quality of life and community integration. *"Lets say from putting on our clothes and getting into a person's house and helping them actually making it liveable – to showing them how a shower operates – to working with them on the very basics of mental health, personal hygiene, literacy, communications, up to the higher functioning end of things, where you are introducing a person to the options that they have in the bigger communities such as college, or work, work experience, so the range is as wide as the number of people that we have"* (staff member).

Identifying possibilities and being facilitated to access information and resources

"If somebody takes the trouble to tell you what's out there, and be supportive and come back every week that's important".

Receiving concrete information about available resources in the community and being facilitated to access these resources was also a benefit for participants. One person articulated very clearly how he struggled with accessing information about possibilities particularly because of his depression as *"my confidence has taken such a hammering over the 18 months, you know it's hard to get out of bed some days and let alone suddenly decide... I'll ring up and I'll try and sort out a course out for myself"*. He found the staff team **reliable** as *"they put their money where their mouth is, rather than telling you oh ya you can do this, this and this, and just leaving it at that, they've actually physically got me into a position when I now have funding, you know to go on a course and I now know where I can go to go on a course"*.

The same participant appreciated that the team facilitated his transport to the location of the training centre rather than expecting him to leave his house, a place he likes and *"has worked to make home"*.

Another participant said that the main strength of the project is that the staff team *"keep you aware of opportunities"* referring to job and training opportunities. The same person said that the team would provide support if he gets a job.

A further participant talked about the advantage of getting access to a computer at home and *"I can use it whenever I want to, and you wouldn't have that facility with other mental health services"*. The same person also said that through the Home Focus team, it was possible to access information about and apply for a County Council grant for home improvements, which will have significant impact on his quality of life.

The staff team also acknowledged the significance of accessing information and resources. *"Even from a purely practical point of view, at one stage we had, and we still have, a participant who identified transportation as a main problem so we needed to get a driving licence, and we couldn't afford that on our budget, the participant*

couldn't afford that, so the Disability Guidance Team came up with the funding for 15 driving licences, and that person now has bought a car".

A staff member also said *"getting people to do training at home that they never would have done otherwise. Watching them progressing through that, it's important that they are progressing through that, then getting involved in social activities within their own local community and supporting them to do something that they might not have done otherwise, they certainly weren't doing it prior – even with all these achievements, it's about ultimately aiming for the person to be doing, accessing this stuff on their own and working towards that".*

Furthermore, participants talked about the value of getting information about issues that concern them, including mental health and medication. For example, one participant who is concerned about the potential addictive nature of his medication said *"Well do you know sometimes when I'm down, I can ask them any medical questions about certain tablets, that I wouldn't have time for when I go into a doctor to ask him about them".*

Working in one's own environment - A striking difference from previous experiences of the mental health system

"I think the major thing is seeing people in their own environment...whereas going to see the Psychiatrist in a clinic... whereas Home Focus will come to you in your environment and see what you're about and that type of thing – that's very good"
(participant on the Home Focus project).

A strong point was made by participants when comparing *Home Focus* with previous experiences of care.

People described being more settled now as they are in an environment where they feel comfortable: *"I'm not used to being locked inside at all for four weeks, I'm used to my freedom, get up in the morning, go out, have a cup of tea and a slice of bread, go out and get the parlour ready..."*

"Oh Jesus Christ hospital is the last word – it's like jail to me. Like being in prison....you're upset and scattered inside".

"...any of experience I've had with going to hospital, going to a mental hospital, I found it kind of a cold experience you know, mental hospitals aren't nice places you know, some people say they're OK, they've had a good time there like, but I don't know, that was my experience of them anyway, I just found it cold. I suppose it's not an easy job either for the people that are working in these places, it's not an easy job like you know".

"I prefer being at home. It's better than plastic forks and knives and spoons and doing work therapy or whatever, almost a factory environment, and that's regarded as therapy but I prefer to work at home, it's easier".

Working in their own environment made people more relaxed with professionals.

"It's easier all right. I used to be nervous [in hospital], if you make a mistake or something like that ... when you're in the home house you relax more.....If I wasn't here this morning I wouldn't be that relaxed at all".

"Well it's better really because you're probably more relaxed and you can be more focussed then on what you want to talk about..."

Participants also said through this service they can be more open about identifying their own needs as *"the onus is on you to bring up whatever you want"*. As another participant suggested, this work allows more room for service users to ask questions to professionals. *"Well the difference between this type of work and others that I've seen...what I've been doing before I went to Home Focus is going for my three monthly appointment to see the public psychiatrist and he would just ask you the same questions all the time, so at least they don't do that, they don't ask you the same questions all the time, you know.... it's up to you to ask questions..."*

Participants also identified that working from home makes it possible to access help which would have been difficult to access otherwise. *"The fact that they are coming to you instead of you going to some place that maybe you're not comfortable with, or you mightn't be feeling that well, and you don't want to go out that day, have an appointment or something, and they can come to you, and that's a big help, because a lot of time when people are sick mentally, or going through depression or... whatever they are going through, they are not in a frame of mind to go out of the house..."*

Working in an environment where people are comfortable also creates more possibilities for the participants. One person who began a computer course at home said *"...well I couldn't get out now to anything, I couldn't get out to do any courses or anything, so them coming to the house means a lot"*. On a similar note, another participant who withdrew from an NLN course because he wasn't *'comfortable being around people'* said that he feels more comfortable at home where he has started an ECDL course.

Furthermore, working within a relationship where people felt comfortable and respected facilitated them to set goals for themselves and *"to find out what was out there, what was available, where could I go, what could I do..."*.

The staff team also confirmed that as their engagement with the project progressed, participants became gradually more relaxed in their presence.

A safe informal space

A significant contributor to relationship-building between staff and participants was the informal nature of their contact. This was much appreciated by participants. As one person put it, this facilitated him to *'talk about things and how I feel'*. A number of participants expressed a sense of safety with the team and said that they look forward to their visits.

One participant who said she gets frustrated in the presence of others because *"I find it very difficult to converse with people, and I feel I have nothing in my head..."*. said that *"... it's nice to have them [staff team] in the house, it's nice to have them coming... I like chatting to them. It's company and the hour seems to go quickly which is good"*.

Participants also talked about the benefit of having a space to express their fears and concerns *"...I suppose it [the contact with the staff team] gets ... my fears out. I'm very fearful of what will happen to me, and I can't walk or I can't think or anything, and I don't know what's going to happen to me"*.

Furthermore, receiving support at times of possible crisis is crucial for all participants. A participant whose father died last year found Christmas difficult but acknowledged the support received from the team. *"Christmas - I was having tension around Christmas all right, tension all right, but I suppose I got through it"*.

In terms of physical safety, a number of participants talked about feeling safer by knowing that the staff team is in regular contact with them.

Feeling better, getting better

Without using the word *'recovery'*, service users made reference to the process of feeling better since they engaged with the project. This was also confirmed by the *'Pen Picture'* document where staff reported *'reduction of symptoms along with increased relaxation'* amongst some participants. On one particular occasion, they also observed *'less reference to paranoid ideas'* and on occasions *'where ideas are still present they are not being so dominant in their [service users'] life.'* This is a good example of conceptualising recovery as a process that moves beyond the absence of symptoms.

These are some of the ways in which participants defined a movement towards well-being. *"Ya it works for me, and you know I just carry on from day to day, I don't think much about medication, I just kind of carry on and do the best I can, I don't"*

think too much about it. I used to think a bit more about it before you know - but I'm happy enough". As another person put it, "I am definitely feeling a bit better since I've been talking to [staff name].. Actually I had a lot of pressure in my head there over the summer.....but I find in the past few days that that's after clearing up a bit you know... I don't know there seems to be some bit of release of pressure or something". The same person said at a later interview "I'm more relaxed, my thoughts don't race as much about myself and about other people and all that, and I'm more relaxed". A further participant talked about how through his contact with the team he has developed a better understanding of his own mental health.

People also recognised how their contact with the project motivated them to work towards some changes in their lives. "...[staff names]... *they were advising me that I should do something, probably only for them I mightn't have done anything you know, I might have just carried on the way I was".*

"I'll be starting a job now on Monday, I'll be trying to focus on other things, focus on the job, trying to do my best at it, and hopefully stick it out for as long as I can anyway... I had a kind of tendency in the past to just kind of give up for no reason really... but hopefully that won't happen this time. If I do feel that coming on me again I can – you know Home Focus are always there, I can give them a ring and tell them".

Another interesting comment comes from a participant who, during a follow-up interview, talked about taking a more realistic assessment of his situation. *"I've actually taken a bit of time to reassess my situation, and get more realistic about things, and it was nice to be able to talk to [staff] and he was encouraging and supportive and it was fantastic, and also continued with information, because I'm discussing doing advocacy work, because that's really, I feel really what I want to be doing".* The same person who was previously adamant about not moving out of his current accommodation is now considering moving in to a less isolated part of the country where he will have more access to employment opportunities, activities and so on.

Other participants welcomed the opportunity to do *'things you are interested in'* or things they found helpful. For example, two participants did things they found helpful; one person mentioned health management which helped him get over a cold more quickly, while another person mentioned how home management can help him feel more confident about looking after himself.

Being empowered to take responsibility for one's life is central to the recovery process. This was clearly articulated by one participant who said that "...*what I like, they've made their position clear... that what they can help you do, it's not like we'll do this for you – it's what we can help YOU to do, which is also important because it's like, it's that balance isn't it of not making you reliant on other people to do things for you, but to get yourself motivated enough to say right I need to do this for myself, so I think that is very important... it's good to have that because you know that you've got to put a bit of effort in as well*". Participants also talked about how they realise that, no matter how much support they receive from the project, achieving change is 'up to them', and while this can be scary it has also been experienced as an empowering prospect.

Through these new opportunities, many project participants have developed a broader view of their lives. As a consultant psychiatrist (also member of the management team) put it, " [what changed] *fundamentally is how they [participants] view the illness as just one context of their lives and that they are not locked into... their illness*".

It is important to note that participants felt supported in their vision of recovery. As one participant said "[staff] *always emphasised to me, you know you're going to have it, you know you're going to come out the other side, and try and focus on, you know it's hard to do but when you are in that place, to try and say to yourself, you'll come out the other side*". This vision was also articulated by the staff team. As one staff member suggested "*I think we probably focus more on recovery rather than... goals, and about having people, somebody to come to a place where they feel a bit better*

about their lives, not necessarily about getting into college or working, but that they have a definition themselves about what recovery means to them, and if it means that it's easier for them to have a conversation now than it was a year ago, then they are further down in their road of recovery".

Other mental health professionals, outside the Home Focus team, also articulated this sense of participants' movement towards recovery. Psychiatrists, occupational therapists, social workers and nurses expressed the view that people referred to the project had benefited greatly from it.

Developing insight and self-awareness

This is an important part of the recovery process. One particular interviewee was very articulate in relation to the opportunities for insight offered through his work with a staff member. Despite his long-term involvement with services (over 20 years), it is the first time he has had an experience of counselling. He spoke with sadness about how much time of his life had been wasted because this type of work (outreach and counselling) was not available to him before this project.

"Do you know I always seem to be kind of on the run or something like, (laugh) or kind of running from something, and it's only in the past three or four years that I've sat down and kind of thought about it – like what I was doing you know. I don't know, I wish it had happened sooner you know, because I - a lot of years went to waste you know. But that's not saying the next ten or twenty years are going to be perfect or anything like you know (laugh) but maybe they might be some degree better".

The same person said at a later interview *"You know I was too focussed on myself, there's a lot more out there than myself...just dealing with every day life is hard especially when you're in a kind of a cocoon for twenty years... Well I don't think anymore really, I've kind of got over the idea that there's something wrong with me, and I think that comes from kind of talking to people and kind of getting over yourself*

a bit... Before I used to say I'm depressed and I'm this and I'm that, and now I just say I'm normal'.

Another person talked about becoming more aware about how her depression patterns changed "...this [slower move out of depression] is a total change in the pattern... and I think I can see it from a more positive point of view because to go slower in the change might be more beneficial in the long run".

Another participant said that he felt that, through his contact with the Home Focus, it was the first time his depression had been recognised. This was experienced with a sense of relief and also provided him with an opportunity to consider appropriate treatment.

Participants also talked about how this work helped them to become more aware of their position in the social world and in other relationships. For example, a participant who described himself as an "inward person" said "I've noticed that the isolation is stopping relationships, because when I was in the company of others in [name of hospital] I actually had a girlfriend for a couple of weeks, so in that sense the isolation is a problem for personal, and personal development. ... I think the more isolated you are the more difficult it is to be in the situation of mixing with people. The opportunities aren't there." While he didn't express a desire to change his lifestyle, the acknowledgement of contextual and situational factors is of great significance.

Developing a more positive perspective of mental health services

An interesting finding of this study was that some participants who had previously negative experience of services appear to be more open to using available supports, including hospital-based treatment. For example, one participant said that at a crisis point the Home Focus team persuaded her to go to hospital, which saved her life. "I might easily have killed myself – so I mean that's pretty crucial – and it was thanks to the two of them that I came [to hospital]...but if I hadn't been able to get in touch with them, there wouldn't have been anybody who could have persuaded me to come

into hospital, so I think that's the greatest thing I can say really. I must say that they saved my life. What bigger thing can you say than that?"

The staff team also talked about the changing nature of the contact between participants and mental health services. *"For another person it might be a hospital admission on a voluntary basis rather than having to be sectioned as they would have been in the past... that is a huge improvement for some people... the fact that the hospital is there as a place of respite for them, if they feel that life is just getting too much for them, that they know they can go in, stay for a couple of days, or a week or two weeks, and avail of what's there for them, this service has been set up for them, and they can avail of that, and go home when they feel ready to go, rather than feeling that a hospital is some place that they are kept prisoner"* (staff).

While the project is home-focused it is also flexible in its sites of interventions. Where necessary, staff provided participants with support and an advocacy role while in hospital. On a few occasions the staff team physically brought service users to hospital and supported them through their admission. This happened at the request of participants who themselves identified this need for support from the team. One participant expressed concerns in relation to perceived coercion by a team member during his admission to an inpatient unit. According to the participant, this was mainly related to the staff's insistence on compliance with medication. However, this did not affect his overall assessment of the project, but led him suggest that *"two staff members should come together in order to have a more balanced view"*.

Home Focus staff and management also stressed that the expression of a need to avail of a service can be evaluated in positive terms. For example, as one consultant psychiatrist (also member of the management team) said, the involvement of the Home Focus team in service delivery could increase the activity of the community mental health team, which would be a positive step. The impact of the project on service delivery in the West Cork area is discussed in the next section.

3.2 Mezzo-level: Impact on service provision

This section presents both quantitative and qualitative data on the impact of the Home Focus project on service provision. Quantitative information presents the considerable reduction in hospital days for participants who engaged with the project and highlights the subsequent savings in hospital-based care. The qualitative section considers the views of Home Focus staff and management on the contribution of the project to service provision. Service users were not directly asked to consider this question; however, indirect references were made to the nature of mental health service they wish to receive.

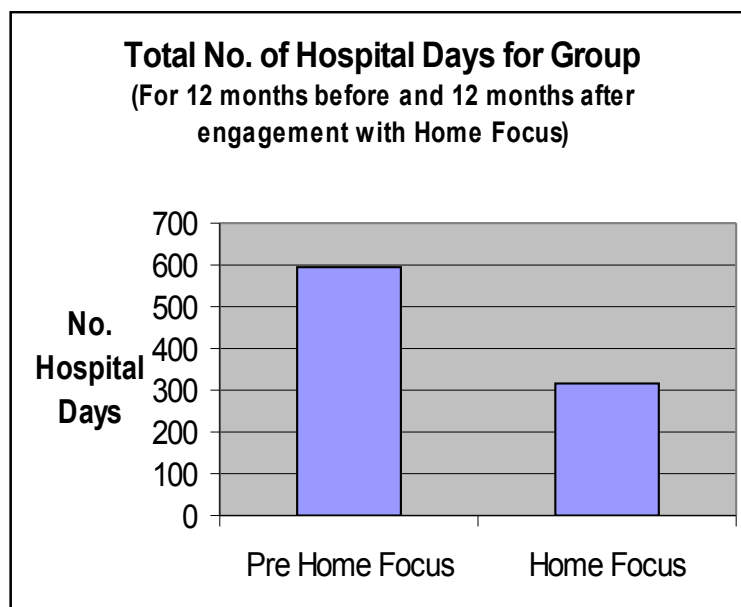
While primarily focusing on the impact of the project at the local level of West Cork, it is important to recognise that Home Focus articulated the possibility of providing an alternative model of community support within a recovery framework. This has significant implications for service provision at a national level as well. The first part of this section discusses how the Home Focus approach impacted on service provision. The second part considers administrative and operational issues related to the project.

3.2.1 New approaches to service provision

A significant reduction in hospital days

The Home Focus project provided intensive, consistent and person-centred support to its participants, which was a unique experience for them. This intervention has also affected their need for long-term hospital care. As a staff member put it “...*before our intervention the cycle would have been pretty well defined, hospitalisation, a brief period of relative wellness, then the deterioration through drink and maybe non-compliance with medication, and eventually back into the hospital again and the cycle would have been maybe as short as six or eight weeks, whereas that cycle has been broken and there have been no more hospitalisations, and the person is relatively stable, which was as good as we could have ever hoped for, for that particular person*”.

The following table provides a picture of the reduction of hospital days for Home Focus participants, over a period of 12 months.



This represents a 47% decrease in the number of hospital days for the group. This also represents significant savings in hospital admissions.

Savings in Hospital Admissions

Total number of hospital days for the group over the 12 months preceding

Home Focus engagement: 595

Total number of hospital days for the group over 1st 12 months of Home

Focus engagement: 318

This represents a saving of 277 days at €1,268.25* per day over a 12-month period equalling a total of: €351,305.25

*Information received from Management Accounts Office, HSE.

Articulating a vision for recovery and community support

"Home Focus is a wake-up call in relation to collective pessimism and a collusion of chronicity within the service itself..." (management member).

Home Focus management and staff stressed that the project played an important role in service provision at a local level as it provided an additional resource for intensive support closer to people's life situations. It has also contributed to a broader view of service design as it demonstrated the possibility for a flexible, user-centred service which is community-based and recovery-oriented. On a similar note, the project provided an opportunity to consider what could be achieved if (a) additional input was provided to service users, and (b) thinking informing service provision shifted beyond the current medical paradigm.

As a member of the management team said, the project showed *"it's demonstrably possible to do mental health working in this kind of way; it's safe, it's productive, it's a good way of working and... by showing that it can be done I would be hopeful that we can influence future directions of services"*.

Inter-service relationships

Overall, staff and management described their dealings with partner agencies as positive and from an early stage had an expectation that the Home Focus project 'will go well'. Reference was also made to the good relationship between mental health services and the staff team, facilitated by the new post of the mental health team co-ordinator. Staff and management consider this post as a positive development towards a co-ordinated approach in the delivery of the project. The Home Focus team regularly attended sector meetings where new referrals and participants' progress were discussed.

The links between the Home Focus team and mental health services were described by a member of the management team. *"I think that it's worth emphasising what I*

thought was excellent liaison and respectful liaison as well. I think the focus was on rehabilitation and to be able to offer home visiting and involve the family so it was an extension of what is being done already, but a more thorough extension of that. And then it did have an emphasis on recovery and rehabilitation so that was a positive thing – so these were the strengths as I thought”.

Professionals working within the mental health service have given very positive feedback on the Home Focus team’s openness to new referrals, and their enthusiasm and commitment. *“They’ve worked very hard to put in place a very flexible responsive service.... we’ve not had any difficulties with referring people to them, they’ve never really come back with any bureaucratic kind of stuff about ... ‘we can’t take this person because they’ve got this diagnosis, or that diagnosis’, they’ve basically been open to taking whoever was – as far as I can see and that’s really what you want in a mental health service, and what we often don’t get. I’m very pleased with the philosophy that they have developed which I think is very progressive, user-focussed philosophy, they haven’t got tied up with all the technology of diagnostic systems... It’s about human contact, human time and imagination really about trying to find a path forward for people”* (consultant psychiatrist & management member).

The partnership approach

The strengths of the partnership approach underpinning the formation and running of Home Focus were identified from the early stages of the project. The partnership was seen as an important element of the success of the project. The inter-agency partnership was identified as the way forward to service provision as it brings the responsibility for mental health out of mental health services to a broader range of services and interest groups.

Early comments on the strengths of the partnership approach were that through the *“different perspectives of the different partners, there is the potential to learn from each other and further development to be gained from the partnership”* (management member). In addition, it was felt that the participants will benefit from this approach

as more resources will be available to them. Indeed, the staff team talked extensively about the benefit of drawing from a wide and diverse range of sources. As a staff member said *"We have a lot of expertise sitting around the table... psychiatrists... psychologists... nurses... management, people from the Advocacy Network... Disability Guidance and they are all coming from different angles, they all have very worthwhile things to say"*.

As the project progressed, differences in approaches between partner organisations became more apparent, particularly in relation to the Home Focus target group. This is discussed later in this chapter. However, all stakeholders stressed that the partnership was able to focus on the project's success, to work through some of these differences and to maintain good relationships. Furthermore, it was acknowledged that while some partners were located more in the background rather than the frontline of the project, they were very important in shaping the holistic orientation of the project, by providing advice and resources. As a management member put it, these partners *"made us think outside the box in some cases"*.

A number of management members proposed more regular meetings between all partners, in order to have more opportunities for collaboration, shared learning and development strategies.

Community, outreach approaches as 'the way to go' - Mainstreaming

"It's the best service I ever had anyway I'll tell you that"

(participant on the Home Focus project).

In discussing the impact of the project on service provision, all stakeholders (i.e. service users, staff team and project management) recognised that community-based outreach work is one of the ways forward for mental health care. This recognition, however, has led to considerable levels of anxiety, as Home Focus is a pilot project operating within a tight time frame of eighteen months.

At the time of writing this report, a decision regarding mainstreaming has not yet been made. The pilot project was to come to an end in December 2007 and, through internal funding, has been extended to June 2008. As a result, the project has operated within a climate of uncertainty which has been stressful for participants, staff and management. Staff have expressed serious concerns about the impact of this short time-frame (and the imminent termination of the project) on service users who, possibly for the first time, have had a positive engagement with a service. *"How do you withdraw it if you have done all this which is ethical and good, how do you withdraw that then, and what does that mean for the individual, and creating false expectations"* (consultant psychiatrist & management member).

As a staff member said *"it's unfortunate that the mainstream decision has to be made so close to the end of the project given the nature of the individuals and what we're doing, because that definitely has an impact on people. The prospect of stopping coming up to a Christmas [2007] was very stressful for participants"*. The uncertainty about the sustainability of the project also affected the availability of the staff team to take new referrals.

The majority of the service user interviewees also indicated the necessity for the outreach approach to become mainstreamed. A participant who described himself as *'security conscious'* said he wished the project was *"24-7... it would be even better, if something did happen over the weekend"*. Another person recognised how much time of his youth was wasted because he did not get appropriate support and, making reference to the project, said *"I wish it had happened earlier"*, while a third person said *"...it would be a crying shame if the funding was pulled on that [Home Focus], [if] that wouldn't be available any more"*.

Another participant talked very emotionally about the need for this work. *"We need it – I'd go crazy without it, I think this would be a void in my life if [staff names] were taken away....I mightn't do anything desperate or I might, but I doubt if I would because I have got myself to a calmness now, I think my faith keeps me going, but I*

need them at the same time, because I feel very weak at times and they are a great help to me”.

3.2.2 Administration and Operational Issues

The Referral process

The referral system is administered through the mental health team co-ordinator who is located in the Bantry Hospital and is the link between the HSE and the Home Focus Project. The team co-ordinator receives the referral forms and passes them on to the staff team. The staff team attends the meetings of the two mental health sectors. In these meetings, staff receive and discuss new referrals and bring feedback on their work to the mental health team. As previously stated, the post of the team co-ordinator was considered a positive development, contributing to the standardisation and consistency of the referral process. Staff members are introduced to participants by their Community Mental Health Nurse (CMHN). This process has worked well because of the predominantly good relationship between participants and CMHNS.

The staff team said that the criteria for referrals to the project need further definition and that a review is needed to agree on the target group. They recognised that it is hard to get a definition covering the diverse group of people that the team engages with, and they also recognised that such criteria should not lead to a practice of exclusion or ‘cherry-picking’. However, the team acknowledges that they cannot accommodate everybody, and in particular people who are already engaged with other services.

Staff said that such criteria should be included in the referral form. This would help people making the referral to be clear about whether and how Home Focus can meet the needs of the individuals referred to the project. The staff team is also aware that the flexible nature of the project should be reflected in referrals and said that such criteria should be constantly considered rather than ‘set in stone’. The staff team also

stressed that, at the end of the pilot programme, it is important to have the referral parameters clearly defined so that the project can be communicated more easily to other sources of referrals such as GPs.

This evaluation study identified different views among partner organisations regarding referral criteria, length of interventions and referral process. Firstly, in relation to referral criteria and length of interventions, the National Learning Network proposes focusing on individuals with lower level of need, providing short-term and outcome-oriented interventions such as re-engagement with studies or training. On the other hand, mental health services view as the primary target group individuals with enduring mental health problems, who are disengaged from services, their communities and their sense of themselves as citizens. Mental health services recognise that this group requires a flexible approach to meet their diverse needs and propose a model of long-term interventions. Secondly, regarding the referral process, some concerns were expressed about the need to move this process beyond the mental health system. Some management members are of the view that the referral system has to open up to primary care teams and GPs as well as to self-referrals so that people who are not currently engaged with mental health services could access support. Others expressed some reservations about this opening as it may lead to excessive workloads from a group that is relatively 'well', while not affording time for those with long-enduring problems who need this time to build trusting relationships. Despite these different views on the referral process and the target group, all partner organisations recognised the benefits of the Home Focus intervention on all participants regardless of their level of need.

Resource issues

- **Direct work of service-user staff with participants.** The staff team and two members of the management group identified the lack of a service user in the staff team working directly with participants. Having service users working at that level was considered valuable as they can better connect with participants' experiences.

"I think that that is something that we are missing and we have felt the need for it right through the programme, because if somebody, if one of our participants is describing their experiences to us, and why they haven't been able to get out of the situation they are in, none of us can look him straight in the eye and say 'I know how you are feeling or I know what you are going through' – because we don't. We can look at it from the outside but we haven't gone through it ourselves, so I think having somebody there as an advocate who has been a service user or is a service user is hugely important for any future programme anyway"(staff).

- **Covering a big geographical area.** This needs to be factored into the workload. As it is a small team covering a big rural area, the possibility of not being able to accommodate further referrals in the future was identified. This was a concern as it meant that people who could benefit from the service could not be included.

The issue was discussed in the management group and the need to keep some spaces available was identified. Another proposal was to rationalise resources through a better planned combination of high and low maintenance caseloads.

- **9-5 Monday-Friday service.** Despite the flexibility of the staff team within the 9-5 time frame, this structure is a concern for the team as weekends and holidays are the times when people experience more isolation and their need for support is more intense. The Christmas holidays (2006 & 2007) were also a concern for staff as there was no contact between the team and participants for 1-2 weeks.

The staff team discussed extensively the need (a) *"to be careful of [professional] boundaries"*; (b) *"for participants to understand that staff will not always be there, particularly that you are not setting up a permanent 'buddy' type system for people"*, and (c) *"focusing on exit strategies"*.

- **Resources and support to staff team.** The staff team were satisfied with the training opportunities provided by both NLN and other sources. The team said that training was both accessible and available. The team itself has also been a good source of support. During the duration of the project, the staff

team has been in regular contact with both NLN and the mental health services.

- **Working in isolation.** The nature of the work (i.e. visiting people's houses and spending a lot of time 'on the road') can mean that staff work in isolation as that team support is not always readily available.
- **Staff Supervision.** The staff team recognised that *"this kind of work even when running smoothly can be emotionally draining or charged"*. Independent supervision (i.e. from outside project management) was mentioned by some staff as a space to deal with personal and professional issues arising rather than containing them within oneself or *'dumping on co-workers'*.

3.3 Macro-level: Impact on the community

Home Focus has operated on a pilot basis for a period of approximately eighteen months, and the community is only gradually 'becoming aware' of the project. This has made it difficult to consider comprehensively its impact at a community level, at least during its first year of delivery. However, from an early stage, there has been general agreement that the programme has provided an opportunity for intensive, user-centred support at a community level which was not previously available.

As the project progressed, staff and management talked extensively about a positive impact on the community and recognised that Home Focus itself has a high profile. *"I think the mental health, the profile of mental health in West Cork as a result of the programme in the community definitely is higher than ...before"* (management member).

A community development approach

The project is committed to a community development approach and a collective way of addressing mental health difficulties. As discussed earlier, this is evident in the partnership between statutory, voluntary organisations and service user groups allowing for a holistic and contextual approach to responding to mental distress. The community development philosophy is also confirmed by the creation of the recovery

resource worker post as part of the Home Focus staff team. This post is located in the West Cork Community Resource Centre.

The recovery resource worker, who is also a mental health service user, is involved in a number of innovative community initiatives including the West Cork Mental Health Forum (WCMHF) and the C.R.O.W. Centre in Bantry. The West Cork Mental Health Forum is a broad coalition of individuals and organisations who have come together to develop a positive agenda around mental health in the West Cork area. At the heart of this development is a concern to overcome the social exclusion of those who use mental health services.

The C.R.O.W. (Community, Recovery Ownership Wellbeing) Centre is a user-run centre aiming to provide a drop-in service, information and support for mental health service users. The C.R.O.W. Centre seeks to work actively with other groups and organisations related to and associated with mental health, disabilities and care in the community, as well as the mental health service providers themselves, whilst at the same time maintaining its independence and its unique sense of identity. Through his involvement with the C.R.O.W. centre, the recovery support worker supports the development of an advocacy, user-centred approach. *“If some person is feeling depressed or ...low... they get a bit of a burst of enthusiasm for life when they show up at the C.R.O.W. centre, and they come across other services that they wouldn't have come across otherwise because they hear from of them [members of the centre]– it's definitely very good – the service users would be totally at sea only for showing up at C.R.O.W.... one fellow says that it gives him a reason to get out of bed in the morning”* (recovery resource worker).

The role of the recovery support worker has been key in researching and developing community resources and in promoting awareness around mental health issues. A particularly positive outcome of this post was the production of the information booklet 'Signposting; Community Supports and Services in West Cork' (October 2007). The purpose of this booklet was, as the name suggests, to indicate to the general public how to access various services and bodies in West Cork. The booklet is included

in Appendix 10. Service users found the booklet particularly useful. As the recovery resource worker put it *"they were amazed that there were so many [services], a lot of service users didn't realise there were so many people out there willing to help them and paid to help people"*.

The recovery resource worker has also contributed to the organisation of the two World Mental Health days in 2006 and 2007 in West Cork organised by WCMHF and the C.R.O.W centre. These events took place in Bantry, Clonakilty and Dunmanway and included information sessions, dialogue on mental health, art exhibitions and cinema. The events were well advertised and well attended by members of the community who had an interest in mental health. Above all, these events provided space for dialogue on mental health issues and for the voices of service-users to be heard and validated. As the recovery resource worker suggested, *"a lot of service users [participated] and some of them gave a testimonial, and that really impressed people, especially it impressed the service providers, they were just amazed at what a person could go through and still come out smiling at the end of it"*. These events also provided an opportunity for the promotion of the Home Focus project in the broader community.

Normalisation - Locating care for mental distress within mainstream services

Locating the community support element of the project within a mainstream service (such as the community resource centre) was considered important for bringing mental health into the 'centre of community'. It was a step towards shifting mental health away from the monopoly of mental health services and working towards a partnership approach involving various community groups and services in responding to mental distress. Shifting the responsibility for mental health supports into the community *"de-stigmatises mental health issues and makes the use of a service normal, easy, and accessible"* (management member).

Stigma and community education

While 'community involvement' is considered as an indicator of 'progress' for a participant, the staff team acknowledged that this could be a daunting task as stigma is still prevalent. Staff mentioned one example of a negative reaction by a community social organisation which, when asked about a possible linking of a project participant with them, *"... made every excuse possible not to allow that person into their particular social group, and it's just something, it caught me [staff] by surprise"*. Staff acknowledged that a lot of work needs to be done at a community level to *'avoid setting service users up for exposure to stigma and all the stress'*.

A community development/education perspective provides a platform for such negative attitudes to be addressed and challenged (see chapter two). It was also suggested that the community development aspect should be developed further and *"hopefully this will help create a strong service user group"* (management member). The expansion of the open mental health days (discussed previously) was seen as an avenue to achieving a better engagement of the community with mental health issues. Home Focus staff and management suggested that such events need to have a more continuous and consistent presence in the community in order to provide a forum where people with an interest in mental health can interact and plan further actions.

"I think there could be more open days I think, because people were just starting to get to know each other and make other links during the meeting, but then the day ended and they haven't seen each other again then, since then, and they've lost contact and some people were feeling very enthusiastic about everything after the open day but then it all faded away then again as they were separated from each other again" (staff).

The staff team also acknowledged the need for community education initiatives to engage with the general public rather than people who are in the service or are affected by mental health. To achieve that, the Home Focus project cannot work in isolation but needs to be part of a larger long-term initiative focusing on education forums (such as schools) and media (such as television and entertainment).

Home Focus as component of a changing system

As already stated, Home Focus provided an excellent resource in the community and articulated a model of working creatively with people in the context of their lives. However, sustaining the positive contribution of Home Focus to the community requires the project to be part of an integrated comprehensive network of community resources rather than working in isolation as an 'additional' resource filling existing gaps. The need for a broader network of community services offering more options to service users and linking people with their communities was identified by staff and management. Particular gaps identified in community resources included services for alcohol and substance misuse (including prescription drugs) and gambling, as well as broader amenities including recreation, leisure and transport facilities – all of which are important to the promotion of mental wellbeing.

At a broader level, the Home Focus project is an example of how the recommendations of the Mental Health Strategy "*A Vision for Change*" (2006) can be implemented. While the project itself has been very successful it cannot be sustained in isolation. It has to be part of a broader changing system where (a) the community is a source of support for mental distress; (b) recovery is an underpinning philosophy, and (c) the service user is at the centre of all interventions.

Chapter Four: Conclusions and Recommendations

The wider implications of the evaluation study

This evaluation study examined the Home Focus project within (a) the local context of service provision in West Cork and (b) the broader context of adopting a recovery perspective to service provision for people with mental health problems in the community. The impact of the project was considered in relation to three different levels: service users (micro-level); service providers (mezzo-level) and the community (macro-level). In this study, the review of the Home Focus experience and the literature on mental health, community and recovery approaches enables us to learn in a way that is potentially transferable to other areas where mental health innovation is required.

Furthermore, this study proposed an evaluation framework where the experience of service users is central in constructing evidence of recovery. This is of particular importance in a period where evidence-based practice is central to service development and delivery. A broader conclusion to be drawn is that mental health research, and more specifically the evaluation of mental health services, needs to both reflect and influence innovative approaches through the development of participative methodologies and the generation of outcome indicators based on service-user experiences.

Strengths of the project

In line with national mental health and primary care policy, the Home Focus project provides flexible, intensive and person-centred support to its participants. Service users are met in the context of their own lives, in their homes and communities, which is a unique experience for them. The quality of the service provided, the commitment and enthusiasm of the staff team was remarkable. This is a summary of the strengths of the project as identified by the evaluation study:

- ***Gains achieved by project participants*** included reduction in hospital days; health and social gain; improved social engagement; linking with community

groups and support organisations; improved mental health; improved independent living skills; employment; further training and certification.

- **Positive service-user experiences.** The project is underpinned by a user-focused philosophy and the team deliver an individualised service to people in their own environment where they feel comfortable and respected. Participants felt listened to by the staff team, they also felt they had choices in their interactions with the team. They appreciated opportunities to build social relationships and liaise with resources in their communities. Participants also identified a hopeful vision for their future and an improved sense of themselves in the world.

- **The project's resources.** The diverse and rich experience of the staff team (including occupational analysis, counselling and focusing on mental health problems, and community development) is a great asset to the project. The enthusiasm and commitment of the team, their flexibility and ability to engage with people beyond psychiatric labels is also important. The partnership approach between statutory and voluntary organisations provides access to diverse resources and expertise, which are very beneficial to project participants.

- **The nature of the service.** Home Focus delivers a user-centred, outreach service based on a recovery approach to mental health. The relatively small caseload allows the staff team to build relationships with individual participants. The flexibility of the approach taken and the creative methods of engagement made the contribution of the project a unique experience for its participants. Taking a community development collaborative approach to service delivery allowed providers to think 'outside the box'. The partnership approach also facilitated an improved co-ordination between services and the best utilisation of existing resources in the community.

- ***Demonstrating possibilities for future development of community mental health projects based on partnership.*** The Home Focus project articulated the possibility of providing a recovery project within a community-based setting. It also demonstrated that:
- It is possible to move supports for people with mental health problems beyond the territory of mental health services to the broader community
 - The community needs to take an active role in supporting individuals who suffer from mental distress
 - A partnership approach is the way forward in the provision of services for people with mental health difficulties
 - Advocacy and user-led services contribute greatly to mental health recovery
 - A community development approach is central in broadening the understanding of, and responses to, mental distress.

Challenges

As Home Focus is a new pilot project, a considerable amount of time and resources were utilised in setting it up. Given the limited time frame available for the project delivery (18 months), this has 'eaten up' time from direct work with participants. The main challenges faced by the project are related to the fact that in many ways Home Focus operates in isolation, as it is not supported by a network of parallel developments at a community and national level. Furthermore, the uncertainty about the continuity of the project through mainstream funding has created and sustained high levels of anxiety among participants, staff and management.

The partnership approach also posed some challenges to the project, as different philosophies, procedures and views emerged in relation to operational and administrative matters. Despite this, all stakeholders acknowledged the strength of the partnership approach as a way forward to service provision. Moving supports for mental health beyond the territory of mental health services is viewed as a positive challenge, as it provides opportunities for a holistic approach to materialise and for the community to play a more active role in the promotion of good mental health.

A further challenge was posed by the size of the geographical area and the scarcity of resources in the local communities. Travelling long distances (approximately 637 km weekly) limited the time staff could spend with participants and the team's capacity to accept new referrals. This is a concern as it means that people who could benefit from the service could not be accommodated. The lack of resources at local level (including health and social care, transport, recreation facilities, etc.) has also been a concern as it restricts the possibilities for participants to be liaised with aspects of their communities.

Recommendations

- **Mainstreaming as part of a commitment to recovery, community-based supports at local and national levels.** The Home Focus project contributed positively at three different levels:
 - (a) Service users – by providing a new, unique, individually-designed service to people who have, overall, limited or negative experiences of services.
 - (b) Service providers – by articulating the possibility of a recovery-oriented, community-based, outreach service and by enhancing collaboration between statutory and voluntary organisations.
 - (c) The community - by providing an additional resource and by bringing the community to the centre of service provision.

Based on the findings of this study, it is recommended that the project should be mainstreamed in order to (i) continue and expand its contribution to service users in the community; and (ii) provide a model of good practice which can be transferred to other parts of the country. However, this study also suggests that the project's contribution depends on it being part of a broader commitment to service provision, where community supports and service-user involvement are central in the recovery process.

- **Breaking social isolation – continuity of care.** Through participants' positive experiences of the project, a number of unmet needs at a community level were identified. The majority of people referred to the project were isolated in both social and geographical terms. Many of their difficulties were a product of this sense of isolation rather than their mental health problems. This study found that the principal needs of many people suffering from poor mental health are about basic human contact, relationships, meaningful activities, and practical and ongoing support. This does not suggest that Home Focus is the only or the best service to respond to these needs. However, the project laid the foundations to explore other ways of providing continuity of care in the community. For example, one possibility to provide ongoing but low intensity home-base support is through the expansion of the HSE Home Help system to the area of mental health, after the relevant staff receive appropriate training (at a FETEC level 4 or 5). Furthermore, as the project's approach is based on a user-centred philosophy it would be appropriate to involve service users in providing both formal and informal support to other service-users in the community. The Peer Advocacy Training Course provided by the Irish Advocacy Network could provide training for this purpose.

- **Community development.** A community development approach to mental health is essential in shifting the responsibility for mental health to the community, recognising the contextual factors that contribute to well being, and combating the stigma associated with mental health problems. The partnership approach adopted by the Home Focus project is a good model of collaboration between various actors, which allows for a more holistic response to mental health difficulties and a better utilisation of community resources.

- **Geographical considerations.** To be effective (cost/impact), there is a limit to the territory a single team can cover. For the West Cork project, it is recommended that the West Cork catchment area be divided into two geographical regions, with one team delivering the programme in each region.

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Appendices

Appendix 1

Interview Questions for Home Focus Participants (Baseline)

1. What kind of things you do with (name of staff)?
2. How is it (this work) going so far?

Probes: - Likes
 - Dislikes
 - Anything you would like to change?
3. Is working at home different from other contacts you had with mental health services?

Please explain
4. How does this work compare with previous dealings with/experiences of mental health services?

Please expand
5. When you started working with (name of staff) what were you hoping to achieve?

Probes: - What changes did you want to see happening in your life?
 - Anything else you hope to achieve?
6. Any other comments?

Appendix 2

Interview Questions for Home Focus Participants (Review)

1. What kind of things you do with (name of staff)?
2. How is it (this work) going so far?

Probes:
 - Likes
 - Dislikes
 - Anything you would like to change
3. When you meet who decides what you will talk about?
4. Can you ask for a meeting if you want one? What happens if you do?
5. Is working at home different from other contacts you had with mental health services?

Please explain
6. How does this (work) compare with previous dealings with/experience of mental health services?

Please Expand
7. When you started working with (name of staff) were you hoping that some things would improve? How do you see the progress so far?
8. Anything else you hope to achieve?
9. Has the support that you have received from the team had an affect on your life?
 - Living situation
 - Occupation/training
 - Relationships with other people
 - Use of leisure time
 - Physical and mental health
 - Personal safety (how safe do you feel?)
10. Any other comments?

Appendix 3

Interview Schedule for Home Focus Participants

Participant	Baseline	Review 1	Review 2*
1	October 2006	April 2007	February 2008
2	October 2006	April 2007 (Exit)	
3	October 2006	April 2007	February 2008
4	October 2006	February 2008	
5	January 2007	February 2008	
6	January 2007	Not appropriate- disengaged from project	
7	January 2007	November 2007	
8	January 2007	Not contactable	
9	April 2007	January 2008	
10	April 2007	September 2007	
11	April 2007	Exited program	
12	September 2007	January 2008	
13	November 2007	November 2007 (baseline & interim)	
14	September 2007	January 2007	

* A second review interview only took place with two participants who agreed to be interviewed at an early stage of the project.

Appendix 4

Interview Questions for Home Focus Staff Team (Baseline)

1. What is your role in the Home Focus project?
2. What is your previous experience (if any?)
 - a. in the area of mental health?
 - b. in assertive outreach/community based interventions?
3. What is your understanding of 'assertive outreach'?
4. What are your expectations of the project?
5. In your opinion what are the strengths of the project (assertive outreach in particular)?
6. In your opinion what may be the areas that need to be further developed?
7. At this point do you think that you have:
 - a. adequate in-service and other training?
 - b. appropriate support in your position?
 - c. adequate resources to do your job as you think it should be done?
8. Current mental health policy advocates quite radical changes in service delivery. How do you think are these changes manifesting in the practice context?
9. How do you think Home Focus will impact on mental health service delivery in West Cork?
10. Home Focus is a product of a partnership approach between various stakeholders. What are the benefits of the partnership? What are the possible limitations?
11. At the end of the pilot program:
 - a. what would constitute a successful outcome?
 - b. what would constitute failure?
12. Are there any other points concerning Home Focus that you would like to make?

Appendix 5

Interview Questions for Home Focus Staff Team (Interim & Final)

1. How are your expectations of the project being met so far? [in your answer make reference to expectations in relation to (a) service users, (b) service providers and (c) the community (as discussed in the baseline interview)]
2. In your opinion what are the strengths of the project /approach (assertive outreach in particular)?
3. In your opinion what may be the areas that need to be further developed/areas of concern?
4. How do you think the referral process works?
5. At this point do you think that you have:
 - a. adequate in-service and other training?
 - b. appropriate support in your position?
 - c. adequate resources to do your job as you think it should be done?
6. Based on your experience so far what are your views on the partnership between various stakeholders?
7. Based on the work you have carried so far what are the indicators of a positive piece of work? How can you capture positive changes?
8. Are there any other points concerning Home Focus that you would like to make?

Appendix 6

Interview Questions for Home Focus Management Board Members (Baseline)

1. What is your role in the Home Focus project?
2. What is your previous experience (if any?)
 - a. in the area of mental health?
 - b. in assertive outreach/community based interventions?
3. What is your understanding of 'assertive outreach'?
4. What are your expectations of the project for:
 - a. service users?
 - b. service providers?
 - c. the community?
5. In your opinion what are the strengths of the project (assertive outreach in particular)?
6. In your opinion what may be the areas that need to be improved/further developed?
7. Current mental health policy advocates quite radical changes in service delivery. How do you think are these changes manifesting in the practice context?
8. How do you think Home Focus will impact on mental health service delivery in West Cork?
9. Home Focus is a product of a partnership approach between various stakeholders. What are the benefits of the partnership? What are the possible limitations?
10. At the end of the pilot program:
 - c. what would constitute a successful outcome?
 - d. what would constitute failure?
11. Are there any other points concerning Home Focus that you would like to make?

Appendix 7

Interview Questions for Home Focus Management Board Members (Review)

1. How are your expectations of the project being met so far? [in your answer make reference to expectations in relation to (a) service users, (b) service providers and (c) the community (as discussed in the baseline interview)]
2. In your opinion what are the strengths of the project/ approach (as it developed its own identity?)
3. In your opinion what may be the areas that need to be further developed/areas of concern?
4. What are your views on the referral process?
5. Based on your experience so far, what are your views on the partnership between various stakeholders?
6. Based on your understanding of the work carried so far, what are the indicators of a positive piece of work? How can positive changes be captured?
7. Are there any other points concerning Home Focus that you would like to make?

Appendix 8

'Pen Picture' Report: Profiles of Home Focus Participants, Identified Needs and Supports Provided by the staff team

(Initials and location details have been changed for confidentiality purposes)

Personal Profiles

Participant: AC **Age:**49 **Gender:** F

Reason For Referral: Anxiety management, socialisation, literacy training.

Prior Engagement With Services: Many years of involvement with MH services. CMHN also involved.

Education: Primary school, special school in Cork. This participant has a mild/moderate learning disability.

Training: Attended 'Focus' (community-based rehabilitative training programme), became unwell and dropped out, re-attended part-time towards end of programme.

Employment: None.

Social & Family Support: Lives with husband and adult daughter. Supported socially by extended family and some friends.

Aspirations From Project: To develop coping strategies around socializing, help with literacy.

Transport: Family car, in which she refused to travel, travel pass.

Geography: Urban West Cork.

Sense Of Contact With The World: Enjoys socialising once she gets to the social setting. Also enjoys the company of visitors to the house. Has attended GROW meetings in the past, but no longer.

Positive Outcomes, Level Of Engagement With Services, Willingness To Engage With Services, Etc: This participant is now finding it a little easier to leave her home. She has developed some coping skills and some confidence around leaving her house and socializing, has used taxis to attend appointments. MH services attend at the house.

Possible Consequences Of Withdrawal Of Home Focus Service:

Participant will regress, as evidenced on her return from an extended stay in General Hospital). HF team had to start all over again, supporting her to leave the house, all literacy training forgotten.

Supports Needed: Continued CMHN home visits, phone support from hospital, inclusion in any planned excursions with MH services, service-user peer support, and support in attending appointments.

Personal Profiles

Participant: MB **Age:** 54 **Gender:** M

Reason For Referral: Support with mental health issues and to help combat social isolation and provide information on training and educational possibilities.

Prior Engagement With Services: No admissions, seeing Psychiatrist and Liaison Mental Health Nurse.

Education: Upper Secondary.

Training: None prior, currently attending Introductory Skills Training course at NLN, also working with Liaison Mental Health Nurse on schools advocacy programme.

Employment: Worked as a long-haul truck driver. Has also been self-employed in the same line in the past.

Social & Family Support: Separated from spouse, in regular contact with his son overseas, no other family locally, few friends.

Aspirations From Project: Socialisation, mental health management, daily routine and occupation, training/education.

Transport: Own car recently upgraded, full licence.

Geography: Rural, rented accommodation 2 kilometres from town.

Sense Of Contact With The World: Felt completely isolated and undermined within local setting.

Positive Outcomes, Level Of Engagement With Services, Willingness To Engage With Services, Etc. Engaged well and easily with Home Focus team. Currently attending Introductory Skills training course at NLN. Has taken up photography as a hobby and has partaken in a number of exhibitions, has also taken up computers to help with this and other projects. Is currently working with the Liaison Mental Health Nurse in a number of secondary schools as part of a mental health advocacy programme. Is currently looking to relocate to someplace a little more central.

Possible Consequences Of Withdrawal Of Home Focus Services: Has already disengaged from Home Focus, but keeps in contact occasionally.

Supports Needed: Already has a good number of supports within the community.

Personal Profiles

Participant: LG **Age:** 62 **Gender:** M

Reason For Referral: Socialisation, support with more structured daily activities, home management and personal hygiene.

Prior Engagement With Services: Long-term engagement with West Cork Mental Health Services

Education: Lower secondary.

Training: Has attended HSE 'Links' (personal development programme) and NLN 'Focus' (community rehabilitative training) programmes.

Employment: No employment history.

Social & Family Support: Good support from extended family and neighbour, recent increase in support from sibling (who has head injury), attends day-care centre one day per week, recent home help (one hour per week).

Aspirations From Project: Socialisation, mental health management, home management, occupation/activities.

Transport: Uses public transport, recently began using taxi, extended family and neighbour will drive when available.

Geography: Urban West Cork.

Sense Of Contact With The World: Has a good sense of contact with his community, meets neighbours when out walking the dog, converses well and knowledgeably about sport and current affairs.

Positive Outcomes, Level Of Engagement With Services, Willingness To Engage With Services, Etc. General improvements in mental health & crisis management, health & safety, home management & organisation, personal hygiene, communications, personal appearance and grooming. Engages well with home focus team and other services, gets along well with sibling recently.

Possible Consequences of Withdrawal of Home Focus Service: Possibility of personal and home hygiene slipping backward if home help is not kept up, lessening of social contact, fewer supports in managing his mental health.

Supports Needed: CMHN calls to be re-established, increase in home help intervention if possible, inclusion in day care centre activities and possible increase in his attendance at day care centre.

Personal Profiles

Participant: DO **Age:** 70 **Gender:** M

Reason For Referral: Support with MH issues, living arrangements.

Prior Engagement With Services: Long history with West Cork Mental Health Services, seen regularly by CMHN.

Education: Third level.

Training: Trained in Business Studies.

Employment: College Lecturer in Business Studies (retired)

Social & Family Support: Little or no contact with family (they live in UK), home help and her family only social contact.

Aspirations From Project: Computer literacy, support towards home improvement, daily routine.

Transport: Does not drive, home help sometimes drives him to clinics etc. Recently in contact with Rural Transport Initiative in order to provide independent travel to clinic and library.

Geography: Rural, isolated, 5 kilometres to village.

Sense Of Contact With The World: Contact through home help, CMHN, also says that some friends call, maintains an active interest in current affairs through television and radio.

Positive Outcomes, Level Of Engagement With Services, Willingness To Engage With Services, Etc: Engaged well with Home Focus team, attended training days and joined in enthusiastically, worked on computer literacy, joined creative writing group and local library, improved health & safety in the home, applied for and received planning permission for extension, started process of applying for home improvement grant, improvement in general mental health, attends clinics regularly.

Possible Consequences Of Withdrawal Of Home Focus Services: Reduced social contact.

Supports Needed: Continued CMHN visits, continued Rural Transport Initiative intervention to guarantee continuation of library, writing group and clinic attendance. Re-engagement with day care centre.

Personal Profiles

Participant: CS **Age:** 42 **Gender:** M

Reason For Referral: Support with mental health issues, motivation, living arrangements, daily activities and routine, social outlets.

Prior Engagement With Services: Long history with MH services.

Education: Upper secondary.

Training: Trained as a plumber, attended NLN, did not finish employer based training course.

Employment: Has worked as a plumber in Ireland and USA, has worked part-time labouring from time to time. Has recently begun to work on a FAS community employment scheme 19.5 hours per week and is seeing the benefit.

Social & Family Support: Lives with parents, family supportive, has some friends.

Aspirations From Project: To socialise more, to develop friendships.

Transport: Drives the family car.

Geography: Urban West Cork.

Sense Of Contact With The World: Very limited, tends to isolate self. Tries to keep up with sports and current affairs. Sense of contact has improved greatly since beginning employment.

Positive Outcomes, Level Of Engagement With Services, Willingness To Engage With Services, Etc. Has engaged well with HF team over the course of the project, has attended training days, attends GROW meetings, has joined library and uses the computer there for internet purposes, has attended West Cork Mental Health Forum day, has started to work part-time.

Possible Consequences Of Withdrawal Of Home Focus Services: Lessening of support, possible reversion to previous form.

Supports Needed: Continued CMHN visits, possible CBT, supports from FAS employer.

Appendix 9

Home Focus- Positive outcomes identified by consultant psychiatrist from West Cork Mental Health Services (April 2007)

It was stressed that by the nature of their territory the Home Focus team receive referrals for the most difficult (to engage with) patients in the service. *"They are faced with the most severe end of the mental health spectrum and the fact that they have some positive gains from that territory is a credit to them"*.

Specific positive outcomes in relation to particular clients:

Feedback was given on seven out the eleven patients referred to the project.

Two very positive engagements with the project were identified:

- *"For [participant A], great work was done with the intervention of the team. This is very significant, she was self- isolating, not engaging with regular community mental health nursing involvement. It really did need an assertive approach to engage with A, she did respond, engaged with counselling... the last time I saw her she was doing very well"*

- *"For [client B], Home Focus was very positive and **transforming** in fact for him"*

In the following three cases, where the mental health problems were more severe, it was acknowledged that **any** engagement with the team was a very positive step.

- For client C: *"... accepting staff to see him... is a significant improvement in the quality of life for him because he was seeing no one virtually before then [his engagement with Home Focus]"*

- For client D who was recently hospitalised: *"D hasn't been very well... any engagement of the team is very positive...since he went out of hospital [2 weeks ago] the input of the Home Focus team is beginning to have an affect. Now he engaged more with them, has done activities with them... so I think there are some positive gains with D that we wouldn't have got without the involvement of Home Focus"*

- For client E: *"He has accepted to go to NLN and is accepting the input of the Home Focus team. This man wasn't going out at all and becoming increasingly paranoid of his family and everyone around him... he is now signed on to attend NLN and we are hopeful that their input, which is only for a couple of weeks, will work. The fact that they managed to engage with him **at all** is positive"*.

One further client "*did not engage great with the team*" and is currently in hospital care. Another client hasn't been able to engage and has been unwell for a long time.

In the two latter cases it was stressed that difficulties in engagement were not a 'fault of the team'.

Signposting

Community Supports And Services In West Cork October 2007

Prepared By
The West Cork Mental Health Forum to Mark
World Mental Health Day October 10th 2007

Acknowledgement

The West Cork Mental Health Forum would like to thank JJ O Donoghue for his work in researching and compiling this booklet.

The W.C.M.H.F. is a network of people interested in mental health issues including service users, carers, professionals, representatives from voluntary and community organisations.

The West Cork Mental Health Forum was established in 2006 and aims to:

Provide a channel for sharing/facilitate a voice for service users.

Identify supports for families who have experienced mental trauma and act as a signpost for existing services/supports,

Engage with the community about mental health so that there is community ownership and understanding

Work towards making life better for people with mental health issues.

Challenge the stigma for mental health

The purpose of this Booklet is, as the name suggests, to indicate to the general public how to access various services and bodies in West Cork.

Aware

A voluntary body that offers assistance to people who suffer from depression

What service do we provide?

Support groups, LoCall helpline, Beat the Blues schools awareness programme, free info service, education and awareness initiatives.

Who is the service for?

Anyone who experiences depression, their family and friends, and those who want to learn more about the condition.

How can you access the services?

Helpline: available at local call rates from anywhere in the country, 10am -10pm, 365 days a year - 1890 303 302. Details of support groups available on www.aware.ie or 01 661 7211, no referral required.

Contact Details:

Tel: 01 661 721, Southern Office: 066 7132 909

LoCall helpline: 1890 303 302

www.aware.ie

e: info@aware.ie

Clonakilty Bereavement Support Group

A group of volunteers who have experienced grief in their own lives who wish to support the bereaved.

What service do we provide?

Information evenings for the public and a series of evening or weekend support sessions

Who is the service for?

Anybody who is bereaved or has suffered loss of any kind, not only through death but also separation, divorce, loss of health, etc or any other loss

How can you access the services?

By contacting any of the numbers below. Support sessions are generally accessed in Clonakilty and are open to anybody from the area.

Contact Details:

023 34320

023 38927 or 023 33396

Cork County Childcare Committee

The Cork County Childcare Committee is a partnership of individuals, organisations and agencies involved in the provision of childcare. We provide support to potential and existing childcare providers, including childminders and parents. Our guiding principles are; equality of opportunity, diversity, quality, partnership and the needs and rights of the child.

What service do we provide?

- Support and information to existing and potential childcare services/community and private providers.
- Supports for childminders.
- Resource library.

Who is the service for?

Childminders, childcare providers, parents and local organisations.

How can you access the services?

- By Telephone - 023 55962
- Drop into office - details below
- Website www.corkchildcare.ie

Contact Details:

West Cork Office – Unit 12, Underhill Commercial Park,
Underhill, Dunmanway, Co. Cork

Cork Mental Health Foundation

Who are we?

We are a voluntary organisation whose aims are to positive mental health, to support people with mental illness and to create awareness and understanding of mental health

What service do we provide?

1. We facilitate Personal Development programmes in post primary schools
2. We support “Mental Health Matters”, a mental health resource pack for 14 – 18 year olds
3. We give presentations as requested to community and voluntary groups in the area of mental health promotion.
4. We set up a Befriending Project to foster independence and self-empowerment for people with mental health difficulties.
5. Contact us for further detail of projects

Who is the service for?

The service is for anyone who wishes to receive information on mental illness, or who wish to develop a better understanding of mental health difficulties.

How can you access the services?

See Contact details below

Contact Details:

Cork Mental Health Foundation,
Nore House, Bessboro Rd, Blackrock, Cork.
Telephone: 021 4511100
Fax: 021 4511150
Email: cmhealth@eircom.net
Website: corkmentalhealth.com

Cork Mental Health Housing Association

We are a voluntary organisation which empowers people with mental health difficulties through the provision of high quality housing services.

What service do we provide?

- Develop and maintain a variety of high quality housing units in community settings for people with mental health difficulties
- Provide information, training and administration back-up through the Development officers.
- We currently manage over 30 properties throughout the city and county catering for almost 200 residents

Who is the service for?

The service is for people experiencing mental health difficulties who are in need of housing. We offer supported accommodation or can offer independent living accommodation.

How can you access the services?

Access to housing is by referral through the Community Mental Health Nurse.

Contact Details:

Cork Mental Health Housing Association
Nore House, Bessboro Rd, Blackrock, Cork.
Telephone: 021 4511100 Fax: 021 4511150
Email: cmhealth@eircom.net

Website: corkmentalhealth.com

C.R.O.W.
(Community, Recovery, Ownership, Wellbeing)

We are a drop-in centre run by mental health service users in Bantry.

What service do we provide?

We aim to provide a safe, positive and relaxing environment, a listening ear, independent advocacy services, an empathetic and empowering approach, and an advice centre.

Who is the service for?

It is open to anybody who suffers from anxiety, stress or depression or if you feel lonely and isolated.

How can you access the services?

Drop in Centre at Bantry Community Resource Centre, Glengarriff Road is open:

Monday 10am-1pm

Wednesday 10am-3.30 pm

Friday 10am-1pm

Contact Details:

Phone- 027 51315

Foróige.

We are a National Youth Development Organisation whose purpose is to enable young people to involve themselves actively and consciously in their own development and in the development of society. Foróige is present in a lot of West Cork communities in the shape of Foróige Clubs and projects.

What service do we provide?

- Foróige Clubs
- Foróige managed Projects.
- Local Youth Services.

Foróige trains, assist and support adult volunteer leaders in clubs and projects who in turn empower young people to learn by doing.

Who is the service for?

Foróige clubs are for young people between the ages of 12-18.
Foróige Projects are for 10-18 year olds.

How can you access the services?

By contacting your local Foróige Youth Officer by phone or by e-mail.

Contact Details:

John Dennigan - West Cork Regional Youth Officer – 021 - 4395903/ 086 -9795199
john.dennigan@foroige.ie.

Gwen O Donovan/Tina O Callaghan- Beara Youth Development Project – 027 - 71885
gwen.odonovan@foroige.ie tina.ocallaghan@foroige.ie

Annette Fleming-Bandon Garda Youth Diversion Project – 023 - 43997.

Julie Cummins- Bandon Community Drugs Initiative. julie.cummins@foroige.ie

GROW

GROW is a 12 step support group for people with mental health difficulties i.e. depression, anxiety, panic attacks etc. We are anonymous, confidential, non-denominational and open to all. No fees are charged.

What service do we provide?

- Support
- Friendship
- Safe environment

Who is the service for?

Open to all

How can you access the services?

Bantry- Cois Cuan (behind fire station)

Mondays @ 7.30pm

Leap- Myross Wood Retreat Centre

Thursdays @ 8pm

Clonakilty-St. David's Resource Centre

Mondays 7.30pm

Kanturk-Duhallow Day Centre

Mondays @ 8pm

Macroom, Cathereine McCauley Centre, Chapel Hill, Tuesdays @ 7.30pm

Contact details

021 4277520

Home Focus

A multi-disciplinary team made up of a Community Mental Health Nurse, a Recovery Resource Worker, a Recovery Support Worker and a Rehabilitative Training Instructor.

What service do we provide?

We work with participants to provide any training and support they might need in making identified changes in home, individual or community aspects of their lives, for example, mental health, independent living skills and social engagement, creating links with community and support groups, and supporting moves towards education, training and employment.

Who is the service for?

People with severe and enduring mental health issues who typically do not engage effectively with the traditional or current services.

How can you access the services?

Currently, all referrals come through the multidisciplinary West Cork Mental Health Team.

Contact Details:

Home Focus, Cois Cúan House, Reenrour West, Bantry, Co. Cork.
Phone: 027 – 56667 Fax: 027 - 56668

Irish Advocacy Network

We are a service user run, service user led organisation working in the area of mental health

What service do we provide?

We provide support and choice for those who have experienced mental health difficulties. We do this by befriending, listening to the person, providing information and advocating on persons behalf when requested. We also provide advocacy training and staff awareness training.

Who is the service for?

People who experience mental health difficulties

How can you access the services?

People self refer

Contact Details:

Noreen Fitzgibbon, Regional Co-ordinator, Irish Advocacy Network, 71 Penrose Wharf, Penrose Quay, Cork.

Tel: 0879922997

Email: noreen@irishadvocacynetwork.com

Irish Wheelchair Association

National Voluntary organisation with local branches and services

What service do we provide?

Support, Advice, Information, Advocacy. Resource and outreach centre activities, Transport, Social and Trips. Home & carer support. Wheelchair loan/rental. Advice and information on aids and appliances.

Who is the service for?

People with physical and sensory disabilities and mobility difficulties.

How can you access the services?

Direct contact with local office in Bandon. Referral through other agencies eg H.S.E.

Contact Details:

Michael Crowley,
Resource And Outreach Centre,
Irish Wheel Chair Association,
Millbrook, Bandon, Co. Cork

Fax/Tel: 023 43283
Emergencies:087 6685484
Email: iwa@eircom.net
Web: www.iwa.ie

West Cork Money Advice & Budgeting Service.

MABS, is a national FREE, confidential and non-judgemental service for people in debt or in danger of getting into debt.

What service do we provide?

(1) Provide assistance in working out a budget suited to the individual/family.
(2) Enable people to gain control of their finances. (3) Negotiate with creditors as necessary. (4) Raise awareness of debt issues in the community by way of talks in school, community groups etc.

Who is the service for?

MABS is for individuals or families, primarily those on low incomes, who need help/advice in managing their household finances in order to avoid getting into difficulties with creditors.

How can you access the services?

You can contact this service by calling into the office at the address below, by phone, fax, email or writing to us.

Contact Details:

Ph: 023-55155, Fax: 023-55886, email: dunmanway@mabs.ie, or write to West Cork MABS, Unit 11, Underhill Commercial Park, Dunmanway Co Cork.

Mid - Cork Adult Basic Education Service

Park Road, Dunmanway, Co Cork

Who are we?

The Adult Basic Education is funded by County Cork Vocational Education Committee. The Service aims to ensure that everyone in the region has an opportunity to avail of their right to develop their literacy and numeracy skills to enable them to live full and meaningful lives.

What service do we provide?

This free and confidential service is provided by trained tutors in Reading, Writing, Spelling, Maths, Basic Computer Skills and form filling. This can be done on a 1:1 or small group basis.

Who is the service for?

All Adults who need support in any of the above tuition, can avail of the service, free of charge.

How can you access the services?

Contact your local centre coordinator by telephone, whenever suits, to be assured of a prompt appointment to discuss a suitable learning programme specifically for the needs of the individual.

Contact Details:

Dunmanway Centre 086/8239149 Dorothy Beamish

Kinsale Centre 086/8239092 Dympna Duddy

Macroom Centre 086/8239097 Sheila Scully

Or the Service Organiser;

Anne O Donovan. 086/8337704 /023-56957.

Or FreeFone 1800 40 41 41

National Learning Network West Cork

The National Learning Network is the training and education division of The Rehab Group.

What service do we provide?

We deliver high quality, flexible and responsive training, education and employment opportunities.

Who is the service for?

People with disabilities and others distant from the labour market who are over 16 years of age, want to make changes to their lives and are motivated to make that change. No formal qualifications are necessary to access courses which operate on a continuous intake basis.

How can you access the services?

Contact National Learning Network, your local FÁS office or HSE Disability Guidance Service.

Contact Details:

National Learning Network, Donemark, Bantry, Co. Cork, 027 51027, bantry@nlm.ie,
www.nlm.ie

FAS, Barrack Street, Bantry, Co. Cork, 027 50464

HSE Guidance Service 021 4927120

Postnatal Depression Support Group

We are a group of women that provide support to women going through the effects of Postnatal depression.

What service do we provide?

Once a month support group meetings

Telephone support line

One to one support

Website discussion support

Who is the service for?

The sufferers of Postnatal Depression and their carers.

How can you access the services?

Support Line: 021 4923162

Support Group: Last Tuesday of each month @ 8p.m. in the meeting rooms @ Cork University Maternity Hospital.

e-mail: support@pnd.ie

www.pnd.ie

Contact Details:

The service is co-ordinated by Madge Fogerty with support from the HSE and a group of volunteers.

Public Health and Community Nursing Service

Public Health Nurses, Registered General Nurses, Home Help Organisers and Home Helps

What service do we provide?

Assessment of needs - Referral to other agencies if required - Care Planning - Home Nursing -Health Education - Child Development and welfare

Who is the service for?

All children –All over 65-People with Physical /Sensory/Intellectual/Disability-Mental Health Patients and families who require public health nursing input

How can you access the services?

Through local health centre/GP Referral/Self Referral/Referral through other Health Care Providers/Voluntary Agencies

Contact Details:

Nursing office at 028 40429 9am- 5pm Mon –Fri (excluding 1pm-2pm)

Recovery Int (International)

We are a non-profit community based organisation founded in 1937 by the late Abraham Low MD, a Chicago neuropsychiatrist

What service do we provide?

Our goal is to help people with nervous and emotional disorders reduce their suffering and improve their mental health. People who attend the weekly group meetings are offered a system of self-help techniques which members learn and then practice in their daily life.

Who is the service for?

Recovery helps people who struggle with obsessions, depressions, panic attacks, phobias etc. Symptoms include palpitations, sweats etc.

How can you access the services?

Wednesdays 8-10 pm Resource Centre,
Bank Place, Castletownbere, Co Cork

Contact Details:

Recovery International, Bridge House, Cherry Orchard Hospital, Dublin 10.

Phone: 01 6260775

E-mail: recovery@indigo.ie

Web: www.recovery-int-ireland.ie

RehabCare

RehabCare operates a wide variety of health and social care programmes and support through person-centered planning in cooperation with other community based services.

What service do we provide?

- Long Term Service User Unit
- Physical and Sensory Unit. Bus service provided.
- Outreach Physical and Sensory Unit in Castletownbere. Bus service (Mondays only)
- Housing Unit. Semisupported housing for people associated with RehabCare and NLN
- Respite House within Housing Unit
- Drop-in Service on Wednesday Nights 6pm-9pm

Who is the service for?

People with disability and their carers.

How can you access the services?

Through Disability Guidance Service, Public Health Nurse, Bantry Psychiatric Unit, or through RehabCare Bantry.

Contact Details:

RehabCare, Droumleigh, Bantry, Co Cork. 027 51414/ 027 53698

Fax 027 53290. Bantry@rehabcare.ie

Schizophrenia Ireland

We are the National Organisation concerned with the interests of people with schizophrenia and their caring relatives and friends.

What service do we provide?

Information Helpline, Phrenz Support groups – for people with self experience, Relatives Support groups, Family support initiatives, Counselling, Advocacy, Employment Services, Lucia National Awareness week, Biennial Conference, Seminars and Information Evenings, Information Service, Resource Centres in Dublin and Cork.

Who is the service for?

For people with self experience of Mental Illness, caring relatives and friends.

How can you access the services?

By phone 021 4808124 Regional Office 32 South Terrace Cork City.
Basement Resource Centre 32 South Terrace Cork City 021 4808094.
Advocacy Service 32 South Terrace 021 4808189.
Counselling Service 32 South Terrace 021 4929210
Website; www.sirl.ie and www.recover.ie

Contact Details:

Miriam Murphy Regional Development Officer (Cork and Kerry)
Ph 021 4808124 or 086 852 5755 and email mmurphy@sirl.ie

The Social and Health Education Project

A registered charity which seeks to help people to achieve optimal wellbeing, both as individuals and in communities.

What service do we provide?

- Support Services including low-cost counselling (Coiscéim), facilitated support groups, and advocacy for older people.
- Training in personal development and social awareness.
- Tutors to facilitate courses for community groups
- Organisational development, training and support for community and voluntary groups.

Who is the service for?

The service is open to all in Cork and Kerry.

How can you access the services?

We can be contacted by phone or through our website.

Contact Details:

Tel: Coiscéim Counselling Service 087-7998602

The Social and Health Education Project 021-4536600

Fax: 021-4536619

Website address: www.socialandhealth.com

The Attic Bantry's Youth Café

We are a drop in facility which offers an alcohol and smoke free environment and facilitates youth work and leisure activities

What service do we provide?

A safe youth centred environment where young people are valued. It also provides informal learning opportunities for youths and active support for early school leavers.

Who is the service for?

The service is open to all young people aged 14-19 years old.

How can you access the services?

The Youth Café is located at the corner of Marino St. and Barrack St. in Bantry town.

Tuesday, Wednesday, Thursday 3.30pm – 7 pm

Friday 3.30 pm – 11pm

Saturday 6pm – 11.00pm

Contact Details:

Phone: 027 56856

For upcoming gigs, workshops, courses etc. Check out

www.theattic-attic.bebo.com

General details about the youth Café can be found at

www.bantryyouth.net/attic/

Welfare and Protective Services for Older People

I am a Single handed Senior Social Worker Practitioner in West Cork.

What service do we provide?

- Support, information and advice for older people, their families and other professionals.
- Investigation of allegations of abuse against an older person
- Social Assessments
- To advocate on behalf of the older person
- To access other services for the older person
- Facilitation of family meetings or case conferences

Who is the service for?

Any person aged 65 or over, living in the West Cork area, who is experiencing any of the below forms of abuse:

- Physical abuse
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Neglect including self-neglect or acts of omission
- Discriminatory abuse

Institutional abuse

How can you access the services?

Anyone can refer to this service

Contact Details:

Senior Social Worker: Welfare and Protective Services For Older People,
Cork, South-West Community Services,
Health Centre, Coolnagarrane,
Skibbereen, Co. Cork

Tel; 028-40568

West Cork Adult Guidance Service

We are part of County Cork VEC Adult Education Service

What service do we provide?

We work with adults who want to return to education, providing information, advice and guidance. We offer free, confidential, one-to-one guidance to help adults make choices around education and training.

Who is the service for?

Adults who want a second chance at education

How can you access the services?

Call us on 028 40294 and we will arrange to meet with you at a venue in your local area, or visit our Information Office at the Sutherland Centre, in Skibbereen.

Contact Details:

West Cork Adult Guidance Service,
The Sutherland Centre,
North Street,
Skibbereen,
Co. Cork

Tel: 028 40294

Email : info@wcaded.ie

West Cork Adult Learning

Co. Cork Adult Basic Education Service

What service do we provide?

Basic education and literacy

Who is the service for?

Adults who are not in the school system

How can you access the services?

Bandon	023 42870, 086 8239094
Bantry	027 53970, 086 8239140
Castletownbere	027 70292, 08 68239147
Clonakilty	023 36968, 086 8239089
Schull	028 27628, 086 8239150
Skibbereen	028 23502, 086 1909694

Contact Details:

Eleanor Calnan, ALO Co. Cork VEC
Sutherland Centre, North Street,
Skibbereen, Co. Cork

West Cork Carers Support Group

The WCCSG provides support & information to family carers in West Cork. The group is open to all carers.

What service do we provide?

- A Lo Call confidential support-line 1890 201533
- Support Group meetings every second month in Dunmanway and Clonakilty.
- A respite fund enabling carers to take a break.
- Three Seminars per year on issues of relevance to carers.
- Carers' information and Resource Base including internet access at our centre in Bantry

Who is the service for?

The group is open to all carers

How can you access the services?

Self-referral.

Contact Details:

West Cork Carers Support Group, Round Tower, Main St, Bantry, Co Cork

Tel: 027 53848 Fax: 027 51731

Lo Call Support Line 1890 201533 (open Wed & Thurs from 10 AM to 1 PM)

E-mail- westcorkcarers@eircom.net

Web Site- www.westcorkcarers.ie

West Cork Citizens Information Service

We provide Citizens Information Services in Bantry & Macroom and weekly outreach services in Castletownbere & Dunmanway.

What service do we provide?

The Citizens Information Centre (CIC) can provide you with information, advocacy & advice on all your rights & entitlements e.g. on social welfare, employment rights, family issues, disability issues, housing, migrant rights, consumer issues & much more.

We have a monthly Free Legal Advice Clinic (FLAC) & a weekly MABS clinic in the Bantry CIC

We provide information talks to local groups.

Who is the service for?

It is a free, confidential and independent service for all members of the community

How can you access the services?

Contact can be made by dropping in to one of our centres, by telephone, by email or letter. No appointment necessary.

Contact Details:

Manager, West Cork Citizens Information Service, Wolfe Tone Square, Bantry, Co.

Cork, Tel: Bantry 027 52100;

Tel: Macroom 026 42179

Email: westcorkcis@citizensinformation.ie

West Cork Crisis Pregnancy Counselling Service, Skibbereen

A confidential pregnancy counselling by a professional counsellor who can give you full information on all your options: parenting, adoption and abortion.

Ongoing support throughout the pregnancy and after the birth, if required.

Information regarding your rights and entitlements.

Counselling after an abortion.

Support counselling to partners and other family members affected by crisis pregnancy.

Who is the service for?

The service is available to any woman or their partner/ family experiencing a crisis pregnancy.

How can you access the services?

Locall 1890 252 359

The lines are open Monday to Friday 9.30 am to 3 pm, ring to make an appointment

West Cork Traveller Centre

We are a traveller led not for profit, Community Development Project.

What service do we provide?

- Primary Health Care Programmes
- Outreach services
- Women's Groups
- After - school Clubs
- Information, Support and Advocacy
- Referral to educational and training services
- Information and training for the general public on Traveller Cultural Awareness and Discrimination.

Who is the service for?

All Travellers.

Training and information on Traveller Cultural awareness issues is available to the general public.

How can you access the services?

The service can be accessed by contacting the Clonakilty based centre.

Contact Details:

Tel: 023-35039

Mon-Thu; 9am-1pm and 2pm-5pm.

West Cork Women Against Violence Project

W.C.W.A.V.P. is a confidential, non-judgemental, support and information service for women who are living in or who have left an abusive / violent relationship.

What service do we provide?

Emotional support, information on legal and other options available to women.
Accompaniment: e.g. to Court, Gardai as well as transport when resources allow,

Who is the service for?

All women in the west cork area that experience abuse.

How can you access the services?

- Freephone Helpline 1800 203 136
- Drop in to our office on Tuesdays 10am to 4pm
- Drop in Outreach service in Skibbereen (over Sounds Store) each Friday 11am to 2pm and in Castletownbere (over the computer shop in the Square) on the 1st and 3rd Wednesday of each month 12 noon to 3pm.
- No appointment is necessary on these days.

Contact Details:

- 7 Lower Glengarriff Road, Bantry.
- The office is open each weekday 10am to 1pm. 027 53847.
- Freephone Helpline each Tuesday 10am to 4pm. 1800 203 136

WorkStart West Cork Ltd

We are a free, FÁS funded, supported employment service for people with mental health, learning, sensory and physical disabilities.

What service do we provide?

Client led, one to one service with job coach who helps client secure work in the open labour market.

Who is the service for?

People with learning, mental health, sensory and physical disabilities who are seeking employment.

How can you access the services?

Contact WorkStart Co-Ordinator,
Celine O'Donovan on 027-53765 or 086-8546559 or via FAS.

Contact Details:

See above



**COMMUNITY
RESOURCE
CENTRE
BANTRY**



National Learning Network
Investing in People, Changing Perspectives