



***Paper to inform National Social Inclusion Office involvement in Service User consultations
and the development of Service User frameworks.***



The following paper outlines key considerations for the development and enhancement of service user engagement in the planning and co-design of services, with specific reference to vulnerable service-users including but not limited to the following groups:

- People living in Homelessness
- People with problem alcohol and other drug use
- Migrants, refugees, beneficiaries of temporary protection and international protection applicants
- Travellers
- Roma
- LGBTI+
- Victims/survivors of DSGBV

This paper provides an overview of the policy context and unique considerations for engagement with the above-listed populations, including specific challenges and enablers to engagement. A non-exhaustive list of current initiatives that are aimed at engaging these service-user groups in Ireland has also been provided for reference and consideration.

In addition to the below, the HSE National Social Inclusion Office is undertaking a project to inform and develop a social inclusion implementation framework for involving lived experience in the design of health and social services including guidance on tools to advance involvement of social inclusion vulnerable groups in evaluating and co-designing services. This paper was developed to inform the development of the [HSE Better Together Patient Engagement Roadmap](#).

HSE Social Inclusion

HSE Social inclusion aims to reduce inequalities in health and improve access to mainstream and targeted health services for vulnerable and excluded groups in Ireland. We work closely with different sectors and organisations to improve the health of vulnerable persons. Many vulnerable persons face inequities in accessing healthcare and barriers to engaging in their own healthcare and healthcare services.

Our services are unique within the HSE, because while we provide some of them directly, most are delivered through funding we provide to non-governmental organisations (NGOs) within the community and voluntary sector. Although we are based within HSE Community Care, Strategy and Planning, we work across much of the HSE. We represent the HSE on a range of cross-government groups and take part in joint projects with other HSE divisions, government sectors, NGO's, academic bodies and training settings.

We also aim to enhance the participation of vulnerable and excluded groups in health services particularly in relation to:

- planning;
- design;
- delivery;
- monitoring; and
- evaluation.

1. Key documents/ policy context for consideration

Various cross government strategies contain specific actions assigned to the HSE in respect of the health status, experiences and outcomes of members of migrant communities, people with problem alcohol and other drug use, Travellers, Roma, LGBTI+, victims/survivors of DSGBV and people living in homelessness. Policy responsibility for responses to address the needs of vulnerable groups rests across a number of different departments, necessitating whole of Government responses under various policy headings:

The Migrant Integration Strategy: A Blueprint for the Future	Department of Justice and Equality, (2017a)
White Paper on Ending Direct Provision	Department of Children, Equality, Disability, Integration and Youth, (2021)
National Traveller and Roma Inclusion Strategy 2017–2021	Department of Justice and Equality, (2017)
National Traveller Health Action Plan 2022-2027	Department of Health and HSE, (2022)
Third National Strategy on Domestic, Sexual and Gender Based Violence 2022–2026	Department of Justice, (2022)
Ireland’s Third National Action Plan on Women, Peace and Security, 2019–2024	Department of Foreign Affairs and Trade, (2019)
National Strategy for Women and Girls 2017-2021	Department of Health, (2017)
Female genital mutilation: Information for health-care professionals working in Ireland 3rd edition	AkiDwA, RCSI and HSE, (2021)
National LGBTI+ Inclusion Strategy (2019-2021)	Department of Justice and Equality, (2019)
Reducing Harm, Supporting Recovery: A Health-led Response to Drug and Alcohol Use in Ireland, 2017–2025	Department of Health, (2017)
Second National Intercultural Health Strategy 2018-2023	HSE, (2019)
Connecting for Life, National Strategy to Reduce Suicide 2015-2020	HSE, (2015)
Sharing the Vision, a mental health policy for everyone 2020-2030	Department of Health, (2020)
Roma in Ireland: A National Needs Assessment	Pavee Point Traveller and Roma Centre and Department of Justice and Equality (2018)
Rebuilding Ireland Action Plan for Housing and Homelessness	Department of Housing, Local Government and Heritage, (2016)
National Standards for Safer Better Healthcare	Health Information and Quality Authority, (2012)
Housing for All – a New Housing Plan for Ireland, 2021-2030	Department of Housing, Local Government and Heritage (2021)
Housing First National Implementation Plan 2022-2026	Department of Housing, Local Government and Heritage (2021)

2. Overview of vulnerable and excluded groups

Individuals and families who are homeless

In November 2022, there were 11,542 people recorded as homeless in the Dublin region, including 8,048 adults and 3,494 children (DHLGH, 2022). People experiencing homelessness present with unique health challenges and are at higher risk of experiencing multiple simultaneous chronic conditions, termed multimorbidity as well as the simultaneous trimorbidity of physical ill-health, mental ill-health and substance misuse. Over 70% of the Homeless population live in the Dublin area. The most recent winter rough sleeper count for Dublin, conducted in November 2022, identified 91 people sleeping rough in Dublin region (DRHE, 2022). A study by Ní Cheallaigh et al. (2017) demonstrated how homeless people in Dublin have much higher rates of inpatient admissions with longer lengths of stay and increased readmission rates compared with the housed population. The median age of homeless medical inpatients is 20 years younger than that of housed patients. Ivers and Barry in their 2018 report, showed how homeless population experienced higher rates of mortality than the general population. The average age of death for homeless women is 37 years and for homeless men is 42 years.

Migrants, refugees, beneficiaries of temporary protection and international protection applicants

In relation to international protection applicants, as of January 2023, there were 19,635 residents in 168 centres. The International Protection office in Ireland received 13,651 applications for international protection in 2022. The top 5 nationalities applying for international protection were Georgia, Algeria, Somalia, Nigeria, Zimbabwe.

On 10 September 2015, as part of Ireland's response to the migration crisis in central and southern Europe, the Government established the Irish Refugee Protection Programme (IRPP). Under this programme, the IRPP has seen the arrival of over 4,000 refugees under various resettlement strands, the largest of which is the UNHCR led programme. In December 2019, the second phase of the IRPP (IRPP II) was put in place to welcome up to 2,900 refugees through the UNHCR programme between 2020 and 2023 through a combination of resettlement and new community sponsorship initiatives. The majority of arrivals under the programme are Syrians (96%) and the remaining 4% include refugees from Afghanistan, Iraq, Libya and Myanmar. Approximately 550 Afghans have arrived since 2021. Projected arrivals for 2023 is 800.

The EU Temporary Protection directive was activated in response to the Ukraine Crisis. The Directive is an emergency provision designed to quickly and humanely respond to the mass displacement of Ukrainian people. Ireland participates in this measure, which has been given legal effect under Section 60 of the International Protection Act 2015. Under the terms of the Directive, those fleeing the conflict in Ukraine will be eligible for temporary protection, initially for one year and on a renewable basis. The directive applies to those arrived into the State from Ukraine since conflict began on 24 February 2022.

Members of the Traveller community

Census 2016 reported the total number of Travellers, usually resident in Ireland in April 2016, as 30,987, and recorded 8,717 households.^[1] The majority of Traveller households were living in private dwellings; 2123 in detached houses, 2597 in semi-detached houses, 1919 in terraced houses, 678 in flats/apartments/ bedsits and 1015 in caravans or other mobile temporary structures. A small number, 639, were enumerated in communal establishments. The number of Travellers recorded as homeless in Census 2016 was 517.

^[1] The ethnic question in the 2016 Census was through self-identification. Traveller representative group's estimate there is in excess of 60,000 Travellers in Ireland.

Members of the Roma community

The report *Roma in Ireland – A National Needs Assessment* estimated the population of Roma at between 4,000 and 5,000. The research found that one-fifth of Roma people in Ireland are completely marginalised from State services and supports. In the context of the Covid-19 pandemic, HSE estimated 300 individuals (plus children) who are most vulnerable in the Roma community.

People who use drugs or have alcohol dependency

People who use drugs or have alcohol dependency are a risk group given lifestyle, medical comorbidities and compromised immune system and as a result of acute harms associated with illegal substances. Regarding the prevalence of problem opiate use, in 2014 there was an estimated 18,988 people who used opiates in Ireland (Hay, et al. 2017). There are currently in the region of 11,400 individuals on opioid substitution treatment (OST). These are considered the most vulnerable people who use drugs. Around 1,400 of these are registered as homeless. The latest general population survey indicates that 26.4% of Irish adults aged 15 and over report using an illegal drug in their lifetime with 7.5% reporting use in the last year and 4.0% in the last month. Lifetime usage of cannabis (24.0%) is considerably higher than any other form of drug.

Data from the Health Research Board (HRB) suggests that there are between 150,000-200,000 dependent drinkers in Ireland and 1.3 - 1.4 million hazardous/harmful drinkers in Ireland (Mongan & Long, 2016). Ireland also has one of the highest rates of binge drinking in the world, with 37% of the population reporting binge drinking in the 2018 Healthy Ireland survey.

3. Considerations for participation and engagement

Broadly, across all social inclusion groups, many challenges and barriers exist to service users engaging in service planning, design, delivery and evaluation. It is important to note that barriers also exist in relation to these groups accessing health services in the first instance, which means that feedback from and engagement with individuals who do not access services is also vital when considering appropriate service design.

3a. Barriers and challenges to participation and engagement

Some of the key **barriers and challenges** to service-user access, participation and engagement across social inclusion groups are as follows:

- Low income and lack of resources, such as food poverty, lack of social and support networks, low education, inadequate accommodation or unemployment (Farrell, et al. 2008).
- Digital exclusion. This includes reduced access to technology that enables participation, particularly throughout the COVID pandemic. These groups include people who do not have easy access to the internet, who cannot afford connectivity, who are not computer literate, people with literacy difficulties generally, non-native English speakers, and older people for whom the use of digital technologies to support the provision of public services is challenging rather than enabling (Norris, et al. 2022).
- For people with long-term conditions, the point at which people are approached within the illness trajectory can affect participation (Tallon, et al. 2011). Multiple and complex underlying health issues, such as long-term chronic illnesses, mental health/dual diagnosis can affect ability to participate. Unlike the health needs linked with ageing, their health issues usually reflect health inequalities linked to the social determinants of health (i.e., inadequate housing, poverty, education, employment).

- Vulnerable groups are at heightened risk for certain mental health disorders, including post-traumatic stress, depression and psychosis often due to their social situation, migration experiences and other past experiences of trauma (Hameed, 2018).
- Due to mental health and addiction difficulties, trauma and physical conditions associated with cognitive decline, many individuals from vulnerable and excluded groups have limited cognitive functioning including attention, sequencing and concentration. For people with intellectual disabilities in particular, time is an essential factor in facilitating involvement: providing the space necessary for people to express themselves and to provide on-going support throughout the process (Cambridge and Forrester-Jones, 2003, Fraser and Fraser, 2001, Kaehne and O’Connell, 2010, Tuffrey- Wijne and Butler, 2010). People can experience fatigue when completing surveys and interviews and so need regular breaks, therefore extending the time taken to collect the data. It can take longer to find out information from people with cognitive and communication difficulties due to the need to ask questions more than once and perhaps in different formats, as does allowing people the time to formulate and express their views (Davies, et al. 2010).
- Lack of access to health services and low health literacy. Individuals may experience difficulties in accessing GP services or lack information on support services and their entitlements. Low health literacy can stem from lack of confidence in dealing with health services, language or cultural issues, poor communication and understanding of the needs of vulnerable and excluded groups by providers of health services and lack of information about where to seek help (Allen-Meares, et al. 2020).
- Stigma, discrimination, active-prejudice and/or racism from the public and mainstream services is frequently experienced by our service-users. This also includes self-stigma, a phenomenon whereby a person becomes aware of public stigma, agrees with those stereotypes, and internalises them by applying them to the self which can lead to feelings of unworthiness and reluctance to seek help (Corrigan and Rao, 2012). Experiences of compounded stigma (cumulative impact of being a member of several marginalised groups) shape service users’ modulate their journeys in accessing services and impact participation.
- For some people in the migrant, Traveller and Roma groups’ additional shame and stigma may be experienced when discussing certain topics, for example mental health and LGBTI+. In addition, there may be gaps in services on how to discuss these topics from a culturally sensitive standpoint. Rugkasa and Canvin (2011) found that cultural issues create barriers to inclusion. A cultural distance between researchers and the researched group can create misunderstandings between them (Proctor, 2001).
- Members of these groups may have a high level of mistrust of people in positions of authority, including HSE personnel, the legal system, Gardaí, social workers and sometimes GPs due to negative past experiences. This mistrust can also be impacted by the lack of signs of diversity and/or inclusion in services (e.g. gendered spaces, lack of understanding of LGBTI+ experiences, etc.) Some studies found that past negative experiences with the health services or broader institutions create a culture of mistrust and suspicion about the purpose of the study (Harkins, et al. 2010, Tuffrey-Wijne, et al. 2008).
- In case of victims/survivors of DSGBV, they may be accessing the same services as their aggressor, which could lead to disengagement from the service, or higher levels of mistrust/avoidance.
- Previous experience of participation without any feedback or follow-up and fear that they are not the 'expert' in terms of their contribution may lead to reluctance to participate (Omeni, et al. 2014).
- Lack of access to transport and child care, particularly for women, to enable participation (Fayter, et al. 2007).
- For those with an addiction issue, there may be a fear of impact on their treatment by

engaging in and possibly opposing ideas/policy development, which may lead to a reluctance to seek treatment and engage with services.

- In the case of undocumented migrants, they may not have eligibility to health services except in emergency situations, which holds implications for health status and for appropriate access to care and treatment (IOM, 2016).
- At times, members of vulnerable groups are sometimes unable to obtain a PPS number even when entitled to one, due to low literacy levels and discrimination.
- The language barrier and/or lack of literacy (including comprehension of medical and other technical terminology) experienced by migrants and refugees is a major barrier to service user participation and access to services (Al Shamshi, et al. 2020).

3b. Enablers to engagement and participation

While there are significant barriers and challenges to access and participation, the below list explores a number of **enablers** to participation that seek to overcome limitations presented above:

- Allocation of resources to support engagement, including but not limited to mobile phone/internet costs, child care costs, transport costs, support person/s, interpreters.
- Creative and flexible methods of engagement that take into consideration level of functioning, individual limitations/barriers and capacity to participate.
- Clear parameters for purpose of engagement, length of engagement, expected outcomes or improvements for participants, including follow up post consultation or participation.
- Emphasis on building trust and developing safe, respectful, culturally-sensitive and inclusive environments that recognise and respect diversity, trauma and emotional experiences.
- Existing service users often have access to a key worker, case-manager or other support worker that may be in a position to support their consensual participation in service user involvement activities
- Peer advocates and grass-roots NGO's/projects are instrumental in supporting and promoting service-user engagement (e.g., Primary Health Care for Travellers Projects (PHCTPs)).
- Provision of information in their own language where possible and access to interpreters.
- Visible signs of diversity and inclusiveness of marginalised groups, including the language used in questionnaires and forms.
- Involving service users in the initial planning, delivery, implementation and evaluation of the particular planned engagement.
- Training and support for members of vulnerable and excluded groups, for example communication skills, computer literacy/technology skills, health and social system navigation.
- Training and education for healthcare and other service providers to improve awareness and understanding on how to support and engage vulnerable service user groups and reduce stigma, racism and discrimination, for example, culturally-sensitive service delivery and trauma informed approaches.
- Training for services/policy makers to enable full understanding of meaningful service user participation and enable reflection on current practices and provoke change.
- Provision of additional supports, supervision or mentoring to promote and enable participation that does not endanger or negatively impact their recovery or treatment.
- The provision of a dedicated service user engagement implementation framework for this cohort including the identification of national peer-advocates to support national engagement activities.

3c. Methods of involvement/consultation

(i) Service user consultations (online, face to face and by phone)

Technology

- Ensure participants have access to technology (smart phone/computer).
- Support should be provided to access technology/programme if required.
- Consider reimbursement of funds to pay for phone credit and ensure access to data or Wi-Fi.

Consultation

- Ensure length of consultation/meeting/panel is appropriate for this population and that attention can be sustained.
- Provide a clear explanation of what is expected or what is hoped will be achieved through the consultation.
- Provide feedback on any outcomes following the consultation.
- Ensure a referral pathway is identified if risk/needs are identified.
- Use clear plain English and avoid use of acronyms.

Information/Language

- Use clear plain English and avoidance of acronyms.
- Language and literacy barriers exist.
- Provide interpreters if required
- Provide written materials in plain English and make translated versions available if required.

Other

- Build trust in services, some service users have no trust in services.
- Train health care providers/ facilitators on culturally-sensitive service delivery and trauma informed approaches.
- Consider the use of language referring to service users when conducting any of the consultations, survey, research, for example, being aware of the language used to introduce or refer to people. (e.g., rather than “This is our Service User representative” use “This is John, who is representing the people who use our services” etc.)

(ii) Service user surveys

Design of Surveys

- Provide for facilitated and self-completed surveys.
- Use clear plain English.
- Develop short surveys.
- Use of a mix of online and paper surveys.
- Develop the survey tool in consultation with the people using services (valuable contributions regarding what questions to ask and how to ask them).

Technology

- May not have access to technology (smart phone/computer).
- Support should be provided to access technology/programme if required.
- May lack access to funds to pay for phone credit.
- May lack access to data or Wi-Fi.

Information/Language

- Provide a clear participant information sheet.
- Use clear plain English.
- Provide assurance of anonymity.
- Consider literacy levels and ensure appropriate support is available if required.

- Provide interpreters if required.
- Provide written materials in plain English and make translated versions available if required.

Other

- Provide support to complete the survey (in person, technological etc.)

(iii) Service user participation in meetings

Support

- Provide a pre meeting support session outlining where the meeting will be, who will be there, how to get there, what the purpose of the meeting is.
- Provide support at the meeting, bearing in mind some will never have been at a formal meeting and may be intimidated and feel they do not belong there.
- Provide introductions.
- Use clear plain language and avoid jargon or acronyms.
- Put in place post-meeting support.
- Supervision and support should be offered and a structure for same in place.
- Establish clear parameters, including purpose of involvement, length of involvement, proposed outcomes or benefits to involvement.
- Train health care providers/facilitators on culturally-sensitive service delivery and trauma informed approaches.
- Engage with Peer advocates to support engagement.
- Consider support from NGOs.
- Be supportive, non-judgmental and non-directive.
- Ensure confidentiality.
- Be respectful of diverse ethnic, cultural and religious backgrounds.

Information/language

- Provide interpreters if required.
- Provide written materials in plain English and make translated versions available if required.
- Be aware of potential literacy difficulties.

Considerations specific to Travellers

- Respect the rights of Travellers.
- Be aware of the particular experiences of Travellers.

Considerations specific to LGBTI+ populations

- Respect the rights of LGBTI+ people.
- Be aware of the particular experiences of LGBTI+ people.
- Use appropriate language and terminology that includes gender diverse people.
- Be respectful of people's names and pronouns.

(iv) Service user panels

Support

- Supervision and support should be offered and a structure for same in place.
- Establish clear parameters, including purpose of involvement, length of involvement, proposed outcomes or benefits to involvement.
- Train health care providers/facilitators on culturally-sensitive service delivery and trauma informed approaches.

- Engage with Peer advocates to support engagement.
- Consider support from NGOs.
- Be supportive, non-judgmental and non-directive.
- Ensure confidentiality.
- Be respectful of diverse ethnic, cultural and religious backgrounds.

Information/language

- Provide interpreters if required.
- Provide written materials in plain English and make translated versions available if required.
- Be aware of potential literacy difficulties.

Considerations specific to people with problem alcohol and other drug use

- Be mindful of inclusion of people at various stages of treatment and recovery, and of protecting their recovery within that.

Considerations specific to Travellers

- Support via Traveller Health Units or Primary Health Care for Travellers Projects (PHCTPs)

Considerations specific to Roma

- Establishment of a network of Roma Health advocate workers who could facilitate focus groups with interpreter

(v) Service user research projects

Information/language

- Information sheets and consent forms should be developed in plain English and verbal consent sought where the service user has indicated that they have understood requirements.
- Consider creative methods and outreach for hard-to-reach groups not engaged with services.
- Provide easy read formats of all materials and make translated versions available if required.
- Provide interpreters if required.

Considerations specific to Travellers

- In addition to development of all materials in plain English or easy read format, consideration should be given to Traveller specific promotion for the engagement, i.e., posters, resources and material.

3d. Considerations for consultations based on the experience of Professor Kieran Walsh, Director of the Irish Centre for Social Gerontology and lead investigator in the Older Traveller and Older Homeless (OTOH) research study (2021).

<https://icsg.ie/our-projects/otoh/>

(i) Preparation:

- Be very clear on objectives.
- What level of engagement do you want from this and why?
- Always ask - how can we make this meaningful for people?
- What do you want from ongoing consultations?

Broad considerations:

- A 'one-size-fits all' approach can often times exacerbate issues for socially excluded groups

- (feeling of further exclusion).
- Build long-term relationships and trust with service users through engagement activities such as the HSE consultation - 'set the scene' for future engagement i.e., reference panels, opportunities for training, consultation re proposed frameworks for Social Inclusion etc.
 - Literacy levels vary - use images for icebreakers, develop visual presentations (video format) in advance of sessions so participants can digest the information rather than PowerPoint presentations with text.
 - Ratio of 1:1 facilitator to participant is desired.
 - Encourage someone to be physically present with the participants for support/encouragement.
 - Train peers in direct participation i.e., facilitating research activities (focus groups, consultations, recruitment etc.). NUIG is training peers in facilitating aspects of the research through three workshops.
 - Be aware of diversity within specific cohorts i.e., age, gender, individual journeys/experiences.
 - Suggestions and recommendations that apply to social inclusion groups could also apply to other vulnerable groups that aren't often consulted (i.e., ageing population).

(ii) Specific methodology:

- Create safe and trusting environments.
- Focus groups are a useful forum to gain context. Allow people to speak via open questions/imagery/other prompts, which encourage service users to voice concerns, issues and suggestions that may not have otherwise been considered.
- Participatory learning in action - ranking exercise allows for individual voices to be heard and allows researcher to ask the direct question.
- Gate people were relied upon in recruitment (NGOs/support persons) - until a 'bank' or 'reference group' is established, this is common method of engagement.
- In-depth interviews provide additional depth in data and opportunity for others to engage that may not feel comfortable in group settings.

4. Good practice examples

Homelessness	Peer Specialists and Housing First	Ensuring the ongoing inclusion of the client perspective in the Housing First programme while reducing the boundaries between professional staff and clients. Peer support staff can interpret and explain the client's experience to the professional staff and the other way around. They serve as role models for both clients and professional staff. (A Housing First Manual, Ch. 8 p.79) https://www.housingagency.ie/sites/default/files/A_HOUSING_FIRST_MANUAL_IRELAND.pdf#page=78
Homelessness	Homeless Health Peer Advocacy Programme (DePaul)	Based on the Groundswell programme in UK - trained volunteers providing peer support to access health services, take active role in health/care planning, capture lived experience. https://groundswell.org.uk/what-we-do/homeless-health-peer-advocacy/hhpa-dublin/

Homelessness	HAIL peer support service (funded through Sláintecare)	Supporting peer involvement of those with housing and mental health needs through co-design, peer support and a volunteer programme. http://www.hail.ie/tenant-centre/support/peer-support-service
Travellers	Primary Healthcare for Travellers Projects	Primary Health Care for Travellers Projects (PHCTPs) established a model for Traveller participation in the development of health services. Travellers work as Community Health Workers, allowing primary health care to be developed based on the Traveller community's own values and perceptions to achieve positive outcomes with long-term effects.
Migrants, refugees and international protection applicants Roma	HSE Social Inclusion Community Healthcare Organisation Area 5	The HSE's Community Healthcare Organisation Area 5 (the South East), as part of the National Intercultural Health Care Strategy, are aiming to improve the health outcomes for minority and vulnerable communities, including Roma. In the South East, a number of creative and innovative models of working have been developed that support both service user and service provider and that are designed to address the gaps and barriers preventing equitable health outcomes. This has included facilitating focus groups for service user feedback i.e., the Roma COVID-19 Service User Experience Survey.
Migrants, refugees and international protection applicants Roma	HSE Social Inclusion Community Healthcare Organisation Area 5	Intercultural Health Hub overall aim of the Intercultural Health Hub is to improve the health outcomes of International Protection Applicants, Refugees and Roma. The Intercultural Health Hub is funded by HSE Social Inclusion Southeast Community Healthcare who work towards achieving equality of health outcomes for minority and vulnerable communities in the Southeast. https://wstcys.ie/services/intercultural-health-hub/ The role of the Intercultural Health Workers is to support access to health information and health services and supports for Asylum Seekers, Refugees and Roma Communities. The workers assist in <ul style="list-style-type: none"> the delivery of key health messages, facilitate the development of health initiatives/programmes in response to health needs and provide health advocacy supports when required.

		<ul style="list-style-type: none"> • The provision of health information on a range of topics including mental health, immunisation, asthma, diet, exercise and over the counter medications etc. • Support with applying/renewal for medical cards. • Support with making and attending medical appointments. • The provision of information on access routes and referral pathways to health services and supports. • Delivery of health literacy programmes. • Provision of general health advocacy and referral support service. • Promotion of availability of translation and interpretation services for health service users.
People with problem alcohol or other drug use	Recovery Academy of Ireland	<p>(i) Supporting and advocating for people in recovery: promote recovery; provide support for people in recovery and their families; organise recovery activities; raise awareness about recovery; provide workshops and training on recovery; conduct research; and advocate on policy. Contact Coordinator Paul Duff pduff@recoveryacademyireland.ie</p> <p>(ii) An approach for consideration when thinking about service user engagement – community participation action research, an example from the Recovery Academy</p>
People with problem alcohol or other drug use	The South East Task Force	Service User Involvement staff training manual available https://www.srdatf.ie/wp-content/uploads/2015/06/FINAL_Service-User-Manual-March-2015.pdf
People with problem alcohol or other drug use	Naloxone Demonstration Project, Quality Improvement Project Team	Service User representative group UISCE sit as equal members on the QIP group for the Naloxone project. There is also representation from the National Family Support Network, NGOs and the HSE. Role of the group is to provide governance for the naloxone roll out nationally. In addition, the group supports and rolls out training. UISCE have a key role to play in providing training both to NGOs and to peers. Training and educational resources are also developed with their input and consultation with their constituency.
People with problem alcohol or other drug use	Working Group on development of Supervised	UISCE as the Service User representative group for People Who Use Drugs, sat on this group with the HSE and the Department of Health to produce a report and document

alcohol or other drug use	Injecting Facility model	that was used to tender for the first SIF in Ireland. As part of their work on the group they carried out a survey with street injectors to ascertain views in relation to the utility and shape of the facility. This survey plays a key role in the design and operational structure of the proposed facility.
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