



**The Education and Training
of
Severely and Profoundly
Mentally Handicapped Children
in
Ireland**

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*Report of a Working Party to the
Minister for Education and the
Minister for Health and Social Welfare*

January, 1983.

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CONTENTS

	Page
Membership of the Working Party	(viii)
 Chapter One—Introduction	 1
1.1 Terms of Reference	1
1.2 Modus Operandi of the Working Party	1
1.3 Plenary Meetings and Subcommittees	1
1.4 Questionnaire to Care Units	2
1.5 Implications of Research findings	2
1.6 Submissions from Individuals and Groups	2
1.7 Integration in ordinary schools not considered feasible	2
1.8 Acknowledgements	3
 Chapter Two—Summary of Recommendations	 4
 Chapter Three—Historical Perspective	 8
3.1 Introduction	8
3.2 Absence of Education or Training Programmes ...	8
3.3 Early Provision limited to Mildly Mentally Handi- capped Children	8
3.4 Extension of Education to Persons with a greater degree of handicap	9
3.5 Extension of Education to Severely Mentally Handi- capped Children in the U.K.	9
3.6 Early Development of Services in Ireland	10
3.7 Initial involvement of Medical and Nursing Professions in caring for Mentally Handicapped Persons	10
3.8 Establishment of Schools for Moderately Mentally Handicapped Children, and development of Day Services	10
3.9 Establishment of the Commission of Inquiry ...	11

3.10	Commission's recommendations regarding educational provision for Mentally Handicapped Children ...	11
3.11	Commission's recommendations for low Moderate and Severely Mentally Handicapped Children ...	12
3.12	Commission's definition of Care Units and Nursery Units ...	13
3.13	Commission's recommendations regarding the programme to be followed in Day Care Units ...	13
3.14	Commission's recommendations for Residential Centres ...	13
3.15	Developments in schooling for Moderately Mentally Handicapped Children since the Commission's Report ...	14
3.16	Development of Vocational Training Centres ...	14
3.17	Development of Services for Severely and Profoundly Mentally Handicapped Children since the Commission's Report ...	15
3.18	Improvements in the quality of Residential Services for Severely and Profoundly Mentally Handicapped Children ...	16
3.19	Development of Programmes in Day-Care Units ...	17
3.20	Assessment and Diagnosis ...	17
3.21	Working Party on Services for the Mentally Handicapped 1980 ...	18
3.22	Conclusion ...	18

Chapter Four—Children with Severe and Profound Mental Handicap ...	20
4.1 Classification of Mental Handicap ...	20
4.2 Quadripartite Classification of Mental Handicap ...	20
4.3 Confusion caused by the use of different classifications ...	21
4.4 Some educational provision already for Severely Mentally Handicapped Children in schools ...	21
4.5 Estimate of the number of children involved ...	21
4.6 Reconciling apparent discrepancies between responses to Questionnaire and the Report of the Working Party, 1980 ...	21
4.7 Total Population estimated at 2,000 ...	22
4.8 Characteristics of children with Severe and Profound Mental Handicap ...	22
4.9 Prevalence of additional handicaps in Severely and Profoundly Mentally Handicapped Children ...	23
4.10 A case study: the population in St. Michael's House Service ...	23
4.11 Conclusion ...	24

Chapter Five—Education and Training Needs of Children with Severe and Profound Mental Handicap	26
5.1 General and Specific Needs	26
5.2 Early Diagnosis	26
5.3 Basic areas of need: Care, Specialised Treatment, Child Rearing, Education and Training	27
5.4 The Need for Care and Child Rearing	27
5.5 The Need for Specialised Treatment	28
5.6 Aims of Education and Training	28
5.7 Defining Educational Needs	29
5.8 Right to Education	29
5.9 Major Curricular Areas to satisfy Learning Needs of Severely and Profoundly Mentally Handicapped Children	30
5.10 Methodology	30
5.11 Specific <i>Time</i> and <i>Space</i> and Individualised Programmes required	31
5.12 Summary of Education and Training Needs	31

Chapter Six—Present Provision for Children with Severe and Profound Mental Handicap	33
6.1 Sources of Information	33
6.2 Growth in Provision of Places	33
6.3 Location of Day Care Units	34
6.4 Size of Care Units	34
6.5 Designated Education/Training Space in Residential Units	35
6.6 Type of Accommodation provided in Day Care Units	35
6.7 Adequacy of Present Accommodation	35
6.8 Disciplines involved in Education and Training	36
6.9 Programmes of Education and Training	36
6.10 Constraints on the implementation of Appropriate Education and Training Programmes	37

Chapter Seven—Proposals for Establishing a System of Education and Training for all Children with Severe and Profound Mental Handicap and the Personnel Required to Implement these Proposals	39
7.1 Necessity for an Integrated Approach	39
7.2 Skills necessary for Personnel formulating and implementing an Education and Training Programme	39
7.3 The contribution of Teaching	40
7.4 Issues raised by the introduction of Teachers to centres for Severely and Profoundly Mentally Handicapped Children	40

7.5	Expanding the role of Schools for Moderately Mentally Handicapped Children	41
7.6	The introduction of Teachers to separate Day Care Units	43
7.7	Schools with small Care Units on the same Campus	43
7.8	Introduction of Teachers to Residential Centres for Severely and Profoundly Mentally Handicapped Children	44
7.9	Staffing Requirements for Care Units	44
7.10	Responsibility of the Departments of Education and Health	45
7.11	Redesignation of Care Units as <i>Developmental Education Centres</i>	45
7.12	Transport	46
7.13	Staff Training	46
7.14	Involvement of Parents and Families	47
7.15	The role of Untrained Staff	47
7.16	Trainee Nurses of the Mentally Handicapped	48
7.17	Continuing Education	48
7.18	Introduction of Teachers on a Phased Basis	48

Appendix I

Summary of significant statistics from replies to Questionnaire	50
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Appendix II

Copy of Questionnaire issued to Agencies providing services to Severely and Profoundly Handicapped Children, May, 1980	59
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Appendix III

List of Individuals and Organisations from which written submissions were received	67
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*Resigned during period of Working Party's meetings.

øAppointed in replacement of resigned member.

CHAPTER ONE

INTRODUCTION

Terms of Reference

1.1 The Working Party was established in 1980 by the Minister for Education and the Minister for Health and Social Welfare, with the following terms of reference:

1. To examine the educational and training needs of children with severe and profound mental handicap.
2. To consider the nature of the personnel necessary to meet these needs.
3. To make appropriate recommendations to the Minister for Education and the Minister for Health and Social Welfare.

Modus Operandi of the Working Party

1.2 The Working Party interpreted its terms of reference as including all those children between the ages of 4 and 18 years who are at present excluded from the formal educational system because of low intelligence. It also included those moderately mentally handicapped young children who attend pre-school units attached to centres catering for severely and profoundly mentally handicapped children. The Working Party recognised that it is not meaningful arbitrarily to set an upper limit of 18 years of age for participation in programmes of education and training for severely and profoundly mentally handicapped persons. It will argue later in the report for the inclusion of severely and profoundly mentally handicapped adults in appropriate education and training programmes. It is felt, however, that such programmes should not be conducted in children's centres, and the deliberations which led to this report have not included discussion of education and training programmes for adults.

Plenary Meetings and Sub-Committees

1.3 The Working Party held a total of 22 plenary meetings. In addition, small groups of members visited a number of day and residential centres for severely and profoundly mentally handicapped children. Some of the members who had visited centres abroad made reports of these visits available to the Working Party. A sub-commit-

tee considered the staffing levels necessary in care units and its recommendations were considered by the Working Party as a whole.

Questionnaire to Care Units

1.4 In the Summer of 1980 a questionnaire was issued to the managements of all known agencies providing services for severely and profoundly mentally handicapped children. A total of 51 agencies were contacted and 48 responded. Where the information returned was amenable to processing, this was done through the co-operation of the Electronic Data Processing Unit of the Department of Education. This information provided invaluable data for informed deliberation at the Working Party meetings and several references will be made to it throughout this report. What were considered to be the most significant findings are included in Appendix I of the Report.

Implications of Research Findings

1.5 The Working Party had available to it reports of relevant research in Ireland and elsewhere. Some of these reports are included in the list of submissions made to the Working Party and other findings are contained in the Official Reports on Mental Handicap issued from time to time. In particular we drew heavily on the Report of the Commission on Mental Handicap (1965), the Report of the Working Party on Services for the Mentally Handicapped (1980) and the various reports of the Medico-Social Research Board. We considered carefully the recommendations made on a similar population in the United Kingdom by the Committee on Special Educational Needs, (1978), chaired by Mrs. M. Warnock (The Warnock Report). We studied the pamphlets issued by H. M. Inspectorate at the time when the Department of Education and Science in the United Kingdom took over responsibility for the education of severely and profoundly mentally handicapped children. The Working Party also studied the implications of the United States Public Law 94-142 (The Education of All Handicapped Children Act, 1975) and some of the specialist commentaries on the implications of that law.

Submissions from Individuals and Groups

1.6 Advertisements in the public press in Summer and Autumn of 1980 invited interested parties to make written submissions to the Working Party. A complete list of all individuals and groups who responded to this invitation is included in Appendix III. The Working Party also heard an oral submission from a delegation representing the Irish Nurses Organisation and the National Council of Nurses.

Integration in Ordinary Schools not Considered Feasible

1.7 The Working Party is mindful of the debate on the question of

integrating handicapped children, including the severely and profoundly mentally handicapped, in ordinary schools. It is the policy of the Government to integrate as many handicapped children as possible in ordinary schools. Whatever about the merits of integrating less handicapped children in ordinary schools, the Working Party is of the view that the education and training needs of severely and profoundly mentally handicapped children are such that they could not be met, in the foreseeable future, by attendance at ordinary schools.

Acknowledgements

1.8 The Working Party wishes to acknowledge the co-operation which it received from officials in the Departments of Education and Health. It also acknowledges the willing co-operation which was received from the managements and staffs of centres which completed and returned questionnaires. The delegations from the Working Party were received with great courtesy and hospitality in the centres which were visited. A special word of thanks is due to Ruairí Ó Cillín, Uasal, Inspector of Schools, who was mainly responsible for processing the returned questionnaires, summarising the huge volume of written submissions and collating the material for the final report. The Working Party wishes to offer thanks to Máiréad Ní Mhurchú, Analyst, Department of Education, for her advice in drawing up and processing the questionnaire and to the staff of the Electronic Data Processing Unit of the Department of Education. The preparation of the various drafts of this Report added considerably to the workload of Miss Marie O'Neill and her staff in the Department of Education typing section. We are deeply grateful for the unfailing service which was provided. Finally a special word of thanks is due to Tomás Ó Cuanaigh, Uasal, Assistant Principal Officer, Department of Education, the appointed secretary to the Working Party. He was responsible, not only for arranging the meetings and writing minutes, but also for collecting and issuing the documentation which was examined by the Working Party. We are deeply indebted to him for his unfailing courtesy, patience and understanding at all times.

CHAPTER TWO

SUMMARY OF RECOMMENDATIONS

2.1 In future only the WHO quadripartite classification of mental handicap should be used in Ireland and all statistical data should be converted to that classification. (Par. 4.3).

2.2 Counselling and support services should be further developed for parents and families of all handicapped children, with particular attention to severely and profoundly mentally handicapped children. (Par. 5.2).

2.3 All centres for severely and profoundly mentally handicapped children should have an education and training programme and specific times should be set aside for it. Furthermore, designated space should be made available, separate from the living quarters of the children, for this purpose. (Par. 5.11).

2.4 Each child should have access to an education and training programme designed with his particular learning needs in mind, and subject to review from time to time. A detailed progress record of each child's development should be maintained, and this should be transferred with the child if he moves to any other agency. (Par. 5.11).

2.5 As a first priority, adequate care facilities should be made available for all those severely and profoundly mentally handicapped children who are still excluded from a suitable service in their own area. (Par. 6.2).

2.6 Teachers, paid and supervised by the Department of Education, should be made available to severely and profoundly mentally handicapped children. (Par. 7.3).

2.7 Any lower limit of eligibility for enrolment in schools for moderately mentally handicapped children should be removed, and the decision about individual children should be left to the discretion of Boards of Management, in consultation with the inspectorate of the Department of Education. Where the Board feels that the curriculum in the school can be adapted to meet a child's needs it should be free to accept such a child. (Par. 7.5).

2.8 Where a school for moderately mentally handicapped children agrees to enrol pupils assessed as severely or profoundly mentally

handicapped, additional resources should be made available by the State to satisfy the additional special caring and learning needs of these pupils. A flexible approach should be adopted, and the needs of each school examined on an individual basis, including the teaching duties of the Principal. (Par. 7.5).

2.9 The question of the funding of services, other than teaching services, in special schools generally should be examined by the appropriate authorities. (Par. 7.5).

2.10 In the case of large separate day care units, the present structures should be maintained, but one teacher should be introduced for each 12 children. Such teachers should be eligible for recognition in schools for moderately mentally handicapped children, and should be attached for salary, superannuation and seniority purposes to the nearest school for moderately mentally handicapped children. Such teachers would report to the Principal Teacher of the school to which they were attached but would work as members of an interdisciplinary team within the care unit. They would have special responsibility for educational curriculum planning and implementation, under the general guidance of the Principal Teacher. The head of the care unit would have responsibility for coordinating the work of all the disciplines. Where a number of teachers are assigned to a particular unit, one or more of them should be appointed to posts of responsibility in the care unit, and such post holders would be responsible for the coordination of the educational programme on a day to day basis. (Par. 7.6).

2.11 In the case of schools with small care units on the same campus, teachers should be assigned to such care units in the ratio of one teacher to each 12 children. (Par. 7.7).

2.12 Where the number of children is very small the Principal Teacher should be responsible for the day to day educational programme planning for both school and care unit. (Par. 7.7).

2.13 Responsibility for capital expenditure, running costs and salaries of staff, other than teaching staff, should continue to be accepted by the health agencies as at present. Where a need for such a unit is recognised, it should be funded on the basis of an agreed annual budget. (Par. 7.7).

2.14 Until such time as it is possible to provide designated teaching space in all residential centres, one teacher should be provided for every 12 severely and profoundly mentally handicapped children and a teacher should spend some time each day with each child. The appropriate authorities should reconsider the wisdom of providing for large numbers of non-ambulant profoundly mentally handicapped

children in one central location in each area and explore the possibility of integrating small numbers into more localised services. (Par. 7.8).

2.15 Public money should be made available for the purchase of additional specialised equipment to allow for the greater stimulation of such children, e.g. walking aids, hoists, electric wheelchairs, etc. (Par. 7.8).

2.16 In addition to one teacher per twelve children, each care unit should have a minimum front line staff of 15 for each group of 50 children, the exact proportion of each discipline involved to be determined by the needs of each centre. (Par. 7.9).

2.17 The Department of Education should be responsible for remuneration of the teachers and they should be subject to the rules and regulations for national schools. (Par. 7.10).

2.18 The Department of Health and the Health Boards should be responsible for the funding of capital and other running costs of the care units, and no change is envisaged in the present arrangements for recruitment and remuneration of staff other than teachers. (Par. 7.10).

2.19 Any centre offering a formal educational programme for a specified time each day to all children in space specially allocated for that purpose should be redesignated a Developmental Education Centre. (Par. 7.11).

2.20 A comprehensive system of transport should be established for all handicapped children attending Developmental Education Centres on a day basis. Where the Department of Education and any health agency are providing transport for handicapped people to adjacent day facilities, there should be coordination at local level, with a view to apportioning costs and to providing the most efficient service possible. (Par. 7.12).

2.21 Any system of transport operating to Developmental Education Centres should be sufficiently flexible to allow for the use of vehicles and escort personnel in connection with out-of-school and leisure activities. (Par. 7.12).

2.22 (i) Formal induction training should be provided for all teachers who are about to take up duty with severely and profoundly mentally handicapped children.

(ii) Teachers employed in recognised Developmental Education Centres should be eligible for secondment to the Diploma Course in Special Education, and that course should be modified and expanded to meet their special needs.

- (iii) All teachers during their basic training should be acquainted with the methodology, theory and practice of teaching children with mental handicap, including severe and profound mental handicap. (Par. 7.13).

2.23 Programmes of parent education should be associated with all Developmental Education Centres, and parents and other members of the child's family should be involved fully in the education and training programmes. Where appropriate, professionals, including teachers, should work with the families at home. (Par. 7.14).

2.24 Young people should be encouraged to work in the education and training of severely and profoundly mentally handicapped children when participating in prevocational training and youth employment schemes, and the necessary financial resources should be made available to make such participation possible. (Par. 7.15).

2.25 Where trainee nurses are engaged in education and training programmes, and, where their own training demands that they be absent from the team for certain periods, they should be employed as additional to the basic staff complement. (Par. 7.16).

2.26 The relevant authorities should formulate a definite policy on the provision of continuing education for adult severely and profoundly mentally handicapped persons. (Par. 7.17).

2.27 Teachers and formal educational programmes for severely and profoundly mentally handicapped children should be introduced on a gradual basis. Such programmes should be monitored carefully and their efficacy evaluated scientifically. (Par. 7.18).

2.28 An experimental and research orientated approach should be adopted in relation to the new Developmental Education Centres, and a considerable degree of flexibility should be allowed to cater for particular needs. (Par. 7.18).

CHAPTER THREE

HISTORICAL PERSPECTIVE

Introduction

3.1 It is necessary to see the provision of education and training for severely and profoundly mentally handicapped children within the context of the development of education programmes for mentally handicapped persons generally. The provision of special education appropriate to the needs of mentally handicapped persons is of relatively recent origin. Although it started in the middle of the nineteenth century, real and dramatic growth in the availability of services has occurred only in the latter half of the twentieth century. This growth has followed the development of techniques to identify the characteristics and needs of children with varying degrees of mental handicap and the development of suitable programmes of education and training to satisfy those needs.

Absence of Education or Training Programmes

3.2 Despite the work of pioneers, such as Itard, Seguin and Montessori, there was no education or training programme available for the vast majority of mentally handicapped persons until relatively recently. In Ireland, mentally handicapped persons were generally placed in psychiatric hospitals, county homes and hospitals for the physically handicapped, under the Poor Relief (Ireland) Acts of 1838 and 1847, and the Poor Afflicted Persons (Relief) Act of 1878. The Elementary Education (Defective and Epileptic Children) Acts of 1899 and 1914, in England, attempted to identify those children over seven years of age who would benefit from a modified education programme, and made it mandatory on local authorities to provide facilities where such programmes could be followed. The 1921 Education Act imposed on local authorities in England an obligation to make provision for the education of defective children in special schools or classes. These Acts (1899, 1914 and 1921) did not apply to Ireland.

Early Provision Limited to Mildly Mentally Handicapped Children

3.3 In all this development consideration was given only to those who were seen as capable of benefiting from a modification of the

programme for ordinary schools i.e. those who would now be described as mildly mentally handicapped. Persons with a greater degree of mental handicap were regarded as ineducable. Caring programmes were formulated to cater for their physical and medical needs and were available only in residential institutions. The work of Binet, Burt and others, in a scientific approach to intelligence testing, highlighted the various needs of the handicapped person. By identifying and quantifying those needs the position of education was made prominent in the treatment of mental retardation. Successive Education Acts in the U.K. made education for mildly mentally handicapped children mandatory and universal. The U.S. and Scandinavian countries followed similar patterns of development, so that today virtually full provision for the education of mildly mentally handicapped persons exists in developed countries.

Extension of Education to Persons with a Greater Degree of Handicap

3.4 It is only in more recent times that public awareness has grown of the benefit of educating children with more severe degrees of mental retardation. Public school programmes for moderately mentally handicapped children were initiated in the U.S., in 1914 in St. Louis, 1929 in New York City, and in 1934 in St. Paul's, Minnesota. In the early 1950's public school programmes were set up for those children described as the trainable mentally handicapped. These were children with I.Q. below 50 who had been previously regarded as ineducable. The Education of all Handicapped Children Act, 1975 (U.S. Public Law 94-142), made the provision of free appropriate education for all children compulsory, no matter how severe or profound their handicap.

Extension of Education to Severely Mentally Handicapped Children in the U.K.

3.5 In the U.K. the 1970 (Handicapped) Act required that all mentally handicapped children, including the group then termed the severely subnormal (i.e. I.Q. under 50), be provided with appropriate education. Local education authorities were given responsibility for the provision of a suitable programme of training. Former Junior Training Centres were redesignated Special Schools for E.S.N. (S) Children. In sub-normality hospitals, where no separate classroom accommodation was available, special education was to be provided in the wards by teachers. The policy was that ultimately children would attend schools outside their living quarters. The concept of education was regarded as central to treatment, and no lower limit was set for the acceptance of children. Many E.S.N. (S) schools in the U.K. have special care classes or Units for the Most Severely Handicapped where children who are severely or profoundly mentally

handicapped are enrolled. In other instances such children are enrolled in classes for E.S.N.(S), but with additional support staff.

Early Development of Services in Ireland

3.6 As early as 1869 Stewart's Hospital, Palmerstown, Co. Dublin, began to provide residential care and treatment for mentally handicapped persons. It had accommodation for one hundred persons, both male and female. No further services exclusively for mentally handicapped persons were added until after 1922. Religious Orders were the initiators of most of the services which were developed in the second quarter of the twentieth century. The Daughters of Charity of St. Vincent de Paul established their services in 1926, and the Hospitaller Order of St. John of God in 1932. Over the next twenty five years the Brothers of Charity, the Sisters of Jesus and Mary and the Sisters of La Sagesse became involved in providing services. These were followed by other religious congregations which had a traditional involvement in Irish education. Most of these congregations purchased large buildings during the thirties in rural areas, and the services which were set up tended to be residential and to serve national needs rather than community orientated and to serve local needs. The early development of services in Ireland was not accomplished by legislation or by state initiative but, rather, by the state agencies agreeing to support the initiative of religious and other non-statutory bodies, or responding to needs highlighted by associations of parents and friends of mentally handicapped children.

Initial Involvement of Medical and Nursing Professions in Caring for Mentally Handicapped Persons

3.7 From 1930 onwards some educational provision was made for mildly mentally handicapped children in special schools which, initially, were not state aided. Eventually these schools were recognised within the national school system. In caring for moderately and severely mentally handicapped children, however, the religious and voluntary bodies drew their expertise from the various branches of the medical and nursing professions. In 1959 An Bord Altranais approved the first syllabus for a course of training for Registered Nurses in Mental Handicap, recognising that mentally handicapped persons required more than care. [This syllabus was again revised in 1977]. Gradually other disciplines, such as speech therapy, physiotherapy and psychology began to make contributions to the care and training of moderately and severely mentally handicapped children.

Establishment of Schools for the Moderately Mentally Handicapped and Development of Day Services

3.8 The role of education in the care of moderately mentally handicapped children was officially accepted from 1953, with the recogni-

tion by the Department of Education of special schools for this group. These schools, like other special schools, are recognised as National Schools. In addition to the religious and other corporate bodies, local associations have emerged as patrons of these schools. The pioneers of this development were the St. Michael's House organisation in Dublin and the Cork Polio and General Aftercare Association in Cork. These local associations placed their main emphasis on the establishment of day services. The National Association of Parents and Friends of the Mentally Handicapped was founded in 1961 with the object of giving those involved in the provision of services, and other interested parties, an opportunity of educating the public through the dissemination of knowledge. Some teachers in special schools were sent for special training in England and Scotland and in 1961 the post-graduate course in Special Education was set up in St. Patrick's College of Education. Largely through the initiative of the parents themselves and supported by the local Health authorities, Day Care Units were established specifically for the care and training of severely mentally handicapped children, and this marked a move towards a community service. The large residential centres were also beginning to provide accommodation designed on a domestic scale for handicapped people.

Establishment of the Commission of Inquiry

3.9 With change and growth occurring over a wide front, the need for proper planning of health, education and social services for mentally handicapped persons resulted in the setting up of a "Commission on Inquiry of Mental Handicap" by the Minister for Health in 1961. The Commission issued its report in 1965, and it marked a watershed in the development of services for mentally handicapped persons in Ireland. Many of its recommendations were implemented in full. Efforts were made to assess and ascertain the capabilities and needs of the retarded. The initial objective was to provide a comprehensive service for children. This involved the setting up of additional special schools and an increase in the number of places for those requiring residential care.

Commission's Recommendation Regarding Educational Provision for Mentally Handicapped Children

3.10 While making extensive recommendations for the continued development of educational, vocational and residential services for mildly mentally handicapped children, the Commission further examined the educational needs of those with a greater degree of handicap. It described severely mentally handicapped persons as follows:

"Severely handicapped persons are persons whose mental handicap is of such degree that they are unable to look after their basic personal needs, or to guard themselves against common physical

dangers and require close and constant supervision. In so far as an intelligence quotient can be regarded as a measure of severe mental handicap, the persons concerned would generally have intelligence quotients of less than 25".

It described moderately mentally handicapped persons as follows:

"Moderately handicapped persons are persons whose mental handicap, though not amounting to severe mental handicap, is yet so pronounced that they need special training, supervision and support. As adults some may be capable of working under normal conditions but most of them will need sheltered employment. In so far as an intelligence quotient can be regarded as a measure of moderate mental handicap the persons concerned would generally have intelligence quotients from 25 to 50".

It must be pointed out that the Commission expressed reservations about the use of I.Q. as "in itself a test of mental handicap", but it recognised it as a "convenient and helpful measure of the level of intelligence of different grades".

While it decided to use the tripartite classification of mental handicap it expressed a belief that

"there is a change, around I.Q. 35, in the educational needs of the moderately handicapped".

In the event, it recommended that special schools should be provided for those in the I.Q. range 35-50. This recommendation represented considerable vision at that time as serious doubt was then being expressed in the U.S. and elsewhere about the educability of these children.

Commission's Recommendations for Low Moderate and Severely Mentally Handicapped Children

3.11 The Commission condemned the practice of placing severely mentally handicapped persons in psychiatric hospitals (Par. 123). It suggested an expansion of residential facilities provided by voluntary bodies and the establishment of day care units, as far as possible in close proximity to schools for the moderately mentally handicapped. With regard to residential accommodation, it was suggested (Par. 121) that two types would be necessary

- (a) separate buildings and facilities for non-ambulant severely handicapped children, possibly in conjunction with buildings and facilities for other purposes, and
- (b) facilities for ambulant severely handicapped children to be made available in the same type of accommodation as that for moderately mentally handicapped children.

Commission's Definition of Care Units and Nursery Units

3.12 A Care Unit was defined by the Commission as

“a non-residential unit where a special form of care and training is provided for the severely handicapped and for such of the moderately handicapped as are unable to benefit from education and training given in the schools”.

Care units would be combined with schools for the moderately handicapped and with nursery units to form “comprehensive day centres”.

The establishment of nursery units was recommended to cater for young children, both moderately and severely mentally handicapped, on a day basis (Par. 60). These units would supplement the work of the family. Habit training, physiotherapy and play therapy were seen as important components of an education programme to be followed in such units. It was recommended that at least one of the staff should be skilled in the care of mentally handicapped children. A registered nurse of the mentally handicapped (R.N.M.H.) was considered to be the most suitable person.

Commission's Recommendations Regarding the Programme to be Followed in Day Care Units

3.13 The Commission's recommendations regarding the programme of training to be followed is more specific for day care units than for residential centres. The work of the day care unit would be a continuation of the work of the nursery unit, with an increased emphasis on training. The aim would be to help children to develop in mind and body so that their dependency would be reduced to the greatest possible extent, and that they would lead as happy and useful lives as their disabilities would permit. The programme, while having regard to individual differences, would focus on the following principal areas: personal hygiene, physical education, the development of a simple vocabulary, self-help, social training, simple domestic tasks and self-reliance. Periods of free play and rest would be necessary. Such units also should be a source of advice to parents (Par. 101). The Commission recommended that Care Units should be staffed by persons qualified and experienced in the care of the mentally handicapped, and nurses qualified in mental handicap where specifically mentioned. It also envisaged some involvement of voluntary workers under the direction of professional staff.

“The staffing of the Care Unit should be combined with that of the nursery unit and the school for the moderately handicapped”.

Commission's Recommendations for Residential Centres

3.14 The Commission was aware that parts of the residential centres (Par. 120)

“must still function as centres for human custody for long periods, possibly for life, . . . but most residential centres have now to fill an active therapeutic role aimed at fitting as many as possible for life in the community and at enabling those who cannot live in the community to use their limited ability to best advantage, to reduce their dependency and to lead as full and happy lives as their disabilities will permit”.

It pointed out that qualities of kindness, humanity and dedication, while still necessary in the staff of residential services, were not sufficient. Training, skill and experience in the care of the mentally handicapped were necessary so that such institutions could fulfil their therapeutic role. In varying degree the services of the following professionals would be required:— psychiatrists, psychologists, teachers, nurses, social workers, occupational therapists, speech therapists and other trained staff. The essential factor was that a residential centre should have the staff necessary to fulfil its role. Where a centre had a double role, custodial and therapeutic, it was essential that a therapeutic or rehabilitative approach should prevail as far as possible.

Developments in Schooling for Moderately Mentally Handicapped Children Since the Commission's Report

3.15 The Commission recommended schooling for moderately mentally handicapped children between the ages of 6 and 16. In the intervening years, as teachers' experience of and competence in structuring programmes for moderately mentally handicapped children developed, the age span for which these schools cater has been extended at both ends. The majority of these schools now cater for children in the age range 4 to 18. The limit of acceptability of children has also been extended downwards with the result that virtually all schools are willing to accept children whose I.Q. exceeds 30, and many schools accept some children with an I.Q. below 30. The I.Q. is no longer the principal determinant of acceptability. In the case of children of the lowest level of ability, decisions on enrolment are based more on the social skills of the child and on the absence of serious emotional disability. In 1972 the Department of Education established a Steering Committee to assist in the development of curriculum guidelines for schools for moderately mentally handicapped children. This committee is composed of teachers, psychologists and inspectors. To date it has produced guidelines on Aims and Approaches, Language, Personal and Social Development and Movement. In addition schools have adapted programmes developed elsewhere to suit their own needs. It can be said that the schools for moderately mentally handicapped children have reached a degree of sophistication which is comparable with the best practices elsewhere.

Development of Vocational Training Centres

3.16 Since the mid sixties some of the larger voluntary bodies have

been providing post-school and pre-work vocational training for moderately mentally handicapped and some mildly mentally handicapped persons in Vocational Training Centres. These centres were developed following the Report "Training and Employing the Handicapped" (1975) under the chairmanship of Dr. J. Robins, Department of Health. The Departments of Health and Education were jointly involved in the development of these centres, and, since Ireland's entry to the EEC, it has been possible to avail of considerable financial support from the European Social Fund. Many of the services for the mentally handicapped have such training centres and others are planned with a view, ultimately, to making work training available to all suitably assessed moderately mentally handicapped school leavers.

Development of Services for the Severely and Profoundly Mentally Handicapped Since the Commission's Report

3.17 In the years since the Commission reported (1964-81) the number of day places available for moderately and severely mentally handicapped children has increased eight fold, and the number of residential places has increased by 20 per cent. The extent of these developments can be seen from the following tables.

TABLE A
Residential Services

	No. of places available for children 1964		No. of places recommended by Comm.		No. of places available to children 1981		
	Moderate	Severe	Moderate	Severe	Moderate	Severe	Profound
I.Q.	25-50	under 25	25-50	under 25	35-49	20-34	under 20
No.	587	490	950	1,000	633	469	186
Total	1,077		1,950		1,288		

1964: 15 Centres. 1981: 22 Centres.

TABLE B
Day Services

	No. of places for children 1964		No. of places recommended by Comm.		No. of places available to children 1981		
	Moderate	Severe	Moderate	Severe	Moderate	Severe	Profound
I.Q.	25-50	under 25	25-50	under 25	35-49	20-34	under 20
No.	285	28	450	450	2,024	368	75
Total	313		900		2,467		

1964: 13 schools and day centres. 1981: 68 schools and day centres.

TABLE A & TABLE B

Places in 1964	Places Rec. by Comm.	Places for Children 1981
1,390	2,850	3,755

In looking at these figures the differing criteria for enrolment in schools must be borne in mind. Whereas all children with an I.Q. of 25-50 are classified as moderately mentally handicapped, an I.Q. of 35 was traditionally accepted as the lower limit of acceptability for school purposes. It will be seen that by far the greatest increase between 1964-1981 occurred in the number of moderately mentally handicapped children admitted to day schools. In the past few years, as small day schools have been established, there has been some reduction in the numbers enrolled in special schools attached to residential centres which formerly accepted children from outside their immediate catchment areas.

Places for severely and profoundly mentally handicapped children numbered 518 in 1964. The vast majority of these places (490) were in residential centres. It was recommended that provision be made for 1,450 in both day and residential facilities, 450 in day centres and 1,000 residential. In fact, by 1981 a total of 1,098 places had been provided, 655 in residential centres and 443 in day centres.

Because the 1981 figures are given under the quadripartite classification and the 1964 figures are under the tripartite classification, it is difficult to make exact comparisons. Suffice it to say that, allowing for the fact that the 1981 figure would cover a larger population, there would still seem to be a shortfall of approximately 300 in the number of places available for severely and profoundly mentally handicapped children.

Improvements in the Quality of Residential Services for Severely and Profoundly Mentally Handicapped Children

3.18 In spite of the large number of places which had to be made available, steady improvements can be noted in the quality of residential services. Most of the expenditure of the larger centres is now recouped by a direct funding arrangement on the basis of agreed pay and non-pay expenditure. This has resulted in the recruitment of additional professional staff and in an improvement of facilities. There has been a marked increase in the number of qualified staff in these centres and an increasing availability of professionals with qualifications in speech therapy and physiotherapy, although there is still a considerable shortfall in the availability of these disciplines. Health Boards are involved on an increasing scale in the direct provision of services, and, in particular, in meeting demands for adult residential places. It is generally accepted that young adults should be moved on to an environment more appropriate to their chronological age and development.

The efforts of the statutory and voluntary bodies are co-ordinated through Mental Handicap Committees which function in the various Health Board Areas. While some centres still provide residential places for children from all parts of the country, there is a move

towards a policy of providing comprehensive mental handicap services within each Health Board for eligible persons residing in its own area.

Development of Programmes in Day-Care Units

3.19 Since 1965 there has been a steady expansion of day services for severely and profoundly mentally handicapped children. Some of these special day care units are provided on the same campus as schools for moderately mentally handicapped children. Others have developed independently of existing facilities. They range in size from large units in urban areas catering for upwards of 100 children to small units catering for 6-10 children. Many of these have preschool units for young moderately mentally handicapped children attached to them. These latter units are staffed by nurses, child care workers and, occasionally, by teachers. Where teachers are employed, they are paid by the employing authority which recoups its expenditure from the Health Board or the Department of Health, and such service is not recognised by the Department of Education for incremental, probation or superannuation purposes.

Most care units provide a specific preschool programme for young moderately mentally handicapped children. For severely and profoundly mentally handicapped children the care and education/training programmes are integrated. The attention given to education/training depends on the following:

- (a) the financial resources available to management,
- (b) the orientation of local management towards a particular kind of service,
- (c) the kind and severity of secondary handicaps presenting in the children,
- (d) the orientation of the professional staff available at any given time.

The larger centres often have available a psychologist who participates in the development of programmes and in the evaluation of children's progress. The smaller centres often have to rely on the skill of one or two professionals who work in relative isolation from their colleagues.

Assessment and Diagnosis

3.20 The expansion in recent years in the number and size of assessment teams has led to an earlier and more accurate diagnosis of severe and profound mental handicap. This has facilitated the development in some centres of programmes of care and stimulation. Health Boards and voluntary bodies are beginning to develop counselling services for parents and families of mentally handicapped children.

Working Party on Services for the Mentally Handicapped 1980

3.21 A working party on Services for the Mentally Handicapped reported to the Minister for Health in 1980. It consisted of representatives of the Departments of Health and Education, the Health Boards and the voluntary bodies providing services. It advocated a strong orientation towards community based services and recommended the full development of such services. It estimated that about 57% of severely mentally handicapped children between the ages of 5 and 19 and 95% of profoundly mentally handicapped children of that age would require residential care at some stage of their development. It recommended that day centres should be provided for those remaining within the community, preferably as an adjunct to schools for moderately mentally handicapped children. It recommended also that the programmes in such centres should lay emphasis on the development of social skills and self-help and should have structured programmes to ensure that they are carried out in an orderly and meaningful manner. The Working Party also suggested that "the extent to which teachers should be involved in the teaching of severely and profoundly mentally handicapped persons is a matter of consideration by the Departments of Education and Health".

Conclusion

3.22 The history of special provision for mentally handicapped persons in Ireland can be seen as an evolution from custodial care for a selected few in County Homes and psychiatric hospitals to the sophisticated differentiation of needs at which we have arrived today. The recommendation of the Commission in 1965 to provide schools for the majority of moderately mentally handicapped children was a far seeing one at the time and has been justified since then. The fact that these children attend special national schools includes them, to an extent, in the mainstream of education. Developments in the Curriculum over the past twenty years have provided appropriate learning experiences and there is a more optimistic expectation of what they can attain. As adults many of them are now making an economic, if limited, contribution towards their own maintenance through meaningful work in open or sheltered settings. The availability of the domiciliary grants since the early seventies provides state support for parents who choose to keep their handicapped children at home. As day schools with suitable transport facilities have developed parents have increasingly opted to keep their children at home. This, in turn, lessens the need to make residential places available for moderately mentally handicapped children. All of these developments have produced a greater degree of acceptance of mentally handicapped persons in the community. Moreover, the countries which share our philosophy on mental handicap have opted, in the main, to provide

education and training for severely and profoundly mentally handicapped children through their formal educational systems. The question as to what extent that should be done in Ireland is the one to which this report addresses itself.

CHAPTER FOUR

CHILDREN WITH SEVERE AND PROFOUND MENTAL HANDICAP

Classification of Mental Handicap

4.1 As already outlined in Chapter 2, the task of defining precisely the number and type of children who come within our terms of reference is made more difficult for us because the Commission in 1965 used a tripartite classification of mental handicap, mild, moderate and severe. In so far as the I.Q. can be taken as a measure of mental handicap, the severely and profoundly mentally handicapped would include all those whose I.Q. fell below 25. The services for the severely mentally handicapped in Ireland, however, provide also for those moderately mentally handicapped persons whose I.Q. falls between 25 and 30. It must be pointed out that the Commission in 1965 issued a very strong *caveat* against the placing of undue emphasis on the results of I.Q. testing alone. It is recommended by the World Health Organisation that the assessment of intellectual level should be based on whatever information is available, including clinical evidence, adaptive behaviour and psychometric findings. It should be emphasised that the score yielded by an intelligence test is only one of the measures to be used in deciding if a person is mentally handicapped or in placing him within one of the categories of mental handicap.

Quadripartite Classification of Mental Handicap

4.2 The classification of mental handicap contained in the 9th Revision of the International Classification of Diseases by the World Health Organisation divides the population with mental handicap into four levels, mild, moderate, severe and profound. Using I.Q. as a measure these four grades are identified as follows.

Mild: 2.0 to 3.3 standard deviations below the mean, i.e. I.Q. 50-70.

Moderate: 3.3 to 4.3 standard deviations below the mean, i.e. I.Q. 35-49.

Severe: 4.3 to 5.3 standard deviations below the mean, i.e. I.Q. 20-34.

Profound: More than 5.3 standard deviations below the mean, i.e. I.Q. below 20.

Confusion Caused by the Use of Different Classifications

4.3 The Working Party on Services for the Mentally Handicapped (1980) recommended that the W.H.O. quadripartite classification be adopted. For purposes of placement in special education the tripartite classification would appear to be still in vogue.

We recommend that in future in Ireland only the W.H.O. quadripartite classification of mental handicap be used, and that all statistical data be converted to that classification.

Some Educational Provision Already for Severely Mentally Handicapped Children in Schools

4.4 For many years now, virtually all schools for the moderately mentally handicapped have been accepting children in the I.Q. range 30-35 and some children with an I.Q. below 30 have been enrolled. If the quadripartite classification is accepted, therefore, it can be seen that already many severely mentally handicapped children are enrolled in schools. Our concern therefore is with those severely mentally handicapped children who are excluded from school and all profoundly mentally handicapped children.

Estimate of the Number of Children Involved

4.5 The replies to our survey from 48 centres revealed that a total of 1,341 children between the ages of 4 and 18 years were attending all centres (867 in residential centres and 474 in day centres). In addition 280 children, described as preschool children with moderate mental handicap, were receiving services at these centres (61 in residential centres and 219 in day centres). The Report of the Working Party On Services for the Mentally Handicapped (1980) estimated that the total number of children between the ages of 0 to 19 years with severe and profound mental handicap was 3,400.

Reconciling Apparent Discrepancies Between Responses to the Survey and the Report of the Working Party (1980)

4.6 The discrepancy between the figure of 1,341 revealed by our survey and the figure of 3,400 given by the Working Party (1980) may be explained by the following:

- (a) The 1980 Report estimated the total population between the ages of 0 and 19 whereas the replies to our survey had varying starting points (e.g. 24 centres reported that they accepted children from the age of 3 upwards). Our survey excluded from its count persons over the age of 18 years.

- (b) The 1980 Report included those children in the I.Q. range under 35 who are already attending schools for the moderately mentally handicapped, whereas this survey excluded them.
- (c) The responses to the survey included only those children receiving services at present and did not include those who are cared for exclusively at home.
- (d) When one excludes from the 1980 Report those children under 4 years and over 18 years an estimated total of 2,300 may be taken to be within the age range 4-18 years.
- (e) The responses to the survey showed that there were 798 children on waiting lists for services in the Centres covered by the survey (482 for residential places and 316 for day places). This number added to 1,341 gives a total of 2,139 in the population. It must be noted, however, that children awaiting placement might be on the waiting list of more than one centre and that some children on waiting lists for residential places may be already in receipt of a day service.

Total Population Estimated at 2,000

4.7 Taking all the foregoing factors into consideration it is estimated that the total number of children between the ages of 4 and 18 years who come within the terms of reference of this Working Party is approximately 2,000. The age range 4 to 18 years has been chosen arbitrarily, as it corresponds to the lower and upper limits of chronological age for enrolment in special national schools at present.

Characteristics of Children with Severe and Profound Mental Handicap

4.8 Children with severe and profound mental handicap share few common characteristics. Indeed the literature from all countries would suggest that heterogeneity is their most common characteristic. It has been traditional in describing them to lay most stress on those areas where they deviate from normality. A common denominator is very limited development in most fields of growth and an inability to learn spontaneously from reasonable exposure to the experiences of everyday life. They have almost total dependence on adults to initiate new learning. The behaviour of these children has been described as varying from almost total passivity to marked hyperactivity, and from consistent to highly inconsistent patterns of activity. Vocalisation varies from random noises to well articulated speech, and language, from no response on the one hand to comprehension and meaningful expression on the other. With some of these children it is hard to discern the development of associations, simple concepts and skills, while others may progress slowly through the early stages of normal

child development. Some children, in addition to sensory and motor impairments, have specific disabilities in perception and communication.

Prevalence of Additional Handicaps in Severely and Profoundly Mentally Handicapped Children

4.9 Research elsewhere has shown that children with severe and profound mental handicap often have additional disabilities of a serious nature. Indeed severe and profound mental handicap of its very nature is often accompanied by a multiplicity of other handicapping conditions, some of which are progressive.

The responses to the survey reported that

52.3 per cent of the children attending Care Centres were receiving medication on a daily basis,

29.7 per cent have an additional physical handicap,

(Cerebral Palsy 16.6 per cent; Spina Bifida 1.3 per cent; Others 11.8 per cent),

31.9 per cent suffered from epilepsy (24.9 per cent controlled and 6.9 per cent uncontrolled),

3.8 per cent were blind and 7.5 per cent partially sighted,

3.5 per cent were diagnosed as having severe hearing impairments,

19.5 per cent displayed severely disordered behaviour,

24.2 per cent were non-ambulant,

37.5 per cent were incontinent.

The large residential centres tend to have a greater proportion of non-ambulant profoundly mentally handicapped children than the smaller day centres. Often there is agreement in a region that local day centres cater for all the less severely mentally handicapped children in their immediate catchment area, while a large centre with day and residential facilities, as well as providing a local service, receives children from a wider area, whose disabilities demand the deployment of more specialised resources, both human and material.

A Case Study: The Population in St. Michael's House Service

4.10 The St. Michael's House organisation which provides a comprehensive care, education and training programme for moderately and severely mentally handicapped children in Dublin has conducted research over the past few years into various areas of its operations. One such study, made available to the Working Party, produced a

detailed report on 119 children with severe mental handicap who were receiving a day care service. This study was conducted by Dr. Roy McConkey, Senior Research Officer, and Mr. David Kenefick, Training Officer, and the following were its main conclusions:

- (a) *Age*: The age range was 5-16 years, with a preponderance of younger children.
- (b) *School Attendance*: 84 per cent have not and will not be considered, because of low intelligence, for trial enrolment in a special national school.
- (c) *Additional handicaps*: 47 per cent have no severe additional handicap. Only a minority of this population could be legitimately described as profoundly or multiply handicapped.
- (d) *Behaviour problems*: Generally there was a low incidence of behaviour problems, the most frequently reported being hyperactivity (17 per cent).
- (e) *Levels of functioning*: 33 per cent were rated as capable of finding things to do and keeping at them.
42 per cent could play with objects if encouraged.
25 per cent were mostly inactive.
30 per cent generally mastered basic self-feeding and toileting skills, were able to keep themselves occupied and were communicating through speech.
- (f) *Conclusion*: Around 30 per cent could be considered borderline moderate/severe (using the tripartite classification). About 20 per cent were profoundly and multiply handicapped, and were highly dependent on others for all basic needs. The remaining 50 per cent fell between these two categories but showed great variability in their levels of functioning.

In the absence of empirical evidence it is impossible to assess how the population in St. Michael's House can be taken as representative of the kind of population in other services. The fact that there is a preponderance of younger children in this service would suggest that some older children are in residential care or had started in some other service before a more localised service was available to them. It is, however, illustrative of the kind of population one might expect in a day service providing for a wide catchment area and may serve as a useful source of information on learning needs of severely and profoundly mentally handicapped children.

Conclusion

4.11 The term severely and profoundly mentally handicapped includes a very heterogeneous population, ranging from children whose level of functioning differs only marginally from that of the

- (v) the ability to set goals, to write programmes, to analyse tasks into sequential segments of behaviour;
- (vi) the ability to organise and manage group situations;
- (vii) the ability to manage, contain and modify behaviours which are disruptive of the child's own learning or that of the group;
- (viii) the ability to adapt programmes to the whole range of age and ability of children within the group;
- (ix) the ability to involve parents and other professionals in the programmes;
- (x) the ability to communicate clearly and to share expertise with other professionals;
- (xi) the ability to partake in inservice training and to adapt the findings of research to the particular needs of the group.

The Contribution of Teaching

7.3 The Working Party fully recognises that existing staffs of care units have many of the skills listed above. The training of teachers, however, has a special orientation towards the acquisition of these skills. While no single profession could provide all the skills necessary for working with children with severe and profound mental handicap, it is unreasonable to expect staff trained in one discipline to adapt fully to skills appropriate to other disciplines. The skills of teaching have developed over the centuries to cater for all children other than the severely and profoundly mentally handicapped, and there is no justification for excluding this population from access to the accumulated expertise of teaching. Teaching is a service for which the Minister for Education has ultimate responsibility. The Working Party is of the view that any teaching services provided for severely and profoundly mentally handicapped children should be the responsibility of that Minister also.

Accordingly, we recommend that teachers, paid and supervised by the Department of Education, be made available to severely and profoundly mentally handicapped children.

Issues Raised by the Introduction of Teachers to Centres for Severely and Profoundly Mentally Handicapped Children

7.4 Teachers have traditionally tended to work with children in classrooms in relative isolation from each other and from other professionals. However, there has been a marked tendency in recent years towards co-operative teaching, and all newly qualified teachers have received some orientation towards co-operation with other teachers. In the special schools for mentally and physically handi-

CHAPTER SEVEN

PROPOSALS FOR ESTABLISHING A SYSTEM OF EDUCATION AND TRAINING FOR ALL CHILDREN WITH SEVERE AND PROFOUND MENTAL HANDICAP AND THE PERSONNEL REQUIRED TO IMPLEMENT THESE PROPOSALS

Necessity for an Integrated Approach

7.1 The needs of severely and profoundly mentally handicapped children are very complex and interlinked, and it is impossible to separate education and training needs from other aspects of caring and treatment. All the adults who come in contact with the child are educators to some extent. The first pre-requisite is to provide a caring, loving, accepting and safe environment, and an attitude of mind among staff which is orientated towards stimulating the child in the direction of greater independence. Hence, it is unlikely that an approach which demands the exclusive interaction of any particular discipline with the handicapped child at any time will be fully successful in meeting his total needs.

Skills Necessary for Personnel Formulating and Implementing an Education and Training Programme

7.2 Persons involved with the education and training of children with severe and profound mental handicap must have the following skills:

- (i) the ability to use and interpret a wide range of individual assessment measures e.g. objective measures of ability and achievement, checklists etc.;
- (ii) the ability to observe and record the behaviour of children in a wide range of structured and unstructured settings;
- (iii) the ability to design, implement and evaluate individual programmes based on observations and assessments. The person involved in the daily education and training of the children must have sufficient skill in this area to work in relative independence and must be involved in the formulation of the programme;
- (iv) the ability to specify objectives in terms of expected outcomes from the children;

- (d) Some of the larger centres are associated with nurse training schools. Trainee nurses form part of the caring teams. During the second year of their course, however, they must spend some time working in other centres away from their normal base, and no substitute staff is available in their place. This often places undue strains on the staff resources available to care units. The end result is sometimes a reduction in the education and training element of the programme.
- (e) As has been mentioned already, many of the larger residential centres have inadequate space for day activities. This in turn leads to a reduction in the opportunities for stimulation available to the children in them.
- (f) Some of the small centres have only one or two qualified staff available. Their efforts are almost exclusively taken up with the basic care needs of the children. This leaves little time for education/training.
- (g) Some centres accept referral, on a regional basis, of a large number of non-ambulant profoundly mentally handicapped children and others with multiple handicaps. The task of caring for these children absorbs so many resources that it can prove difficult to provide an appropriate education/training programme.

There is unanimous agreement within the Working Party that education and training programmes should be made available for severely and profoundly mentally handicapped children.

which provide a highly sophisticated service to those which have no specific learning programme. While some centres have the service of psychologists as programme planners and there is regular evaluation of individual children's programmes, there is no established structure which ensures access for each severely and profoundly mentally handicapped child to an education and training programme appropriate to his needs.

Constraints on the Implementation of Appropriate Education and Training Programmes

6.10 The responses to the survey, the visits to the various centres and the representations made by various professionals involved with severely and profoundly mentally handicapped children indicate that the centres are staffed by people who treat the children with a high degree of commitment, competence and care. It is clear that in the past two decades very significant advances have been made in the quality of care and treatment available to severely and profoundly mentally handicapped persons. A number of factors in the present structures, however, militate against the provision of adequate programmes in education and training. The most significant of these factors are the following:

- (a) Many centres are uncertain about the level of finances available to them from year to year. Almost all of the larger centres operate on the basis of agreed budgets, but smaller centres still rely on a *per capita* or other method of funding from Health Boards.
- (b) The members of staff have responsibility for all aspects of care and training. Many of the heads of units who were interviewed expressed the desire to devise and implement programmes of education and training. The care needs of the children, however, must take priority over education and training. In times of crisis, staff shortages and other emergencies, there is, inevitably, pressure to reduce or eliminate altogether the education/training element. While all staff dealing with severely and profoundly mentally handicapped children have a caring role, the lack of staff available specifically for education and training makes this element in the lives of the children particularly vulnerable in time of crisis.
- (c) Many of the staff of care units have limited orientation towards education and training. While the new syllabus for registered nurses of the mentally handicapped has a much greater orientation towards education and training than heretofore, less than 20 per cent of the staffs of care units hold this qualification. Even allowing for modifications in the new syllabus, nurses of the mentally handicapped are primarily nurses, not teachers.

members of the Working Party held with staffs of centres, it would appear that the amount and type of accommodation is inadequate in most centres to meet the education and training needs of the children. The most acute need arises in those residential centres which (a) have not sufficient designated training space or (b) have to cater for children in inadequate space on a rota basis.

Disciplines Involved in Education and Training

6.8 In a small minority of centres members of staff are employed specifically for education and training purposes. In those centres their attention is often directed to preschool moderately mentally handicapped children. In the centres which responded to the survey, it was found that a total of 774 staff were employed on a full-time basis, and they were recruited from a total of 16 professions, or had no formal qualification. The profession with the largest representation was general trained nurse (147) followed by R.N.M.H. (135) and psychiatric nurse (58). A total of 61 student nurses was also reported. Each of the other disciplines listed was represented by less than 20 persons. A total of 275 staff had no formal qualification at time of enquiry. The numerical distribution of the various disciplines is given in Appendix I, Table 1.

Programmes of Education and Training

6.9 It is difficult to gather precise information about the extent and quality of educational programmes available in centres for severely and profoundly mentally handicapped children. Most centres have a formal education programme for preschool moderately mentally handicapped children. The extent to which structured education and training programmes are available to other children in the centres seems to depend on the policy of the management and of the professional head of the unit and on the range of staff available. No national guidelines are provided to be followed in centres. Some information emerged from responses to the survey and from the visits of the members of the Working Party to selected centres. No formal attempt was made to assess the quality of programmes available. Some centres see the whole interaction of staff and children as an ongoing educational process. Other centres specify special times and places for formal educational programmes which are reinforced during leisure hours. Some centres reported having a written programme for individual children, but the Working Party has no precise information on how these are drawn up, how they are evaluated and whether they are reviewed regularly. There is evidence from the responses to the survey that many centres are aware of published programmes for severely and profoundly mentally handicapped children and are adapting them to their needs. There would appear to be a wide variation in the quantity and quality of educational programmes provided at the various centres. The continuum ranges from centres

Less than 20 children:	8 Centres
Between 20 and 39 children:	7 Centres
40 or more children:	10 Centres

In the case of day centres the figures were as follows:

Less than 20 children:	30 Centres
Between 20 and 39 children:	4 Centres
40 or more children:	3 Centres

Designated Education/Training Space in Residential Units

6.5 Of the 24 residential centres which responded, 13 have specific accommodation to which children transfer during the day to follow a training/learning programme. Eleven centres provide a training/learning programme adjacent to, or in the sleeping quarters of the children. In some of the larger centres, even where a day unit is available, it is not large enough to accommodate all the children at any one time. Local managements arrange to accommodate as many children as possible in the day centre, for parts of the day, on a rota basis. When they are not availing of the programme in the day centre, these children are in day rooms adjacent to their sleeping quarters. (It must be borne in mind that in terms of actual numbers, the majority of severely and profoundly mentally handicapped children are served by the larger residential centres.)

Type of Accommodation Provided in Day Care Units

6.6 The type of accommodation provided in a day care centre varies from place to place. Where it is on the same campus as a special school it is usually purpose-built. At other centres the accommodation used has been adapted from other purposes. A typical smaller centre, catering for up to 30 children, would have one large room of proportions similar to that of a conventional classroom (37-56 sq. m.) with one or two smaller rooms for individual or small group work. The toilet/washing areas are designed specifically to cater for training in toileting and self-help skills. In some of the large centres, where care units are operated independently of schools, the accommodation is not dissimilar to that available in schools, except that the concept of more than one member of staff working in the same area is prevalent. The arrangements for toilet training and physiotherapy are usually fairly elaborate.

Although some common design features are discernible, the type and size of accommodation at any centre tends to reflect the philosophy of the management and the amount of money available to it for capital purposes.

Adequacy of Present Accommodation

6.7 From the replies to the survey and from the discussions which

Location of Day Care Units

6.3 The Commission of Inquiry on Mental Handicap (1965) recommended that care units be established to provide training and care on a day basis, for severely mentally handicapped children and for those moderately mentally handicapped children who were unable to benefit from the education provided in schools for the moderately mentally handicapped. These care units were to be combined with schools for the moderately mentally handicapped and nursery units, to form comprehensive day centres. In the years since 1965, where new schools for moderately mentally handicapped are proposed, representatives from the Departments of Education and Health and the Health Boards have joined with the appropriate voluntary bodies to plan adjoining day care units. Since the early seventies many centres have on the one campus a school for moderately mentally handicapped grant aided by the Department of Education, a care unit for severely and profoundly mentally handicapped and a preschool unit for young moderately mentally handicapped children, both grant aided by the Department of Health or the local Health Boards. There is some sharing of facilities, such as general purposes rooms and cooking facilities, and the same interdisciplinary teams work with both groups. In some instances there is a pooling of resources in transporting children to the centres. In general, however, there is little co-ordination of programmes and the school and care unit/preschool follow separate paths of development. Schools for moderately mentally handicapped children recognised by the Department of Education have been established on the campus of most of the residential centres. These schools are attended by children considered suitable for them, both from the residential centres and from a surrounding day catchment area. These centres provide care and training for severely and profoundly mentally handicapped and for preschool moderately mentally handicapped children. In some instances they have facilities for children attending on a day basis. In most cases some accommodation, separate from the living areas, is available, but not in sufficient quantities for the implementation of programmes of training for all the children in residence.

In addition to those care units which are located on the same campus as schools for the moderately mentally handicapped, there has been a growing trend in recent years to establish care units independently of any other service. Thus, there are often 2 or more care units in an area which is served by one special school for moderately mentally handicapped children.

Size of Care Units

6.4 The majority of care units are very small and provide for less than twenty children each. The results of the survey indicated that the numbers of children in residential centres were as follows:

CHAPTER SIX

PRESENT PROVISION FOR CHILDREN WITH SEVERE AND PROFOUND MENTAL HANDICAP

Sources of Information

6.1 The following sources of information were used as a basis for this chapter:

- (a) The responses to the survey of Autumn 1980.
- (b) The Report of the Working Party (1980) on Services for the Mentally Handicapped.
- (c) The evidence presented by those who made submissions to this Working Party.
- (d) Observations of the members of this Working Party as result of their visits to selected centres.
- (e) The experience of some of the members of the Working Party in the operation of care units for severely and profoundly mentally handicapped children.

Growth in Provision of Places

6.2 In the years following the publication of the Report of the Commission of Inquiry on Mental Handicap (1965) significant advances were made in material provision for severely and profoundly mentally handicapped children. In spite of these advances there are still too many severely and profoundly mentally handicapped children for whom suitable services are not available on a regional basis, and it can be almost impossible to obtain a suitable place for a severely or profoundly mentally handicapped child in some areas. This may be caused in part by the fact that some adult mentally handicapped persons are taking up accommodation in children's centres. Additionally there are insufficient crisis intervention and short-term residential facilities available to supplement day care services. The lack of any available place can cause intolerable stress and hardship to parents and families.

The Working Party recommends that, as a first priority, adequate care facilities are made available for all those severely and profoundly mentally handicapped children who are still excluded from a suitable service in their own area.

the family and those professionals responsible for the day to day care, treatment and training of the child; the part-time team to include those specialists who will see the child regularly on a part-time basis; the consultant team to include those whose consultations will be required only on an occasional basis.

- (5) A planned programme in the areas appropriate to early development, self-help, mobility, communication, daily living, music and movement, etc.
- (6) Methodology which will ensure that the child is exposed to knowledge in a structured manner which will be easily assimilated by him.
- (7) The designation of specific time and space for the education and training programme, and, where space is not available, that time to be made available as a priority.
- (8) Individual learning programmes regularly evaluated.

Research both at home and abroad suggests that, where teaching methods are suitably adapted, severely and profoundly mentally handicapped children can make worthwhile progress in the areas mentioned in 5.9. However, if they are to get maximum benefit from their exposure to these learning experiences, they need teaching methods which are highly specific. Personnel involved in the education/training programme need to be well trained in methodologies such as task analysis, the writing of objectives in terms of child behaviour, evaluation of outcomes of programmes and behaviour modification.

Specific Time and Space and Individualised Programmes Required

5.11 To some extent, the care, child rearing, treatment and educational/training programmes of severely and profoundly mentally handicapped children must be integrated. In some instances very thin boundaries exist between them. At some periods care and treatment become the over-riding considerations. It is the view of this Working Party, however, that specific times and physical space should be made available for training programmes.

We recommend, therefore, that all centres for severely and profoundly mentally handicapped children should have an education and training programme and that specific times should be set aside for it. Furthermore we recommend that designated space should be made available, separate from the living quarters of the children, for this purpose.

We further recommend that each child should have access to an education and training programme designed with his particular learning needs in mind, and subject to review from time to time. A detailed progress record of each child's development should be maintained, and this should be transferred with the child if he moves to any other agency.

Summary of Education and Training Needs

5.12 The education and training needs of severely and profoundly mentally handicapped children may be summarised as follows:—

- (1) The need for a loving caring environment.
- (2) Early diagnosis and appropriate counselling of parents and family of the handicapped child.
- (3) An integrated programme of care, child rearing, treatment and education appropriate to the needs of the child.
- (4) Involvement of teams which would work on a full-time, part-time or consultancy basis. The full-time team to involve

Major Curricular Areas to Satisfy the Learning Needs of Severely and Profoundly Mentally Handicapped Children

5.9 The Working Party is of the view that the care and treatment of severely and profoundly mentally handicapped children should be widened to include specific provision for education and training. An educational curriculum for such children would include elements such as those listed below. It must be pointed out that many of these elements are already being provided in varying degrees by existing staffs in existing services.

A. Basic Skills

- (i) Self-help skills, such as dressing, feeding, washing, toileting.
- (ii) Gross and fine motor skills.
- (iii) Sensory awareness.
- (iv) Simple household tasks and daily living skills, such as cookery.

B. Expressive Skills

- (i) Communication skills, both receptive and expressive, — natural gestures, cues, simple language, sign language where appropriate.
- (ii) Music and Movement.
- (iii) Dramatic activities.
- (iv) Physical Education.

C. Leisure Skills

- (i) Play with toys and with other children and adults.
- (ii) Participation in simple games, both organised and in the form of free play.
- (iii) Horse Riding, swimming and other activities, depending on local facilities.

The foregoing are intended only to identify broad areas of education. Other areas will arise depending on the specific needs of individual children, or arising from the environment in which a particular centre is located.

Methodology

5.10 As has been pointed out already, one of the distinguishing characteristics of severely and profoundly mentally handicapped children is their inability to learn very much from incidental exposure to their environment. What is learned in an informal and incidental manner by ordinary children has often to be made formal and structured for severely and profoundly mentally handicapped children.

excluded from access to education and training because of a very narrow definition of education, and it was felt that certain children's disabilities were so great that they could not benefit from the curriculum in schools. More recently however, the aims of education have been broadened considerably, and there is a worldwide awareness that education can be of help in maximising human potential, even for the most disabled people. The Warnock Report, defined the aims of education as follows.

"The aims of education are the same, whatever the advantages or disadvantages of the child concerned. These aims are, first, to increase a child's knowledge of the world he lives in and his imaginative understanding, both of the possibilities of that world and of his own responsibilities in it; and, secondly, to give him as much independence and self-sufficiency as he is capable of, by teaching him those things he must know in order to find work and to manage and control his own life.

Children have manifestly different obstacles to overcome in their path towards this double goal, and for some the obstacles are so enormous that the distance they travel will not be very great. But for these children any progress at all is significant. For the most severely handicapped, education seeks to help them overcome their difficulties one by one".

Defining Educational Needs

5.7 It is difficult to define long-term educational needs for children with severe or profound mental handicap. It is probably easier to list the areas of conventional education which have no relevance for them. As far as academic learning is concerned, few of them will ever achieve more than an ordinary child will have achieved by the age of three, though many will reach a much higher stage on a social level. Perhaps a summary of long term aims might be that the children will be somewhat less dependent than is currently expected, lead more varied and stimulating lives, develop more as individuals and increase their interaction with others.

Right to Education

5.8 Article 2 of the United Nations Declaration of Rights of Mentally Retarded Persons (December, 1971) upheld the rights of all mentally handicapped of whatever degree to appropriate educational services. Article 42 Note 32 of Bunreacht na hÉireann (1937) would seem to uphold the right of all children to appropriate educational facilities. Ireland was one of the first countries to provide specific educational services for moderately mentally handicapped children. It has now, however, fallen behind some other countries which have extended such services on a formalised and structured basis to children with severe and profound mental handicap.

ionals who are employed to perform this work may come from a variety of backgrounds. Irrespective of the type or depth of the basic training which they have received, these professional care givers need above all else the capacity to provide a warm and loving environment and to involve the family as fully as possible in the programme. Because of the slowness of severely and profoundly mentally handicapped children in reaching the developmental milestones there is a need for a planned programme in all the major developmental areas.

There will be a continuing need throughout life of physical care sufficient to ensure good standards of health and comfort, but not to the extent of being incompatible with the need for training towards independence.

The Need for Specialised Treatment

5.5 Many severely and profoundly mentally handicapped persons need specialised treatment because of the presence of additional handicap(s). This treatment may be necessary either on a continuing or occasional basis. Because of their slowness in reaching developmental milestones severely and profoundly mentally handicapped children need specific programmes in major areas such as motor development, language etc. The specialised treatment arising from these needs is provided by a variety of disciplines, such as nursing, physiotherapy, speech therapy etc. In certain instances the decision about the duration and intensity of such treatments involves other professionals who act on a consultant basis, such as psychiatrists, paediatricians or specialists in the various branches of physical medicine.

The involvement of all of these disciplines is necessary in varying degree if the children are to reach their full potential. One can distinguish however between three levels of involvement, continuing, part-time and occasional. Hitherto the nurse has been the professional who has provided all treatment services on a continuing basis, sometimes assisted by child care staff. Physiotherapists, speech therapists and others from allied disciplines tend to provide direct services to children on a regular but not continual basis. They often initiate programmes which are implemented on a continuing basis by the nurse and the child care worker. On a more occasional basis, those employed in a consultant capacity may involve themselves in the treatment programme, but their principal role is to prescribe and to counsel others more immediately involved in treatment and to monitor progress. Essentially, therefore, the nurse has been responsible for the direct delivery of all treatment services, both medical and educational, on a daily basis.

Aims of Education and Training

5.6 In the past, certain groups of handicapped children were

Basic Areas of Need: Care, Specialised Treatment, Child Rearing, Education and Training

5.3 The basic needs of severely and profoundly mentally handicapped children may be set out as follows:

Care, Specialised Treatment, Child Rearing, Education and Training

All children, whether handicapped or not, have these needs and each takes precedence over the others at certain periods of their lives. In the case of severely and profoundly mentally handicapped children, however, these needs often have to be met concurrently. Whereas there are usually well defined boundaries in the professions which service the specialised components of these needs in ordinary children, there has to be a considerable degree of overlap and co-operation between professions providing for the varying needs of the severely and profoundly mentally handicapped child. Parents of ordinary children generally manage to respond adequately to the care and child rearing needs of their children with minimal external support. The families of severely and profoundly mentally handicapped children require the support of a variety of professions during the child's lifetime to help them to fulfil completely their parenting role. Where support services of adequate quality and quantity have been provided, it has been shown that parents can play the most important role in the rearing of their severely or profoundly mentally handicapped child. At varying times in the child's life the family may require the support, guidance or active intervention of professionals from a variety of specialties, such as medicine, surgery, paediatrics, psychiatry, psychology, nursing, teaching, social work, occupational therapy, speech therapy etc. The services of professionals from these areas may be required at various times on a whole time, short term or occasional basis.

The Need for Care and Child Rearing

5.4 The need of severely and profoundly mentally handicapped children for care and child rearing is continuous and will continue into adulthood and throughout life. Just like other children they need a warm and loving environment with stable and continuous relationships to foster self-awareness and the capacity for individual attachment to others. The father and mother are in a unique position to provide the best environment for growth. Parents, on their own, however, are not able to provide fully for a severely or profoundly handicapped child. They need access at various times to the help and support of specialists such as those mentioned in paragraph 5.3.

As far as possible the emphasis should be on strengthening the child rearing skills of parents. Because of the magnitude and complexity of the task of rearing a severely or profoundly mentally handicapped child, it is often necessary to provide some of this care and child rearing outside the home, in a day or residential setting. The profess-

CHAPTER FIVE

EDUCATION AND TRAINING NEEDS OF CHILDREN WITH SEVERE AND PROFOUND MENTAL HANDICAP

General and Specific Needs

5.1 Children with severe and profound mental handicap have the same general needs as all other children. They need to have security, acceptance, care and attention, to love and to be loved in order to develop to their fullest potential. In order to satisfy some of these needs they need more than ordinary care and attention, and, in addition to the needs of ordinary children, they sometimes have special needs which require special interventions. While this general principle is widely recognised today, historically children with severe and profound mental handicap were excluded from access to some of the resources available to the ordinary population, because of their apparent slowness in responding to ordinary stimulation.

Early Diagnosis

5.2 The first need of the severely and profoundly mentally handicapped child and his family is early diagnosis. Following diagnosis there is a need to assess accurately the precise nature of the child's strengths and weaknesses, so that programmes to help in his development can be specified to suit his individual needs. The involvement of the parents and other members of the family at this stage is of paramount importance. Precise and accurate information should be communicated to the parents by professionals who are skilled in counselling techniques.

We recommend, therefore, that counselling and support services be further developed for parents and families of all handicapped children, and with particular attention to severely and profoundly mentally handicapped children.

The person who would provide this information in the case of individual families could come from a variety of professions. It is important that there should be as much continuity as possible in the relationship between the Counsellor and the family, although it is recognised that the person most closely in contact with the family might change, as the child passes through the various developmental stages and as a particular agency might be the dominant one in the child's life.

moderately mentally handicapped to a number whose functioning in almost every area of human activity is so handicapped by disabilities that they are virtually totally dependent. To compound the problem, our survey has revealed that very few services provide for the full range of severely and profoundly mentally handicapped children. In general the day services have a preponderance of children in the upper and middle range of severe mental handicap, while some of the larger residential centres have an undue proportion of more profoundly mentally handicapped children. These imbalances clearly have implications for the allocation of resources and make it difficult to make firm recommendations which can be applicable in all situations.

capped children, teachers work in close co-operation with personnel from various disciplines. When teachers are introduced into centres for severely and profoundly mentally handicapped children, it is envisaged that there will be further development of interdisciplinary work. Caring, specialised treatment and education will be conducted concurrently. We envisage the addition of a teacher to each team of personnel involved with the primary care of the children. The nurse, the care worker and the teacher will have shared responsibility for the day to day management of each child's total programme. In such a team, each discipline would have a lead role in the area most pertinent to its own expertise, particularly in the area of planning, bearing in mind that a considerable degree of overlap will occur. There would be shared responsibility for the implementation of caring, specialised treatment and educational programmes.

Another issue will be the duration of the education programme. Teachers normally spend about five hours per day in contact with pupils in classes. The time spent with severely and profoundly mentally handicapped children on formal educational programmes would be no greater than this, but learning periods would need to be interspersed with leisure and rest periods. Teachers working in such conditions would need to have terms of employment somewhat different from that applicable in more conventional educational settings.

A third issue which will arise is the length of the school year. While it is not envisaged that teachers in centres for the severely and profoundly mentally handicapped would have leave entitlements less generous than their colleagues in other settings, it would be necessary to ensure a greater degree of continuity of programmes, and a system of staggered holidays is suggested.

A fourth issue is the manner in which the work of teachers of severely and profoundly mentally handicapped children would be coordinated and supervised. The Working Party is making specific recommendations on this matter in paragraphs 7.5, 7.6 and 7.7. These recommendations may involve additional work for principals of schools for moderately mentally handicapped children. Many of these principal teachers are in charge of classes as well as having administrative and supervisory duties. It may be necessary, therefore, for the Department of Education to review its requirements for appointment of non-teaching principals in schools for moderately mentally handicapped children.

The issues raised here can be resolved by discussions between the interested parties, and the Working Party does not propose to make specific proposals on their resolution.

Expanding the Role of Schools for Moderately Mentally Handicapped Children

7.5 For some years now many schools for the moderately mentally handicapped have enrolled some children who would formerly have been excluded if there had been strict adherence to the established

criteria for admission. Some of these children have been integrated successfully into the classes in these schools; in other instances they form special groups, and in many instances the teacher is supported by another member of staff employed to cater for the care needs of the pupils. Many of the newer day schools which cater for an immediate catchment area have adopted a very flexible attitude towards enrolment of these children. In general such children, although their I.Q. would place them well into the range of severe mental handicap, are ambulant, can relate in a group situation and have some understanding of language. If the quadripartite definition of mental handicap is used many of the children in schools for the moderately mentally handicapped would be classified as severely mentally handicapped anyway.

We recommend, therefore, the removal of any lower limit of eligibility for enrolment in schools for moderately mentally handicapped children, and that the decision about individual children be left to the discretion of boards of management, in consultation with the inspectorate of the Department of Education. Where the board feels that the curriculum in the school can be adapted to meet a child's needs it should be free to accept such a child.

The type of curriculum followed in these schools could be modified to meet the needs of more severely mentally handicapped children. The learning experiences which would be offered would differ in *degree* rather than in *kind* from those available to moderately mentally handicapped children.

We recognise, however, that the introduction of more severely mentally handicapped children in significant numbers to any such school might have an adverse effect on the quality of the learning environment available to many moderately handicapped children. It would do a disservice to the schools for moderately mentally handicapped to expect them to cater from existing resources for children with a greater degree of handicap.

We recommend, therefore, that, where a school for moderately mentally handicapped children agrees to enrol pupils assessed as severely or profoundly mentally handicapped, additional resources be made available by the State to satisfy the additional special caring and learning needs of these pupils. A flexible approach should be adopted, and the needs of each school should be examined on an individual basis, including the teaching duties of the principal teacher.

The question of funding of additional resources, including personnel, in schools for mentally handicapped children in these instances is part of a wider issue regarding the funding of personnel other than teachers in special schools generally.

We recommend that this question of the funding of services,

other than teaching services, in special schools generally should be examined by the appropriate authorities.

The Introduction of Teachers to Separate Day Care Units

7.6 Where large day care units are established, there is usually a clearly established hierarchy of posts within them.

We recommend that present structures be maintained, but that one teacher be introduced for each 12 children. Such teachers should be eligible for recognition in schools for moderately mentally handicapped children, and should be attached for salary, superannuation and seniority purposes to the nearest school for moderately mentally handicapped children. Such teachers would report to the principal teacher of the school to which they were attached but would work as members of an interdisciplinary team within the care unit. They would have special responsibility for educational curriculum planning and implementation under the general guidance of the principal teacher. The head of the care unit would have responsibility for coordinating the work of all the disciplines. Where a number of teachers are assigned to a particular unit one or more of them should be appointed to posts of responsibility in the care unit, and such post holders would be responsible for the coordination of the educational programme on a day to day basis.

The implementation of this recommendation will require negotiations between the Department of Education and other interested parties. The Head of the Care Unit will have overall responsibility for coordinating the work of all the disciplines involved in providing services for the children, and it is envisaged that in the day to day management of the service, there should be little need to refer educational matters to the Principal of the associated school. The exact role and conditions of service of teachers working in Care Units should be defined to take account of local circumstances, and it may well be that no single model will be applicable to all situations.

Schools with Small Care Units on the Same Campus

7.7 Many of the small care units are located on the same campus as schools for moderately mentally handicapped children and have only one or two members of staff in them.

We recommend that teachers be assigned to such care units in the ratio of 1 teacher to each 12 children.

Such a teacher would be on the staff of the school and be seconded to work in the care unit.

Where the number of children is very small, it is recommended

that the principal teacher be responsible for the day to day educational programme planning for both school and care unit.

We recommend that responsibility for capital expenditure, running costs and salaries of staff, other than teaching staff, continue to be accepted by the health agencies as at present. Where a need for such a unit is recognised, we recommend that it be funded on the basis of an agreed annual budget.

Introduction of Teachers to Residential Centres for Severely and Profoundly Mentally Handicapped Children

7.8 The role of the teacher in residential centres where designated teaching space is not available, or where large numbers of non-ambulant profoundly mentally handicapped children are housed, will be somewhat different to that obtaining in day care centres.

The Working Party is concerned that adequate designated teaching space be made available in such centres as soon as possible. Nonetheless we are concerned that, even where designated day space is inadequate, such children have access to educational opportunity.

We recommend therefore, that until such time as it is possible to provide designated teaching space in all residential centres, one teacher be provided for every 12 children and that a teacher spend some time each day with each child. The appropriate authorities should reconsider the wisdom of providing for large numbers of non-ambulant profoundly mentally handicapped children in one central location in each area and explore the possibility of integrating small numbers into more localised services.

We recommend further that public money be made available for the purchase of additional specialised equipment to allow for the greater stimulation of such children, e.g. walking aids, hoists, electric wheelchairs, etc.

Staffing Requirements for Care Units

7.9 Because of the complexity of the provision at present available and the heterogeneity of the population, the question of staffing levels needs to be treated with considerable flexibility, bearing in mind the spread of age and ability of the children in each centre. A sub-committee of the Working Party examined this question in some depth.

The Working Party, having examined the report of the sub-committee, was of the opinion that, in addition to the services of one teacher per 12 children, each group of approximately 50 severely and profoundly mentally handicapped children would require the services of 15 staff. These could be in the following proportions: five Registered Nurses of the Mentally Handicapped, one Occupational Therapist, four adults experienced in dealing with these children, one general

trained nurse, two child care assistants and two junior trainees. Apart from the occupational therapist and the general trained nurse the other staff would join with the teachers in "front-line" teams, each team catering for 10/12 children. Other specialist staff such as physiotherapists, speech therapists and psychologists would form teams which would not only work with the children occasionally, but would act in a consultative and advisory capacity to the "front-line" teams who would practise some of these specialist techniques on a daily basis.

The proportions of the various disciplines in the front line teams stated here are not to be taken as definitive, but rather as illustrative of the range of skills required. The precise number of each discipline required for any given situation will be determined by local circumstances.

We recommend, therefore, that, in addition to one teacher per twelve children, each care unit should have a minimum front line staff of 15 for each group of 50 children, the exact proportion of each discipline involved to be determined by the needs of each centre.

Responsibility of the Departments of Education and Health

7.10 *We recommend that the Department of Education be responsible for remuneration of the teachers and that they be subject to the rules and regulations for national schools.*

They would thus be subject to inspection by the inspectorate of the Department of Education and would be fully recognised in special national schools. The Department of Education would also be responsible for curriculum development, inservice training and the provision of grants for educational equipment.

We recommend that the Department of Health and the Health Boards be responsible for the funding of capital and other running costs of the care units, and we do not envisage any change in the present arrangements for recruitment and remuneration of staff other than teachers.

Redesignation of Care Units as Developmental Education Centres

7.11 It is the opinion of the Working Party that the term *Care Unit* will not adequately describe the type of work which will be carried out in centres with formal educational programmes.

We recommend, therefore, that any centre offering a formal educational programme for a specified time each day to all children in space specially allocated for that purpose should be redesignated a DEVELOPMENTAL EDUCATION CENTRE.

Transport

7.12 From our contacts with managements of Care Centres we are conscious that the cost of providing adequate transport for children attending on a day basis places an intolerable burden on local resources. The question of providing transport is not simply one of providing a seat in a vehicle. Often it is necessary to adapt vehicles to accommodate children with serious physical handicaps. Additionally it is unsafe to have the driver responsible for the comfort and behaviour of such children. There is need for a comprehensive system of providing escorts for children on such transport.

We recommend that a comprehensive system of transport be established for all handicapped children attending developmental education centres on a day basis. Where the Department of Education and any Health Agency are providing transport for handicapped people to adjacent day facilities, there should be coordination at local level with a view to apportioning costs and to providing the most efficient service possible.

The Working Party is concerned that many existing transport arrangements, while providing for the transport of children to and from education or training, lack the flexibility to allow for bringing handicapped children to leisure activities and to extra-curricular activities during the day.

We recommend, therefore, that any system of transport operating to developmental education centres should be sufficiently flexible to allow for the use of vehicles and escort personnel in connection with out-of-school and leisure activities.

Staff Training

7.13 Many experienced teachers of moderately mentally handicapped children would be able to transfer without undue difficulty to teaching severely and profoundly mentally handicapped children. The curriculum guidelines for schools for moderately mentally handicapped children, which have been issued in the past few years by the Department of Education, would provide a useful framework for developing a curriculum. The learning experiences appropriate for severely and profoundly mentally handicapped children would differ in *degree* rather than in *kind* from those appropriate for moderately mentally handicapped children.

Other teachers would require additional training, either before or soon after getting some experience with severely and profoundly mentally handicapped children. Inservice training could be provided by utilising the services of various disciplines with experience of children with serious mental and physical handicaps. Such would include experienced teachers of children with low moderate mental handicap and with multiple handicaps. The psychologists at present

engaged in programme planning for severely and profoundly mentally handicapped persons have built up a considerable fund of expertise which could also be used for inservice training of teachers.

We recommend, therefore, that

- (i) *Formal induction training be provided for all teachers who are about to take up duty with severely and profoundly mentally handicapped children.*
- (ii) *Teachers employed in recognised developmental education centres should be eligible for secondment to the diploma course in special education and that course should be modified and expanded to meet their special needs.*
- (iii) *All teachers during their basic training should be acquainted with the methodology, theory and practice of teaching children with mental handicap, including severe and profound mental handicap.*

Involvement of Parents and Families

7.14 The results of our survey revealed that parents and families of severely and profoundly mentally handicapped children were rarely involved in the education/training process. The parents are the most important educational influence on all children in the early stages of development, and particularly so in the case of severely and profoundly mentally handicapped children. In day centres the children spend most of their leisure time within their families. Even in residential centres it is most important to preserve and maintain the child's bond with his family. The Working Party considers it of the utmost importance that the family be involved as fully as possible in the planning of an educational programme, and that systems be evolved for the exchange of information about the child's development between the family and the professionals involved.

We recommend, therefore, that programmes of parent education be associated with all developmental education centres, and that parents and other members of the child's family be involved fully in the education and training programmes. We also recommend that, where appropriate, professionals, including teachers, should work with the families at home.

The Role of Untrained Staff

7.15 The Working Party envisages a continuing and useful role in the education and training programme for some staff who do not possess any formal qualification. Often these are young people whose enthusiasm and idealism can compensate to some extent for the lack of a professional qualification.

We recommend that young people be encouraged to work in the education and training of severely and profoundly mentally handicapped children when participating in prevocational training and youth employment schemes, and the necessary financial resources be made available to make such participation possible.

Where such untrained people are employed they should be a small minority in each Centre and should work under the guidance of trained staff.

Trainee Nurses and the Mentally Handicapped

7.16 Participation in education and training programmes is an invaluable component of training for nurses of the mentally handicapped. Where, however, they are employed as full members of staff, difficulties arise when they must necessarily be absent from the team for training purposes. The new syllabus for Nurses of the Mentally Handicapped requires them to gain experience at other centres during the second year of their training. We are satisfied from our discussions with managements of Centres that this can lead to a serious disruption of the training programme when such trainee nurses are not replaced.

We recommend, therefore, that where trainee nurses are engaged in education and training programmes, and, where their own training demands that they be absent from the team for certain periods, they be employed as additional to the basic staff complement.

Continuing Education

7.17 Severely and profoundly mentally handicapped persons should be allowed to participate in education and training programmes for as long as they are enrolled in developmental education centres or schools. It is appropriate, however, that when they reach physical maturity, around the age of eighteen, they be transferred to settings more in keeping with their chronological age. At that time their capacity to learn will still be developing, and it is important that they be exposed to continuing learning experiences of an appropriate kind. It is outside the scope of this Working Party to make specific recommendations in this regard.

We recommend however that the relevant authorities should formulate a definite policy on the provision of continuing education for adult severely and profoundly mentally handicapped persons.

Introduction of Teachers on a Phased Basis

7.18 The recommendations of the Working Party propose a new departure in Irish education. Furthermore the new Developmental

Education Centres will themselves be highly individual in character. In order to provide for individual needs it is suggested that formal education and training programmes be introduced on a phased basis.

The Working Party recommends that teachers and formal educational programmes for severely and profoundly mentally handicapped children should be introduced on a gradual basis. Such programmes should be monitored carefully and their efficacy evaluated scientifically.

This recommendation might be implemented in the following manner:

- (i) A beginning might be made with the small care units which are housed in the same building as schools for moderately mentally handicapped children. In many of these cases it would involve the assignment of only one or two teachers.
- (ii) Some schools for moderately mentally handicapped children appear to be successful at present in meeting the learning needs of more severely handicapped pupils. These schools might be invited to enrol additional severely or profoundly mentally handicapped children with the addition of the necessary additional teaching and other staff.
- (iii) One or two of the larger care units might be designated "Developmental Education Centres" at an early date and teachers introduced to them in the numbers recommended in this Report. The experience gained in them could serve as a basis for widening the scheme to include all centres.

The Working Party is of the view that because of the heterogeneity of current practice, a highly flexible approach must be maintained in the initial stages, and no single model should be adopted for the whole country.

We recommend that an experimental and research orientated approach be adopted in relation to the new developmental education centres and that a considerable degree of flexibility be allowed, to cater for particular needs.

Signed:

Seán Mac Gleannáin, (Chairman)
Dr. Nóirín Buckley
Celia C. Carney
Sister Conleth Cashman
Dr. John G. Cooney
Joseph Cregan
Donal Devitt
Sean Ó Fiachra
Páid Mc Gee
Breandán Mac Gréine

Dr. J. V. Halpenny
Eamonn Ó Murchú
Eilís Bean Uí Mhurchú
Bro. James Pidgeon
Peter G. Mc Quillan
Dr. Barbara M. Stokes
John F. Toomey
Tomás Ó Cuanaigh
Secretary to the Working Party

APPENDIX I

SUMMARY OF SIGNIFICANT STATISTICS FROM REPLIES TO QUESTIONNAIRE

TABLE 1
Distribution of Staff by Basic Discipline in Care Centres

Staff Category	Full Time	Part Time	With Pre-School Moderates only
R.N.M.H.	135	4	12
R.G.N.	147	4	7
Children's Nurse	12	0	0
Psychiatric Nurse	58	2	1
Primary Trained Teacher	7	0	2
Montessori Trained Teacher	13	0	8
St. Nicholas House Montessori Teacher	4	0	1
Physical Education Teacher	2	9	0
Qualification in Child Care	18	0	4
Qualification in Psychology	5	9	2
Speech Therapist	1	12	2
Occupational Therapist	5	7	0
Physiotherapist	6	24	3
With other University Degree	11	0	1
With other 3rd Level Qualification	14	2	1
Student Nurse	61	0	0
Unqualified Staff	275	15	10
	774	88	54

TABLE 2
Numbers of children receiving Speech Therapy on a daily/weekly/less frequent basis

No. of Centres	No. of Children Daily	No. of Centres	No. of Children Weekly	No. of Centres	No. of Children less Frequently
40	0	40	0	43	0
1	2	1	1	2	1
2	4	1	3	1	2
1	7	1	9	1	20
1	10	1	10	1	24
2	25	1	12		
1	44	1	17		
		1	28		
		1	31		

TABLE 3
Numbers of children receiving Occupational Therapy on a daily/weekly/less frequent basis

No. of Centres	No. of Children Daily	No. of Centres	No. of Children Weekly	No. of Centres	No. of Children less Frequently
40	0	45	0	46	0
1	2	1	6	1	2
1	6	2	10	1	20
1	8				
2	10				
1	12				
1	14				
1	20				

TABLE 4
Numbers of children receiving Physiotherapy on a daily/weekly/less frequent basis

No. of Centres	No. of Children Daily	No. of Centres	No. of Children Weekly	No. of Centres	No. of Children less Frequently
32	0	20	0	42	0
1	1	3	1	1	2
1	2	3	3	1	3
1	4	2	5	1	7
1	7	1	6	1	16
1	8	4	8	1	20
1	9	1	9	1	35
1	10	3	10		
3	12	1	11		
1	14	1	13		
1	15	1	14		
1	16	1	18		
1	20	1	20		
1	31	1	23		
1	54	1	26		
		3	30		
		1	53		

TABLE 5
Number of Speech Therapy Hours available per centre per week

No. of Centres	No. of Hours
36	0
1	1
3	3
1	4
2	5
3	6
1	15
1	40

TABLE 6
Number of Occupational Therapy Hours
available per centre per week

No. of Centres	No. of Hours
39	0
2	5
2	6
2	16
1	25
2	35

TABLE 7
Number of Physiotherapy hours available per
centre per week

No. of Centres	No. of Hours
19	0
2	1
4	2
1	3
4	4
4	6
1	8
1	9
1	10
2	12
1	13
1	14
2	15
2	30
1	32
1	38
1	40

TABLE 8
Number of hours devoted to a Learning/Training
Programme per day

No. of Centres	No. of Hours
3	None
3	Up to 3 hours per day
24	4 or 5 hours per day
18	6 or more hours per day

Note: No clear distinction was made between formal and informal training.

TABLE 9
Days of Training per week reported

No. of Centres	No. of Days
3	0
1	2
37	5
7	7

TABLE 10
The following table represents the number of Centres which stated that they had programmes to encourage the development of the children in the areas mentioned.

Area of Development	No. of Centres with a Programme
Self Care: Washing/Toileting	45
Self Care: Dressing/Feeding	46
Physical Education: Gross Motor	38
Physical Education: Fine Motor	33
Daily Living: House Craft	27
Daily Living: Simple Crafts	16
Communication: Listening	33
Communication: Expressive	37
Basic Music Programme	41
Extra Music Programme	23
Organised Play	44
Play with Toys/Equipment	33
Social Training: Acceptable Behaviour	33
Social Training: Outings	35
Leisure Activity on Campus	37
Leisure Activity outside Campus	34
Holiday at home or away from Unit	33
Other Holiday Outings	31
Activities towards Mobility	16
Activities towards Survival	12

The quality of programming in the above areas of development was not measured.

Table 11**Commercially Produced Programmes which were stated to be in use**

Programme	No. of Centres using it in original form or adapted	No. of Centres not using
B.C.P.	8	40
P.A.C.	14	34
P.I.P.	3	45
Sherbourne Exercises	3	45
Robbins Educational Rhythmics	13	35
Step by Step	7	41
Montessori	6	42
Vineland	1	47
Development Programme for infants	5	43
Wabash	5	43
Portage	3	45
Put 2 Words Together	2	46
Specific Educational Toys	5	43
Other	12	36

Table 12**Centres reporting use of specific commercially produced programmes in major development areas**

Area of Development	No. of Centres Using
P.E. Gross Motor	32
P.E. Fine Motor	31
Physiotherapy: Posture/Ambulation	25
Physiotherapy: Extra	13
Visual: Video/Projector etc.	5
Music Equipment	28
Educational Toys	12
Toys/Play Equipment	35
Montessori Equipment	11
Mirrors	6
Equipment to improve co-ordination	14
Special aids for Feeding/Bathing	4
Special aids for Swimming	21

TABLE 13
Monitoring Procedures Reported

Type of Monitoring Procedure	No. of Centres
Criterion Check Lists	13
Staff Programmes	13
Progress Assessment Charts	7
Individual Check Lists	2
Other Procedures	9
Not stated	4

39 centres reported that the monitoring procedure was carried out twice yearly, and, of those, 26 centres reported revision monthly or more often.

TABLE 14
Involvement of Voluntary Workers

No. of Centres	No. of Voluntary Workers
25	0
4	1
5	2
2	4
6	5
1	6
1	7
1	10
1	12
1	15
1	30

TABLE 15
Nature of Voluntary Workers' Involvement

Nature of Involvement	No. of Centres
Outings	12
Helping with Training	17
Helping with Play	5

TABLE 16
Arrangements for Training of New Staff

Training	For Qualified No. of Centres	For Unqualified No. of Centres
Training Course	11	11
Induction Period	2	1
Ongoing Assessment	1	2
Working with a Qualified Member	15	13
Working with Head of Department	3	4
Attending Training School	2	1
Not Stated	14	16

TABLE 17
Arrangements for Inservice Training and Ongoing Staff Training Reported

Type of Course	No. of Centres attending	No. of Centres not attending
Adjacent Inservice Course	16	32
Behaviour Modification	15	33
Educational Rhythmics	14	34
Educational Toys	6	42
Sign Language	4	44
Educational Objective	1	47
Basic Nursing	1	47
Visits to other centres	9	39
Seminars	18	30
Bliss Symbols	1	47
Child Care	4	44
First Aid/Safety	1	47
Play and Recreation	5	43

Since some Centres encourage staff to attend more than one of the above it could be said that, in general, there is little provision made for inservice training of staff.

TABLE 18**Perception of staffs in Centres of the range of Skills which would Improve Services**

Discipline	No. of Centres Requesting
Medical Personnel — (Doctors Paediatricians etc.	27
Psychologists/Psychiatrists	27
R.N.M.H.	23
Psychiatric Nurses	16
Other Registered Nurses	14
Teachers with training in Special Education or Montessori	26
Specialist Teachers of P.E./Art/Music	24
Speech/Play Therapists	28
Occupational Therapists	32
Physiotherapists	31
Child Care Workers	10
Community Nurse	10
Social Worker	11
More Unqualified Staff with love/concern	5

TABLE 19**Perception of Staff on how education/training programmes of children with severe and profound mental handicap might be improved**

Type of Intervention	No. of Centres Mentioned
Early Intervention	10
Preschool Facilities	10
Better child/staff ratio	20
Guidance/support for parents	13
More integration in the Community	2
Introduction of Teachers	22
More training towards independence	11
Development of new theory/new direction	7
The education of the public	4
Development of smaller living units	10
Provision of more recreational facilities	16
Vocational Training needed	7
Multidisciplinary Training	7
Uniformity of Care	4
Development of a Research/Resource Centre	7

APPENDIX II

COPY OF QUESTIONNAIRE ISSUED TO AGENCIES PROVIDING SERVICES OF SEVERELY AND PROFOUNDLY MENTALLY HANDICAPPED CHILDREN, MAY 1980

An Roinn Oideachais

Department of Education

**Working Party on the Education and Training of Severely and
Profoundly Mentally Handicapped Children.**

**Questionnaire to Agencies Providing Services for Severely and
Profoundly Mentally Handicapped Children.**

1. Name of Centre:

Address:

Telephone No.:

2. Name of Correspondent:

3. Position held by Correspondent:

**4. (a) Is there a special care unit at your centre, providing day care
and training for the severely and profoundly handicapped?**

Yes/No.

(b) Is there a day care unit on its own? Yes/No.

**(c) If yours is a residential centre, please indicate whether all
the children are transferred to a care unit for day activities,
whether the education/training programme is carried on in
the children's living quarters.**

5. (i) No. of children under 18 years of age attending the Care Unit.

- (a) Preschool Moderately Handicapped
- (b) Severely and Profoundly Handicapped
- Total number attending the Unit

Residential	Day

(ii) At what age are children referred to the centre?

(iii) State as precisely as you can the number on waiting list?

for residential care

for day care

6. **Accommodation**

- (i) Please indicate the type of accommodation available for education and training stating whether it is purpose built, number of rooms, approximate area, etc., your opinion of its adequacy.
- (ii) Have the children access to other facilities e.g., gymnasium, physical education, swimming pool, etc. Please specify.

7. **Transport**

- (i) State briefly the transport arrangements for children who are not resident.
- (ii) From what source are transport costs funded?

8. Number and Qualification of Caring/Treatment Staff

Please indicate the number of staff who hold one of the qualifications listed below and the number of hours service given by them each week. Where a member of staff holds more than one of the qualifications listed, indicate only the primary qualification.

An explanatory note may be added to indicate those with dual qualifications.

	No.	No. of hours per week
(1) Registered Nurse of the Mentally Handicapped		
(2) Registered General Nurse		
(3) Registered Children's Nurse		
(4) Registered Psychiatric Nurse		
(5) Primary Trained Teacher		
(6) Montessori (3 yr.) Diploma		
(7) St. Nicholas House Montessori Diploma		
(8) Physical Education Teacher		
(9) Qualification in Child Care (specify qualification)		
(10) Qualification in Psychology		
(11) Speech Therapist		
(12) Occupational Therapist		
(13) Physiotherapist		
(14) University Degree		
(15) Other Third Level Qualification (specify)		
(16) Unqualified		

9. Total number of Staff involved in Care/Treatment Programme on a full time basis.

10. Identify the professions of those listed at (9) above, involved solely or mainly with preschool Moderately handicapped. _____
11. In the case of speech therapist, occupational therapist physiotherapist indicate the number of hours per week when their services are available exclusively for the children in the care unit.
- Speech Therapist _____
- Occupational Therapist _____
- Physiotherapist _____
- Other specialist staff (specify) _____
12. Indicate the number of those listed at (8) above who are employed on a part-time basis.
13. Have you vacancies on your staff which you have difficulty in filling?
14. Outline briefly the sequence of training activities in which the children are engaged during the day, specifying timetable.
15. Indicate the number of hours per day and the number of days per week during which the children are receiving an education/training programme.
16. Indicate whether the education/training programme is discontinued during holiday periods (excluding public holidays) and indicate the duration of such periods.
- 17.
- (i) Indicate whether the members of your full-time staff,
- (a) tend to work with different groups of children throughout the week.
- (b) tend to work with the same group of children throughout the week.
- (ii) Does each member of staff have responsibility for a particular group of children.

18. Indicate the approximate number of children who receive the following specialist services:
- (a) Speech Therapy:
Daily: Weekly: Less frequently:
 - (b) Occupational Therapy:
Daily: Weekly: Less frequently:
 - (c) Physiotherapy:
Daily: Weekly: Less frequently:
 - (d) Other specialist service:
Daily: Weekly: Less frequently:
19. Indicate the approximate number of children who require medication on a daily basis:—
20. Indicate the number of children who in addition to severe or profound mental handicap suffer from serious physical or sensory handicap (visual or hearing impairment), or other handicaps.
- (a) cerebral palsy;
 - (b) spina-bifida;
 - (c) other severe physical handicap; please specify
 - (d) blind;
 - (e) partially sighted;
 - (f) severe hearing impairment;
 - (g) behaviour disordered/constantly disruptive;
 - (h) other handicap (please specify).
21. State the number who are non-ambulant and not likely ever to be ambulant.
22. Indicate the number of children who have severe problems of incontinence.
23. Indicate whether all children are assessed on admission or prior to admission.
24. (i) Outline briefly the procedures for monitoring children's progress during their stay in the unit.
- (ii) State the frequency of such monitoring in the unit.

25. Describe briefly the procedure followed in drawing up programmes to be implemented by the caring/training staff.
- Indicate the role of the various members of staff in this exercise.
26. (i) Indicate whether there is a written programme for the unit as a whole, and who is involved in its compilation.
- (ii) Give some idea of how long this programme has been in operation.
- (iii) How frequently are programmes revised?
27. Indicate to what extent there are written programmes for individual children.
28. If outside experts, such as paediatricians, psychiatrists, psychologists, educationalists, speech therapists, etc. are involved in helping to draw up programmes, indicate briefly the nature of their involvement.
29. Indicate the arrangements which are made for monitoring progress of individual children. Specify any behavioural checklists, commercially produced or otherwise, which are in use.
30. Indicate any arrangements which are made to ensure continuity and uniformity in recording and interpreting written accounts of children's progress.
31. Give a brief outline of the programme followed in the following areas
- (i) Self-care:
 - (ii) Physical Education:
 - (iii) Daily living skills:
 - (iv) Communication/Language:
 - (v) Music:
 - (vi) Play:
 - (vii) Social Training:
 - (viii) Leisure Activities:
 - (ix) Special arrangements for holidays, outings, etc.:
 - (x) Other areas (specify):

32. Name any commercially produced programmes in use in any of the above areas. Indicate your opinion of the relevance of any items mentioned.
33. List some of the equipment, not mentioned already, which is available and indicate the areas in which each item listed is found useful.
34. Indicate whether there is a programme of parent education. Specify what form this programme takes, and at what stage does it commence.
35. Are both parents involved in the parent education programme?
36. In the case of residential children indicate what arrangements are made for visits home.
37. Indicate the rôle, if any, which parents play in the day to day running of the unit.
38. In the case of residential centres how often do parents visit the centres?
39. To what extent are voluntary workers engaged in the care and training programme?

Indicate their number and the scope of their involvement.

40. Give an indication of the staff/child ratio.
41. Indicate what arrangements are made for the recruitment of staff. Give an outline of Management policy in relation to the qualifications and previous experience of new staff.
42. Outline the arrangements made for the induction and *on the job* training of new or unqualified staff.
43. Indicate any inservice training courses attended by existing members of staff.
44. Indicate whether there are some children, excluding pre-school children, in your unit whose developmental levels are such that they could be integrated into a school for the moderately handicapped.
45. Indicate the range of professional skills you consider necessary to meet the educational and training needs of children who are in your unit.

46. Please give your own views or those of members of your staff on any additional matters relating to the educational and training needs of the severely and profoundly mentally handicapped.
47. Any other views which you or members of your staff would like the Working Party to consider.

Signature of Correspondent:

Date:

The completed questionnaire to be returned to the Department of Education, Special Education Section, Marlborough Street, Dublin 1, as soon as possible, but not later than Friday, 4 July, 1980.

APPENDIX THREE

List of Individuals and Organisations from which Written Submissions were received.

1. Association for the Rights of the Mentally Handicapped, per Mrs. Annie Ryan, 53 Avondale Lawn, Blackrock, Co. Dublin.
2. Blount, Mrs. Lila, Assistant teacher, St. John of God School, Islandbridge, Dublin 8.
3. Crosbie, Sister Colette, St. Louise's School of Nursing, St. Joseph's Hospital, Clonsilla, Co. Dublin.
4. Downs Syndrome Association.
5. Drama Study Circle, Fitzwilton House, Dublin, 2.
6. Duggan, Mrs. E., Kelly, Miss Sarah and Rafferty, Miss Eileen, St. Vincent's Centre, Navan Road, Dublin 7.
7. Egan, Mrs. Maureen, 87 Cremore Lawn, Glasnevin, Dublin, 11.
8. Frost, Dr. J. B., Medical Director, Brothers of Charity Services for the Mentally Handicapped, Galway. Memorandum on Services for the Severely Mentally Handicapped, 1979.
9. Gallagher, Mrs. Monica, Cappahard, Tulla Road, Ennis, Co. Clare.
10. Griffin, Dr. John A., Deputy Medical Director, St. Vincent's Centre, Navan Road, Dublin 7.
11. Healy, Mr. Denis, Psychologist, St. Vincent's School and Care Centre, Lisnagry, Limerick.
12. Irish Society for Autistic Children.
13. Irish Nurses Organisation and National Council of Nurses.
14. Kenefick, Mr. David, Training Officer, St. Michael's House, Goatstown, Dublin, 14.

15. McAllister, Mrs. Nuala (deceased), Psychologist, St. Vincent's Centre, Navan Road, Dublin, 7.
16. McCarthy, Miss Anne, Principal, Mill Lane Training Centre, Stewarts Hospital, Palmerstown, Co. Dublin.
17. McGinley, Mr. Patrick, 76 Wellpark Grove, Galway.
18. McSweeney, Mr. Terence, Physical Education Teacher, Cork Polio and General Aftercare Association.
19. Mulcahy, Dr. Michael, Medical Director, Stewarts Hospital, Palmerstown, Co. Dublin.
20. National Association of Teachers in Special Education (N.A.T.S.E.).
21. O'Connell, Miss Anne, Senior Psychologist, Mental Handicap Services, St. Augustines, Blackrock, Co. Dublin.
22. O'Daly, Dr. Séamas, 22 Fitzwilliam Place, Dublin, 2.
23. O'Hanlon, Dr. Rory, T.D., Carrickmacross, Co. Monaghan.
24. O'Hanrahan, Miss Winifred, 99 Gracepark Meadows, Drumcondra, Dublin, 9.
25. O'Kelly, Miss Rita, 102 Celtic Park Avenue, Dublin 9.
26. Phillips, Mrs. Sheila, "Spinnaker", Yellow Walls, Malahide, Co. Dublin.
27. Pickett, Dr. Joyce, 90 Kilbarrack Road, Raheny, Dublin, 5.
28. Principals of Special Schools for the Moderately Handicapped, per Brother Malachy Brannigan, O.H., St. Raphael's, Celbridge, Co. Kildare.
29. Psychological Society of Ireland, 4-5 Eustace Street, Dublin, 2.
30. St. Michael's House, Goatstown, Dublin, 14, per Dr. Barbara Stokes, Medical Director and Mr. P. H. Moloney, Administrative Director.
31. St. Raphael's School Teaching Staff, Celbridge, Co. Kildare.
32. Sayers, Rev. Cornelius, Education Secretariat, Diocesan Offices, Archbishop's House, Drumcondra, Dublin, 9.

33. Sheehan, Dr. Patricia, 16 Whitethorn Road, Clonskeagh, Dublin 14.
34. The Workers Party.
35. Toomey, Mr. John F., Director of Psychology, Brothers of Charity Services, Bawmore, Limerick.
Report of A Controlled Experiment in the Education of the Severely Subnormal, 1976.
36. Walsh, Miss Dympna, Psychologist, St. Vincent's Centre, Navan Road, Dublin 7.

Wt.—.143460. 1,500. 12/83. Cahill. (2401). Spl.