



BORD SLÁINTÉ
AN MHEÁN-IARTHAIR

*

STRATEGY STATEMENT

ON

INTELLECTUAL DISABILITY

Note: The Mid-Western Health Board will not accept liability for any error, omission, misrepresentation or misstatement contained in this Strategy Statement, whether negligent or otherwise, and the statements contained therein are not intended to impose any legal obligation or duty on the Mid-Western Health Board, its servants or agents, in favour of any particular person or class of persons.

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Strategic Statement of Purpose and Intent

Cognisant of the need for development of services in accordance with the principles underpinning the *United Nations Standard Rules on the Equalisation of Opportunities for Persons with a Disability*;

Mindful of the three key principles underpinning the health services declared in the *National Health Strategy* of equity, quality of service and accountability and the concept of health and social gain;

Recognising the values underpinning service provision adopted in the Mid-Western Health Board's *Corporate Strategy* of Equity, Accessibility, Effectiveness, Efficiency, Appropriateness, Responsiveness, Dignity and Farsightedness;

Reaffirming the three guiding principles adopted by the *Commission on the Status of People with Disabilities* of Equality, Maximising Participation and Enabling Independence and Choice;

Recollecting the philosophy underlying the approach of '*Needs and Abilities*' of the right of every person with an intellectual disability to as fulfilling and normal a life as possible;

Recalling the principles for partnership in services to persons with an intellectual disability declared in '*Enhancing the Partnership, incorporating Widening the Partnership*' that the arrangements for a new partnership be based on a recognition of the rights of this client group to quality services which respect their dignity, are provided within the least restrictive environment and aim at the greatest possible inclusion of persons with an intellectual disability in society;

Emphasising that parents, guardians, advocates and organisations of persons with an intellectual disability must be active partners with the Health Board and Service Providers in the planning and implementation of measures affecting their health and social wellbeing;

The Health Board and Service Providers affirm as the Strategic Statement of Purpose and Intent for persons with an intellectual disability in the region that:

The purpose of services for persons with an intellectual disability in the Mid-West region is to provide a 'person-centred' service of the highest quality to individuals with special needs that is the most appropriate to their needs. We aim to deliver services that provide our clients with the opportunity to live the life of their choice to their fullest potential within their home and community setting. We advocate and empower those availing of the services to participate and enjoy fully the rights and privileges available to society, focusing on the uniqueness of each person and his/her right to a dignified personalised life.

The strategic intent requires that the focus of the services be pivotally placed on the individual person with an intellectual disability and their families. The objective of the services is to effect a continuous lifecycle model of service and social support through the provision of an integral 'continuum of support'. Flexibility in service provision will be required as the dictates of the changing internal and external environments determine the precise nature and mix of the elements of the support continuum. The ability of our services to respond to identified, targeted need will be a prime determinant of the effectiveness of the services.

Regular reviews and evaluations of services will be a feature of service planning and delivery. These structures will be informed by the canons of quality assurance, best-practice and evidence-based modes of service delivery.

Glossary of Terms

The following is a selected glossary of terms used in the Strategy Statement:

County Catchment Area

These are Health Board administrative areas. In the Mid-West Region there are currently three Areas as follows: Clare , Limerick and Tipperary (NR).

Sector

These are Health Board administrative sub-areas that cover populations ranging from 20,000 – 40,000 persons. There are five sectors in Limerick , four in Clare and two in Tipperary (NR).

Service Provider Catchment Area

These are defined geographical areas within the Mid-West Region within which each of the four Service Providers in the region (the Daughters of Charity Services, the Brothers of Charity Services – Mid-West Region, St. Anne's Service and the Charleville and District Association for the Handicapped) accept responsibility for a full complement of services to persons with an intellectual disability.

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Executive Summary

Introduction:

Intellectual Disability Services are provided to enable persons with an intellectual disability to live as fulfilling and normal a life as possible, in the light of their needs.

The complex health, social and economic issues relating to the planning, development, implementation and quality assuring of health and personal social services for this client group makes it imperative that an appropriate strategy is formulated to guide decision making over the next five years. An Action Plan and implementation programme will be developed to ensure that the necessary developments are progressed. The purpose in formulating this Strategy Statement is to focus deliberation and discussion among all parties involved in the development of appropriate, responsive and innovative services for persons with an intellectual disability and their families in the region.

The Continuum of Support:

Structuring the range of services delivered to persons with an intellectual disability on the basis of a model of continuous support across the individual lifecycle offers the most appropriate means of identifying areas for change and improvement. The model posits a 'support continuum' structure to eliminate gaps in service delivery and ensure appropriate support at various points on the 'support continuum'. The components of the model are:

- **Preventative Support**
- **Anticipatory Support**
- **Home and Community Support**
- **Residential/Campus Support**

□ Preventative Support

The Mid-Western Health Board and Service Providers recognise that there are a range of preventative measures that can reduce the incidence of intellectual disability. The successful utilisation of Preventative Support will impact positively on the health and quality of life of all individuals in society.

A Genetic Counselling Service has started at the Mid-Western Regional Hospital, which is serviced from the National Centre for Medical Genetics, Dublin. Further development of this service will be encouraged. The research which indicates that leading a healthy lifestyle during pregnancy makes a significant impact on the health of children has led the Health Board to augment its interventions among young people who are at-risk through its teenage pregnancy services and its child and family support services. The National Childhood Primary Immunisation Programme is a key factor in the prevention of disabilities, including intellectual disability. The

Strategy Statement on Child Health outlined a commitment to pursuing an uptake of this scheme of at least 95%, through a combination of planned measures.

Persons with an intellectual disability require the same health education as the total population to ensure a healthy lifestyle throughout their lifespan. Participation in generic population-based programmes, which have been adapted to the needs of this client group, may offer the greatest potential for health gain. A reduction in the number of accidents, including accidental poisoning and parasuicide, will lead to a reduction in the number of cases of acquired intellectual disability. The Health Board's *Action Plan*, prepared in response to the Report of the National Task Force on Suicide, will spearhead the drive to reduce the incidence of suicide and parasuicide in the region.

□ **Anticipatory Support**

Services and structures are required which anticipate the needs of persons with an intellectual disability in the region. By anticipating their needs proactive supports, structures and service programmes can be planned and implemented in the light of the individual's needs.

The screening programmes of the newborn and of early-childhood are aimed at ensuring early detection and prevention of conditions that may give rise to intellectual disability, if undetected. In accordance with the Health Board's *Strategy Statement on Child Health*, enhanced integration of children's services across the region will occur. The development of a Regional Children's Diagnostic and Assessment Service for young people with complex developmental, intellectual, physical/sensory and psychosocial problems is proposed. The development of this service will enable the mainstreaming of diagnostic and assessment services for children with intellectual and physical/sensory disabilities.

The continued enhancement of the Regional Intellectual Disability Database will occur, with development of the structure to facilitate more individualised information on each individual being a priority issue. A Regional Database Committee will be established to achieve enhanced monitoring and development of the database. The Health Board acknowledges the need to further address the issue of information provision to persons with disability and their families. The Directory of Services to Persons with Disabilities will be regularly updated and the recent appointment of an Information Scientist to the Disabilities Unit will facilitate the development of an information dissemination structure within the region.

The recent appointment of Area Managers for Disabilities and the development of Disability Care Groups are a direct response to recognition of anticipatory support structures both within the Health Board's services and across agency-provided services. County Intellectual Disabilities Advisory Committees will also be established within each County Catchment Area that will provide an important mechanism for the establishment of priorities and development of services. A Review of the role and functions of the Counselling Nurses for Persons with Disabilities will be undertaken as part of the initial implementation exercise of the *Strategy Statement*.

As many persons receive services from agencies not directly linked to the Health Board or Service Providers during their lifetimes, it is necessary to develop a formal method of exchanging information, enhancing co-operation and defining roles and responsibilities between the Health Board, the Service Providers and these other agencies. Disability advocacy structures will be established which will address advocacy-related issues. Compilation of dedicated research, with a regional remit, by staff of the Health Board and the Service Providers that will inform best practice, will be encouraged. Disability awareness training can break down mistaken perceptions of persons with a disability and their needs. A planned phased programme of such training for frontline Health Board hospital and community staff will be implemented. In addition, the facilities and systems of all relevant Health Board services will receive disability proofing over the timescale of implementation.

□ **Home and Community Support**

The main aim of the disability services is to enable persons with intellectual disabilities to live lives of integrated, participative and inclusive citizenship within their own communities. The implementation of this aim is dependent on the effective provision of a range of services that can be adapted to individual needs across time.

Priority will be given to clarifying the relationships between the Health Board and Service Providers, within the framework of *'Enhancing the Partnership, incorporating Widening the Partnership'*. The Health Board and Service Providers remain committed to the goal of providing a locally accessible service in all areas of the region. The development of an effective network of localised services, on a sector basis, will be a key element of the future focus of the delivery of services to this client group.

A key component of services to this client group, as identified by both stakeholders and the Health Board, is the appointment of Community Consultant Paediatricians, working in both a hospital and community setting, who would have a special interest in children with disabilities. It is anticipated that the Early Intervention Team, established by the Brothers of Charity on a pilot basis in West Limerick will be extended to other areas in the Mid-West Region.

There is a requirement for ongoing support for individuals and their families, who have received a diagnosis of 'Intellectual Disability'. The valuable role which Social Workers can play in family support services throughout their lifespan to individuals and their families is recognised and a Social Work infrastructure will be developed in each County Catchment Area dedicated to their needs. The provision and coordination of services to the families of persons with an intellectual disability is currently inadequate. As resources are further channelled into community services the range and coordination of support services to families will be enhanced.

The Health Board and Service Providers recognise that multidisciplinary support within the community, such as Physiotherapy, Occupational Therapy and Speech and Language Therapy, is an essential element of a comprehensive service. These services will be developed to meet the needs of the individuals as part of multidisciplinary teams that address the issues of specific groups within the intellectual disability sector. Children with an intellectual disability should ideally be integrated into mainstream pre-schools. A programme of sensitising mainstream pre-

school providers to intellectual disability issues will be implemented jointly by the Pre-Schools Unit and the Service Providers. The needs of the individual child will determine the mix of specialist or mainstream pre-school service provision appropriate in each circumstance.

The policy of increasing the number of Day Places will continue in further years to meet the needs of this client group and All Day Services will be personalised to the needs of the individual with an intellectual disability. The Health Board and Service Providers will respond to the need for enhanced provision of respite support, without undue delay, in accordance with the national provision of resources to this aspect of support.

❑ **Residential/Campus Support**

Current thinking favours the model that encompasses support in group homes or in individually managed accommodation as the ideal form of provision. Where home and community services are insufficient or no longer sufficient to meet assessed need campus services are provided.

The policy shift enunciated in '*Needs and Abilities*' of focusing resources and developments primarily in community settings will be actively pursued by the Health Board and the Service Providers, with the consequent scaling down of campus services in the region. In situations where persons with an intellectual disability, despite the availability of other services, are unable to continue residing in open accommodation or where community services are inadequately developed then the option of residential support must be continued.

Day Services, Therapy/Social Work Services and Respite Support provided in a campus setting will be developed and personalised in tandem with the development of such services, as outlined under Home and Community Support. A process is currently underway to facilitate the transfer of persons with an intellectual disability who are inappropriately placed in the Mid-West region to appropriate support settings. A programme of transferring persons who are less dependent to community settings, with assistance from the Department of the Environment and Local Government's Voluntary Housing Scheme, will be developed.

As with all older people the aim of the Health Board's policies is to ensure a healthy active old age within a community setting, where possible. A phased programme of upgrading the physical standard of all campus-based facilities will be pursued in order to continually comply with ongoing minimum standards.

Discrete Issues:

- ❑ Services to persons with Autistic Spectrum Disorder in the region will be significantly developed through the development of a full Regional Diagnostic and Assessment Team and the provision of Intervention Teams and residential respite facilities in each County Catchment Area.
- ❑ Appropriate development of comprehensive early intervention and children's services for children with acquired intellectual disability will occur within the

intellectual disability services in each County Catchment Area, as part of the development of generic children's services. The level of respite support will also be increased to further support parents of children with an acquired brain injury.

- ❑ The service response to date to persons with a mild intellectual disability in the region who exhibit challenging behaviour has been limited by resources and staff specifically trained to deal with challenging behaviour. This has led to instances where the individual must be placed outside the Health Board area to ensure either the protection of the individual and/or others. A Regional Assessment and Intervention Centre is currently being developed by the Health Board and Service Providers on the Brothers of Charity campus at Bawnmore, Limerick. This will provide focused specialist interventions for this group of people and be a link point for Community-based Specialist Teams which will be developed in each County Catchment Area. The provision of a high support group home in each Catchment Area for this client group is also proposed.
- ❑ In many instances a person with a disability may have both a physical or sensory disability and an intellectual disability. In some cases there may also be multi-disabilities impacting on the full sphere of human functioning. Clear protocols for the management and referral of persons with a dual disability will be developed, in conjunction with the Service Providers.
- ❑ In line with the changed structures following the dissolution of the NRB vocational training and employment services for people with a disability will be the remit of the Department of Enterprise, Trade and Employment, through FÁS. Within this new framework the emphasis will be on progression pathways to employment for persons with disabilities. A specialised training service will remain for persons with an intellectual disability who do not have the skills or ability to access mainstream training or employment. This training will be rehabilitative/life skills focused and the Health Board will work collaboratively with intellectual and physical and sensory disability agencies within the region to maximise rehabilitative training and sheltered and supported employment opportunities.
- ❑ Specific services will be developed in each Service Provider Catchment Area to address the mental health needs of persons with an intellectual disability in the region.

The Strategy:

The Health Board and Service Providers affirm as the Strategic Statement of Purpose and Intent for persons with an intellectual disability in the region that:

The purpose of services for persons with an intellectual disability in the Mid-West region is to provide a 'person-centred' service of the highest quality to individuals with special needs that is the most appropriate to their needs. We aim to deliver services that provide our clients with the opportunity to live the life of their choice to their fullest potential within their home and community setting. We advocate and empower those availing of the services to participate and enjoy fully the rights and privileges available to society, focusing on the uniqueness of each person and his/her right to a dignified personalised life.

The strategic intent requires that the focus of the services be pivotally placed on the individual person with an intellectual disability and their families. The objective of the services is to effect a continuous lifecycle model of service and social support through the provision of an integral 'continuum of support'. Flexibility in service provision will be required as the dictates of the changing internal and external environments determine the precise nature and mix of the elements of the support continuum. The ability of our services to respond to identified, targeted need will be a prime determinant of the effectiveness of the services.

Regular reviews and evaluations of services will be a feature of service planning and delivery. These structures will be informed by the canons of quality assurance, best-practice and evidence-based modes of service delivery.

The Statement of Purpose and Intent is an expression of the strategic vision envisaged for the services to persons with an intellectual disability in the Mid-West Region. The Strategic Objectives of the Strategy, which bring a focus to the vision, are as follows:

Strategic Purpose and Intent:-

- ❑ Provision of 'person-centred' services of the highest quality to individuals with special needs that is the most appropriate to their needs.
- ❑ Provision of appropriate supports to, and within, the home and community setting of the person with an intellectual disability, so that as many as possible can remain in their environment.
- ❑ Ensuring that all adults with an intellectual disability, identified as in need of specialised health and personal social services, will receive their services in an integrated, appropriate setting.
- ❑ Ensuring that all those on waiting lists for day, respite or residential services, as identified by the database, will receive the service appropriate to their needs.
- ❑ Delivery of a continuous lifecycle model of service and social support through the provision of an integral 'continuum of support'.

Preventative Support:-

- ❑ Promotion of preventative strategies to reduce incidence of intellectual disability in the region.

Anticipatory Support:-

- ❑ Development of a Regional Children's Diagnostic and Assessment Service.
- ❑ Development of the internal and public advocacy role of the disability services.
- ❑ Disability proofing of all Health Board services and facilities.
- ❑ Forging effective linkages, developing coherent coordination and defining areas of responsibility with relevant government Departments, particularly the Department of Education and Science.

Home and Community Support:-

- ❑ Development of a comprehensive Early Intervention Service for children with an intellectual disability on a catchment area and sector basis.
- ❑ Further development of multidisciplinary therapy services.
- ❑ Enhanced provision of Day Services.
- ❑ Development of flexible, responsive respite services.
- ❑ Provision of enhanced support to families and carers.

Residential/Campus Support:-

- ❑ Active pursuit of policy of focusing resources and developments in community settings, with consequent scaling down of campus services in the medium/long-term.
- ❑ Ensuring that all persons with an intellectual disability who are inappropriately placed will be relocated to appropriate support settings.
- ❑ Formulation of appropriate policies to cater for the needs of elderly persons with an intellectual disability.

Discrete Issues:-

- ❑ Development of a full Regional Assessment and Diagnostic Team for persons with Autistic Spectrum Disorder.
- ❑ Development of Intervention Teams for persons with Autistic Spectrum Disorder in each catchment area.
- ❑ Development of residential respite facilities for persons with Autistic Spectrum Disorder in each catchment area.

- ❑ Development of an appropriate comprehensive early intervention service for children with acquired intellectual disability within the intellectual disability services in each catchment area.
- ❑ Provision of appropriate multi-faceted, multi-agency interventions to those presenting with Challenging Behaviour to enable the individual to remain in their home and community setting, where possible.
- ❑ Enhancement of the quality of Rehabilitative Training service in the region.
- ❑ Development of community outpatient and acute inpatient, community-based mental health services for adults with a moderate, severe or profound intellectual disability within the intellectual disability services in each catchment area.
- ❑ Development of community outpatient and acute inpatient, community-based mental health services for children and adolescents with a moderate, severe or profound intellectual disability within the intellectual disability services in each catchment area.
- ❑ Development of services for offenders with an intellectual disability, within the context of the emerging forensic psychiatry service in the region.

Human Resource Function:-

- ❑ Development of effective staff recruitment and retention policies/structures and appropriate personal development programmes.

The service principles outlined in *'Needs and Abilities'* of enabling those persons with an intellectual disability with the capability of living in the community to do so while providing residential places to those for whom this is not possible will underpin the strategic action designed to achieve health and social gain for persons with an intellectual disability. The design of services along the continuum of support will facilitate the development of an holistic, continuous lifecycle model of service delivery that is person centred and appropriately supportive.

The Mid-Western Health Board is committed to intellectual disability service provision by the voluntary/community-based sector, with designated service providers accepting responsibility for the full complement of services in each catchment area. These services will encompass all services along the continuum of support.

The role of the Health Board will be, primarily, one of assessment of need, service planning/coordination, research, monitoring/evaluation, quality assurance and promotion of services. Where a lack of expertise or capacity to provide a service exists within the voluntary/community sector the Health Board may become a direct service provider or invite other providers to deliver designated services until such capacity can be established.

The implementation of this Strategy Statement will impact on staffing structures and levels, capital and revenue resources and information and communication policies. The pivotal supporting strategies are the People Strategy, the Resource Strategy

and the Information Strategy. In order to address the issues arising within the Resource Strategy, the Board and Service Providers will compile a detailed Action Plan that will identify and outline the infrastructural, financial, staffing, training and information technology resources required to give effect to the objectives of the Strategy Statement. The Action Plan will embrace the developments prioritised in the National Development Plan over the period 2001 – 2006 for the region with respect to services for persons with an intellectual disability.

A half-yearly Review of the progress in implementing of the Strategy Statement will be held, which will involve senior management of the Disabilities Directorate and representatives of the Service Providers. Prior to the holding of the half-yearly reviews submissions will be sought from all stakeholders on their perceptions of the implementation process and summarised feedback from these submissions will inform deliberations at the Reviews.

Chapter 1: Introduction

Intellectual Disability Services are provided to enable persons with an intellectual disability to live as fulfilling and normal a life as possible, in the light of their needs.

The National Health Strategy, *'Shaping a Healthier Future'* (1994) emphasised the importance of addressing unmet need in the areas of residential places for emergency and long-term support, day services, respite support and home support services. The challenges facing service provision that arise from the increased longevity of this client group were also underlined. The importance of adequate data and information structures, in order to inform an orderly planning of services, was highlighted.

The service principles, outlined in *'Needs and Abilities'* (1990) of enabling those persons with an intellectual disability with the capability of living in the community to do so, while providing residential places to those for whom this is not possible, underpin the provision of services to persons with an intellectual disability in the Mid-West Region.

The principles and structures for partnership, outlined in *'Enhancing the Partnership'* (1997), and *'Widening the Partnership'* (1999) which were initially implemented in the Mid-West Region, highlight the central role which partnership with the Service Providers and voluntary organisations, active in the sphere of service provision to this client group in the region, will continue to play.

Data analysed by the Health Research Board in 1996 and 1997 draws attention to the changing demographics of the intellectual disability population, which will pose particular challenges to the Health Board and the Service Providers in the coming years.

The Health Board has expressed its commitment to the promotion of health and social gain for the population of the Mid-West Region, based on the principles of equity, quality and accountability, in its Corporate Strategy and Corporate Quality Statements. The concerns of persons with an intellectual disability and their families include their independence, dignity, safety of environment, responsive services and some positive control over their health and wellbeing. A health gain focus aims to improve the health status and quality of life of this client group and their families through the provision of appropriate, equitable, accessible and timely interventions and services. A social gain focus aims to improve the person's life by minimising the effects of the disability and resulting disadvantage. The health and social gain targets for this client group are concerned with reduction of the incidence of intellectual disability, limitation of the disabling effects and improved social functioning and inclusion.

The improvement of the health and wellbeing of persons with an intellectual disability is not a single agency task. Society, its institutions and communities can enable and empower the individual person with an intellectual disability to reach his/her potential. The valuable role of organisations of parents and friends of persons with an intellectual disability in the region, in terms of direct/indirect action and advocacy,

is readily acknowledged in this regard. Improving social functioning and enabling inclusion in society for this client group are factors in providing effective responses throughout the lifecycle of the person with an intellectual disability.

The complex health, social and economic issues relating to the planning, development, implementation and quality assuring of health and personal social services for this client group make it imperative that an appropriate strategy is formulated to guide decision making over the next five years. The purpose in formulating this Strategy Statement is to focus deliberation and discussion among all parties involved in the development of appropriate, responsive and innovative services for persons with an intellectual disability and their families in the region.

This Statement, and its sister Strategy Statement on Physical and Sensory Disability, are part of a suite of Strategic Statements being developed in order to give strategic direction to the different Care Groups.

Chapter 2: Strategy Formulation

Following the publication of the National Health Strategy in 1994 a parallel cascading communication process, involving all stakeholders, was undertaken within the Health Board and the Voluntary Organisations through which services for persons with an Intellectual Disability are delivered. The Corporate Strategy and Corporate Quality Statements were developed at Corporate Health Board level and communicated throughout the organisation. Voluntary Organisations conducted major structural and ethos reviews in the light of issues arising within their parent organisations and within the area of intellectual disability locally, regionally and internationally.

Three strands of enquiry directed the approach to the formulation of this Strategy i.e.

- ❑ **Stakeholder Perceptions**
- ❑ **Internal Review Data**
- ❑ **External General Reviews**

2.1. Stakeholders:

Initially, service users and providers were invited to participate in focus groups or facilitated discussions. The participant groups, identified by the members of the Intellectual Disability Services Consultative Committee, included a stratified sample of Health Board and Service Provider Organisation staff, service users, carers and representatives from voluntary organisations. This work was undertaken on behalf of the Health Board by an external consultant in order to ensure objectivity. All of the information compiled was analysed and a synthesis was presented as a Position Paper to a grouping of Health Board staff involved in the management of service provision to persons with an intellectual disability.

From the above process a draft of the Strategy was compiled and, from the feedback received from the Service Providers, an agenda of core issues around which the Strategy revolves was compiled. The Regional Intellectual Disability Services Development Committee established a sub-group to progress the Strategy, which explored the range of strategic issues involved and ultimately led to the compilation of the final draft of the Strategy Statement.

2.2. Internal Review Data:

Internal data utilised in compiling this Strategy included current data from the Regional Intellectual Disability Database, current service activity and performance data submitted by the Service Providers. Reviews by the Intellectual Disability Services Development Committee, senior staff in the Board and Provider Organisations, Service Plans and internal reports were also utilised.

2.3. External General Reviews:

The main sources of external review were:

- ❑ 'Needs and Abilities': A Policy for the Intellectually Disabled (1990).
- ❑ Report of Committee on Mental Handicap Services in the Mid-Western Health Board Area (1992).
- ❑ United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993).
- ❑ The National Health Strategy, 'Shaping a Healthier Future' (1994).
- ❑ Services for Persons with Autism (1994).
- ❑ Report of MWHB Working Group on Services to Persons with Autism (1996).
- ❑ Discussion Document on Mental Health Needs of Persons with Mental Handicap (1996).
- ❑ 'A Strategy for Equality': Report of the Commission on the Status of People with Disabilities (1996).
- ❑ First Annual Report of the National Intellectual Disability Database Committee (1996).
- ❑ An Assessment of Need for Services for Persons with a Mental Handicap, 1997 – 2001 (1997).
- ❑ 'Enhancing the Partnership incorporating Widening the Partnership' (1999).
- ❑ 'Towards Equal Citizenship' (1999)

Chapter 3: Policy and Service Context

3.1. National Policy Context

The five core documents relating to national policy in the area of intellectual disability are: 'Needs and Abilities', 'Shaping a healthier future', 'A Strategy for Equality', 'An Assessment of Need' and 'Enhancing the Partnership, incorporating Widening the Partnership'.

3.1.1. 'Needs and Abilities' (DOH, 1990):

The Review Group on Mental Handicap Services, which compiled the 'Needs and Abilities' Report endorsed the view of the *Report of the Commission of Inquiry on Mental Handicap* (1965) that, as a general principle, community care (i.e. care provided outside residential centres, was therapeutically better, permitted a fuller development of the personality and avoided the problems of adjustment to normal life which were frequently experienced after prolonged care in an institution. It was accepted, however, that community services would not be feasible for all individuals and an appropriate mix of facilities should be provided. (DOH, 1990: 1)

With regard to services to persons with general learning difficulties, the Report felt that children with these disabilities should no longer be referred to centres for intellectually disabled persons for assessment, as had been the practice. Rather the full-time employment of specialist staff in the educational service was recommended or, where these staff were not employed, assessments could be carried out by the multi-disciplinary teams of the intellectual disability services, as an integral part of the school system. The Report recommended that children and adolescents with general learning difficulties should not be referred for residential facilities if the only reason for doing so is to facilitate attendance for special education. Where family circumstances make it necessary to provide an alternative residential arrangement preference should be given to seeking a place for the child with a substitute family and placement should continue only for as long as is deemed necessary. The Report brought to the attention of the Departments of Education and Labour that school leavers with general learning difficulties needed special additional help to prepare themselves adequately to enter the workforce. In addition, training agencies such as FÁS, were exhorted to make special efforts to incorporate these young people into their mainstream programmes of training and preparation for employment.

In terms of prevention of intellectual disability, the Report endorsed the preventative measures outlined in the *Report of the Commission of Inquiry on Mental Handicap* which included health education, obstetrical services, control of epilepsy, early identification, routine testing of infants, genetic counselling and alleviation of cultural or environmental deficiencies. The Report believed that, to be effective, health education programmes aimed at prevention must be promoted at both national and local levels. Early intervention was seen as vitally important in preventing developmental delay, in lessening the impact of intellectual disability on the family and in preventing the growth of secondary disabilities. The establishment of genetic counselling services at a number of regional centres, from which services would be provided locally on a visiting basis, was recommended. Attention was also drawn to

the damaging effects of cultural, social, emotional and material deprivation; the victims of which so often come to be catered for in services for this client group. The Report recommended that more concerted efforts should be made to break the cycle of deprivation.

In analysing the identification and early services the Report emphasised that the resources of the health board pre-school developmental service should be particularly directed to reach those children in districts where cultural, emotional and material deprivation are evident. It was also important that general practitioners and other community care personnel should receive special training in the screening and detection of abnormalities, as, in the absence of a developmental paediatric examination at regular intervals during infancy and early childhood, the identification of a child with delayed development is dependent upon the family doctor and community care personnel. The Report stressed that close liaison was required between the maternity and general community health services for children and the services for persons with an intellectual disability to facilitate referral and ensure that appropriate staff were available to the child and family, as necessary.

The Report recommended that specialist early intervention teams should be available in each region to develop the appropriate levels of expertise and experience in meeting the specialist needs of infants and young children with developmental delay. The teams should be maintained by the health boards or by voluntary bodies, as agents of the health boards. Services for children up to age three should be delivered mainly in the home and should include an initial assessment and ongoing programme to meet the needs of the child and support services to the family. One of the members of the early intervention team should be designated as a 'key worker' who would act as a link between the team, the family, the community and other service providers who would have primary responsibility for coordinating the support services, as required.

The Report advised health boards to encourage the development of support groups such as, mother and toddler groups and parents and friend groups which provide a valuable source of practical assistance for parents through the sharing of experiences. As far as possible, developmentally delayed children should be facilitated at approximately three years to attend local pre-schools or playgroups for other children, subject to the pre-school teachers and playgroup leaders following a programme recommended by the early intervention team. Where pre-schools are unsuitable, unavailable or unable to cope with the child because of the severity of the developmental delay a special child developmental centre would be necessary. Arrangements for substitute families for temporary or long-term care must be facilitated where the child's home is not able to meet his or her needs adequately. The need for a limited number of crisis and planned relief facilities was also emphasised.

In reviewing the needs of children with a moderate degree of intellectual disability of school-going age, the Report emphasised that close liaison would be required between frontline and multidisciplinary support personnel of the pre-school programme and their counterparts in the school programme if the transfer from early childhood development programme, pre-school or playgroup to a special school, special class or integrated education within the ordinary classroom was to be successfully achieved. The localisation of special educational opportunities for such children, which had greatly reduced the need for residential accommodation for

them, was welcomed and the Report advised that no such child should be placed in residential accommodation away from home solely on the basis of the need to avail of special accommodation.

With respect to the needs of children with a severe or profound degree of intellectual disability of school-going age, the Report advised that the Child Education and Development Centre (CEDC) model, recommended for this client group, should be sited convenient to the population served and should always be in facilities which are separate from residential facilities and, preferably, on a different site. The most effective CEDCs were seen to be reasonably small, with not more than ten to fifteen pupils and with a frontline team of staff drawn from a number of disciplines – teaching, nursing, care assistants and household personnel. The Report recognised that a small number of children and adolescents would need to be accommodated outside the family home. While a significant number may be successfully placed with substitute families, the development of a small number of alternative homes, staffed to meet intensive medical needs or provide intensive behaviour management programmes was recommended within each region. The need for development of short-term breaks for those families who have family members with an intellectual disability living at home was also emphasised.

In analysing the day care and employment needs of the adult intellectual disability population the Report emphasised that it was essential that the stimulus and effort provided in early intervention and school programmes should be continued and complemented by appropriate programmes during adulthood. It was felt that the primary concern of services for adults with a moderate and severe intellectual disability should be the provision of training and employment for them and for those with a general learning difficulty who, because of significant additional disabling conditions, would be unable to avail of or benefit from mainstream training programmes. The Report recommended that all pupils who avail of special educational programmes should have access to pre-vocational and vocational training, as appropriate. On completion of their training and further education, and where open employment was not possible, employment in a sheltered environment would be required. This need not necessarily take the form of workshops but could be resource centres based in local neighbourhoods. The Report endorsed the view that the Department of Labour should in future play a greater role in the training and employment of persons with an intellectual disability likely to be capable of following the training provided and considered suitable for open employment.

Commenting on day care for adults with a severe and profound intellectual disability the Report emphasised that provision for this client group simply by way of passive institutional care was no longer acceptable and a more optimistic view of their potential would be of substantial benefit. The provision of intensive programmes in small local units, if at all possible at a separate location from the place of residence, was advised.

In reviewing the living arrangements of adults, the Report recommended that they should continue to live at home if this could be achieved without placing unnecessary strain on parents and relatives or on the persons with an intellectual disability themselves. A range of services and factors would encourage the realisation of this policy, namely:

- Accessible, appropriate and challenging day services

- Access to a multi-disciplinary support service team
- Provision of short-term breaks, on a planned basis
- Provision of well-planned leisure activities
- Ready access to health and welfare services
- Existence of a local community which is sensitive to the needs of this client group
- The immediate availability of alternative, appropriate accommodation for members of this client group, if needed.

If it becomes necessary for a person with an intellectual disability to leave home permanently or for a period of time a range of options for the substitute home, which should have all the characteristics of a good family home might include:

- Care by other relatives
- Adult foster care schemes
- Minimally supervised group homes
- Staffed group homes
- Placement in a residential centre. This is the least favoured option and should be reserved for persons with a severe to profound degree of intellectual disability or for those who have significant additional handicapping conditions.

The Report, in outlining its view on the future of residential centres, stated that:

- Existing residential centres which are older and which are not domestic in scale should be discontinued
- Children and adults with general learning difficulties and persons of all ages with a moderate intellectual disability would in future be more appropriately placed in community-based accommodation
- New accommodation for persons with severe to profound intellectual disability or for those with significant additional handicaps should be domestic in scale and as homelike as possible.

In commenting on the needs of the elderly population among those with an intellectual disability the Report that where they have lived for a significant period of time in a residential centre before moving to independence and request, on retirement, the option of returning to the centre for their retirement that request should be facilitated where possible. The Report further advised that, on retirement, persons with an intellectual disability in supervised accommodation should continue to live in their place of residence and have the option of attending an appropriate facility for older persons a daily basis.

With respect to this client group inappropriately placed in psychiatric hospitals, the Report endorsed the policy enunciated in *Planning for the Future* that no further persons with an intellectual disability be admitted to these hospitals, those presently in hospital should be segregated from psychiatric patients and consideration should be given to relocating some of them to specialised community facilities, with back-up facilities.

In reviewing the issue of disturbed behaviour among this client group, the Report recommended that children with a general learning difficulty who require specialist

intervention should obtain the service from the generic services. In considering the remainder of the population who exhibit disturbed behaviour it was felt that as the quality and scope of services develop, the degree of disturbance among this client group should diminish. The Report believed that consideration should first be given to effecting a change for the better in the individual's daily environment. Of primary importance in the prevention and management of disturbed behaviour was the provision of adequate staffing levels and, in general, the emphasis should be on personnel rather than on special buildings. For the minority of individuals whose behaviour may be classed as a danger to themselves or others the provision of special units was recommended. However, an effective admission and discharge policy was required for these units to prevent them becoming blocked with long-term placements. **(DOH, 1990: 2)**

While a formal review of the implementation of the recommendations contained in '*Needs and Abilities*' has not been conducted at national level, an ongoing review has, in effect, been occurring in that service provision has been altering to meet the changing needs of those using or requiring access to the services over the decade since its publication. **(DOJE & LR, 1999: 1)**

3.1.2. 'Shaping a healthier future' - The National Health Strategy (DOH, 1994):

The National Health Strategy, '*Shaping a healthier future*' defined the primary aims of the health services as the achievement of health and social gain through the enforcement of the principles of equity, quality and accountability.

The Strategy cited the objective of the intellectual disability services as the development of the person with an intellectual disability to the maximum of his/her potential. The necessity of meeting the existing level of unmet need was emphasised, as were the changes in type of need which must be met arising from the increased longevity of this client group. The Strategy outlined an action plan for the development of services for persons with an intellectual disability to be implemented during the period, 1994 – 1997, which included the following:

- ❑ The establishment of a National Database on the needs of persons with an intellectual disability.
- ❑ Improvement of accuracy of data available to health boards on the population of persons with an intellectual disability
- ❑ Enabling the current needs of clients with an intellectual disability to be assessed more accurately
- ❑ Support planning for the future development of services for clients
- ❑ Further expansion of residential and day places.
- ❑ Provision of flexible Home Support Services and Respite Care Services.
- ❑ Continuation of the programme to relocate persons with an intellectual disability who are currently in psychiatric hospitals to more appropriate care settings.
- ❑ Development of a policy for a service for persons with an intellectual disability who have disturbed behaviour and its implementation on a phased basis.
- ❑ The development and implementation of services to Persons with the Autistic Spectrum.

- The provision of Hepatitis B Vaccination for staff, working in the intellectual disability services, and client groups who are considered to be at risk.
- The provision of a genetic counselling service. (DOH, 1994: 1)

3.1.3. 'A Strategy for Equality' - Report of the Commission on the Status of People with Disabilities (DOE&LR, 1996):

The Commission identified three key principles that have informed recent international legislation and practice:

- ◆ The recognition that disability is a social rather than a medical issue;
- ◆ The adoption of a civil rights perspective, and
- ◆ The recognition of equality as a key principle of the human rights approach

The United Nation's Standard rules on the Equalisation of Opportunities for Persons with Disabilities, adopted in 1993, integrate these principles. While not legally binding on UN member states they are intended to provide the basic international legal standard for programmes, laws and policy on disability in the coming years. Their objective is to ensure that all people with disabilities can exercise the same rights and obligations as other people. (DOE&LR, 1996: 1)

The three guiding principles adopted by the Commission to inform its work were:

- (1) **Equality:** this key principle underlay all the recommendations in the report of the Commission. The Commission recommended that the State provide for programmes of affirmative action and positive discrimination to address past inequalities experienced by persons with disabilities
- (2) **Maximising Participation:** this principle implies that people with disabilities have the right to participate in all areas of Irish life to the fullest extent and, conversely, the State should have regard to the needs and interests of persons with disabilities.
- (3) **Enabling Independence and Choice:** this principle implies that persons with disabilities have the right to be able to achieve their full potential; the right to make their own choice concerning the conditions of their lives; and the right to quality services. (DOE&LR, 1996: 2)

The problems most often encountered by persons with disabilities when dealing with the health services were:

- inaccessibility of hospitals, health centres and doctor's surgeries
- the concentration of vital services in Dublin
- the unpredictable availability and underfunding of community services such as, home helps and respite care
- a widespread lack of disability awareness
- the lack of consumer control of services

- lack of clearly defined complaints procedures (**DOE&LR, 1996: 3**)

The Commission issued 36 recommendations in respect of the health services. Among the main issues which arose for implementation were:

- ❑ The allocation of a key worker to facilitate communication between hospital staff and people with disabilities and their families.
- ❑ The need for close liaison between hospital maternity units and all community services for children with disabilities
- ❑ The need for hospital staff at all levels and doctors at both undergraduate and postgraduate level to receive disability awareness training.
- ❑ The need for additional revenue funding to address shortfalls in services for people with disabilities
- ❑ The development of national standards by the Department of Health and Children for services to people with disabilities in the community
- ❑ The rights of patients, the development of effective complaints procedures and the employment of Rights Advisers and Patient Advocates
- ❑ The need for health boards to review existing levels of services with reference to the principles of equity, accountability and quality of services

Since a 'Strategy for Equality' was published, £35m additional revenue will have been invested by the health and personal social services in the intellectual disability sector. (**DOJE&LR, 1999: 1**).

3.1.4. 'An Assessment of Need' (DOH, 1997):

In 1997 the Department of Health published an 'Assessment of Need' for service provision to persons with an intellectual disability for the period, 1997 – 2001, based on data compiled from the National Intellectual Disability Database. The planning and development of services to persons with an intellectual disability was accorded a new dimension with the issuing of this assessment which, as was stated at the time, "puts this country in the forefront of international developments in this field", with the provision of "such detailed national data". (**DOH, 1997: 1**)

In respect of unmet need, the Report indicated that, in total, 2,359 people would require a major element of service over the five-year period, 1997 – 2001. The number of additional places required to meet this demonstrated need was 1,439 residential and 1,036 day places. The major problem to date in respect of respite places was that respite facilities had been blocked by emergency admissions due to the number waiting for services. However, as the number waiting would be reduced, existing respite facilities would be freed up. Account would be taken in the allocation of resources for provision of new residential places of the need for expansion of respite support services, as an element of respite support is built into any new residential facilities provided. The data also revealed a demand for increases access to 'host families' and other 'share a break' schemes. The 'contingency' category on the database is an acknowledgement of the emergency demand for residential places that arises for specific reasons and the investment in new residential places and the development of emergency funds should enable management of these cases.

The Report indicated that 7,722 persons currently received a service, who would require a change in their current service provision over the years, 1997 – 2001. Five areas where service provision would require change over the five-year period, were identified, as follows:

- ❖ **Intensive Placements:** a more intensive placement was identified for a group of clients on the database, already in receipt of services but who had behavioural and severe or profound disabilities.
- ❖ **Residential Services:** a group of clients, currently in residential services would require an upgrading or change of accommodation.
 - a sub-group of these would be more appropriately accommodated in the community
 - the remaining individuals would require a different residential service. The majority of these currently had a seven-day residential service but a more intensive service, involving, in the main, higher staff / client ratios and more specialist interventions would be required because of (i) difficult behaviour, (ii) the degree of disability and (iii) the problems of ageing.
- ❖ **Day Services:** a group of clients on the database would require day service changes involving the provision of early intervention services, educational services and adult services.
 - database information indicated that there would be a decrease in the numbers requiring early intervention and pre-school services over the coming years. It was emphasised, however, that there was a need to enhance the level of early intervention which was available to parents.
 - while the database suggested a significant decline in the number of children requiring an educational service, a precise quantification of likely future demand for special education services could not be derived from the database alone. The conclusion of the deliberations of the interdepartmental committee established to examine the recommendations of the Review Group on Special Education would inform the future development of these services.
 - in the majority of cases, children leaving the school system would be entering the rehabilitative training services. A policy document on rehabilitative training, in preparation by the Department of Health and Children, would make recommendations about how current spending on training can be made more effective. A significant shortfall was evident in relation to the demand for adult day places to meet the changing pattern of care. Additional services would be provided to assist in meeting the needs of this group. A substantial shortfall in the number of available open and supported employment places was also identified.
- ❖ **Additional Support Services:** There was an identified need for an increased level of support for children and adults in the areas of psychological services, speech & language therapy, physiotherapy and counselling services.

This range of services are essential to enable people with an intellectual disability to reside in the community and to enable their families to cope their changing needs. Primary Prevention through health education, genetic counselling, optimal Obstetric and Neonatal services and immunisation programmes is the first objective.

- ❖ **Persons with an Intellectual Disability in Psychiatric Hospitals:** In 1996, there were 970 persons with an intellectual disability accommodated in a psychiatric hospital. Of this group 310 were classified as being inappropriately accommodated and required transfer to the intellectual disability services. 660 persons were considered to be appropriately placed. **(DOH, 1997: 2)**

The analysis outlined in 'An Assessment of Need (1997 – 2001)' was based on the 1996 data compiled in the 1st Annual Report of the national database. In the intervening years some aspects of the demographics relating to the intellectual disability population have changed. For instance, the rising national birth rate of recent years will alter the analysis of service implications for the (0-4) age group. A second edition of 'An Assessment of Need' will be published at the end of 2000 that will reflect the changed demographics of this client group.

3.1.5. 'Enhancing the Partnership incorporating Widening the Partnership' (DOH & C, 1999):

In 1995 the Minister for Health established a Working Group comprised of representatives of his Department, the Federation of Voluntary Bodies Providing Services to People with a Mental Handicap and the Chief Executive Officers of the Health Boards in order to identify and advise the Minister on:

- ◆ The arrangements for a national framework which should be put in place to ensure a smooth transfer of responsibility for funding of Voluntary Intellectual Disability Agencies from the Department of Health to the Health Boards;
- ◆ The process of transferring responsibility for funding from the Department of Health to the Mid-Western and Southern Health Boards of the relevant intellectual disability agencies;
- ◆ The implications of these arrangements for other service providers in the field of intellectual disability. **(DOH & C, 1999: 1).**

The Group recommended the establishment of two Committees in each region in recognition of the importance of a planning and coordinating structure to the systematic development of services for persons with an intellectual disability.

The Intellectual Disability Services Consultative Committee (IDSCC) provides a broadly based forum for the exchange of ideas and information on all issues relating to this client group in the region and advises the Intellectual Disability Services Development Committee on the development and provision of services. Represented on this committee are the Health Board, other statutory bodies, all service providers and parents/families of people with an intellectual disability. The IDSCC:

- Advises the Intellectual Disability Services Development Committee (IDSDC) on the allocation of all statutory resources for new and developing services;

- Advises the IDSDC on any matters relating to the provision of intellectual disability services in the region, including new developments;
- Advises on strategies to maximise cooperation between all stakeholders;
- Agrees mechanisms and actively pursues effective advocacy, in relation to standards and resources.

The Intellectual Disability Services Development Committee (IDSDC) includes senior representatives of each service provider having a service agreement with the Health Board, a senior representative of the Health Board, the Director / Coordinator of Services and the Chairperson of the Consultative Committee. The IDSDC:

- Recommends to the Chief Executive Officer the allocation of all statutory resources for new and developing services and the upgrading of existing services;
- Prepares a development plan for the region;
- Ensures that proper measures are in place to monitor the functioning of the regional database;
- Establishes the criteria necessary to evaluate changing client needs within the region;
- Recommends the establishment of multidisciplinary team(s) to evaluate the clinical needs of persons with an intellectual disability;
- Establishes cost bands for day and residential places by dependency categories;
- Provides an annual report on services for this client group to the Chief Executive Officer.
- Encourages and participates, as appropriate, in the evaluation of service delivery.

Service Agreements:

The National Health Strategy provided that alterations in the funding arrangement between the Department of Health and the directly-funded intellectual disability agencies would be related to the introduction of service agreements between the Health Board and such agencies. Agreed catchment areas were to be taken into account in such decisions. Agreement on the level of service provision committed by the agency in return for the agreed funding provided by the Health Board is the focal point of the process.

The Health Board retains the statutory responsibility for the coordination and provision of services for this client group in their Health Board area. The provision of structures which encourage the development of linkages between the statutory and voluntary services have been assigned particular emphasis. The essential factor in the functional relationship between the managements of the Health Boards and the voluntary agencies lies in the security and protection which the service agreements offer the parties. The principles of autonomy and devolved budgets, together with the emphasis on measuring performance (in addition to activities), are the cornerstone of service agreements. **(DOH & C, 1999: 2).**

In July 1999 these structures were extended to include voluntary organisations funded directly by Health Boards under Section 65 of the Health Act, 1970 under the

aegis of the DOH document *'Widening the Partnership'*. The Working Party who compiled *'Widening the Partnership'* recommended that the principles outlined in *'Enhancing the Partnership'* should be applied to Section 65-funded voluntary intellectual disability agencies. They further recommended that service agreements should be extended to all Section 65 voluntary intellectual disability agencies, provided they would be in a position to meet agreed criteria in relation good practice, accountability and organisational structures. The Report recommended that the revised funding mechanisms, recommended in *'Enhancing the Partnership'*, should be applied to the Section 65-funded agencies, provided they complied with the conditions for inclusion in this process specified by the Minister. Agencies would be required to have appropriate accounting and audit procedures in place in respect of grants paid to them by health boards or other statutory bodies. **(DOH & C, 1999: 3)**. An agreed template for the structure of Service Agreements with the Service Providers in the Mid-West Region is currently under negotiation.

3.2. Service Context

3.2.1. Database and Planning Structures:

The *'Needs and Abilities'* report concluded in July 1990 that a major barrier in the path of systematic planning of services was the absence of reliable data on the extent of need among persons with an intellectual disability in Ireland. **(DOH, 1990: 3)** The purpose of an Intellectual Disability Database was to enable and inform the planning, funding and management of services to persons with an intellectual disability.

The Mid-Western Health Board Database was initially established through the joint work of the Board and the principal Service Provider's in the Health Board's area in June 1992, when an initial database of clients was prepared. The National Intellectual Disability Database was established in 1995 and regional databases were established in each health board area. At regional level the operation of the Regional Database is under the management of a Database Coordinator, who is currently the Director of Disabilities in the Mid-Western Health Board. Information is retained on the database while the individual is in receipt of or in need of services and any individual (or family) who clearly express the wish that information concerning him or her should not be held on the database has this wish respected. The first report of the National Database was published in 1997 (in respect of the 1996 year).

Both of the Committees recommended in *'Enhancing the Partnership incorporating Widening the Partnership'* - the Intellectual Disability Services Consultative and Development Committees - have been established in the Mid-Western Health Board's area, with the consequent dissolution of the pre-existing Mental Handicap Coordinating and Policy Making Committee. The purpose of these committees is to inform the planning process and assist and guide the development of services through the representation of Health Boards, Service Providers and the families of persons with an intellectual disability.

3.2.2. Regional Catchment Areas and Service Provision:

In the early 1990s a growing consensus emerged that in order to facilitate the orderly planning, development and provision of intellectual disability services in the region:

- ◆ Services should be provided on a designated catchment area basis
- ◆ Each catchment area should provide or have access to a comprehensive range of services.

The Health Board reached agreement, in principle, with the Service Providers on designated catchment areas for their services in the early 1990s.

The main Service Providers in the Health Board's area are:

- Brothers of Charity Services (Mid-West Region), based at Bawnmore, Limerick.
- Daughters of Charity Services, based at Lisnagry, Co. Limerick.
- Sisters of the Sacred Hearts of Jesus & Mary, based at St. Anne's, Sean Ross Abbey, Roscrea, Co. Tipperary.
- Charleville & District Association for the Handicapped, Charleville, Co. Cork.

(See Appendix 1 for an outline of the services provided by the four main Service Providers cited above).

The Health Board provides the following services to persons with an intellectual disability in the Mid-West Region:

- Counselling Nursing Service in each of the three County Catchment Areas
- Home Help Support Service
- Early diagnosis of intellectual disabilities, contracted, on a pay-per-case basis, to a Service Provider.
- Services to children by the Public Health Nursing Service.
- Referral of persons to the appropriate assessment and advisory services
- Provision of rehabilitative training in Vocational Training Centres. Assessment for referral to FÁS for vocational training.
- Regional Assessment and Diagnostic Service for Persons with Autistic Spectrum Disorder.
- Early Intervention Service for Persons with Autistic Spectrum Disorder.
- The existing residential support service in St. Joseph's and Our Lady's Psychiatric Hospitals is currently being scaled down.

Chapter 4: A Profile of Persons with an Intellectual Disability

4.1. General:

The World Health Organisation defines intellectual disability as “a condition of arrested or incomplete development of the mind which is especially characterised by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence i.e. cognitive, language, motor and social abilities.” **(RCP, 1995:1)** At one end of the spectrum are persons with an intellectual disability who require little more than special educational supports in order to function in society and at the other end are persons who have such a degree of intellectual disability that they require continuous support throughout their lives. The degrees of severity with regard to intellectual disability, as used by the World Health Organisation, are as follows:

<u>Degree of Severity</u>	<u>I.Q. Level</u>
Mild :	50 – 69
Moderate :	35 – 49
Severe:	20 – 34
Profound :	Below 20

Borderline intellectual disability is a diagnosis given when there is borderline intellectual functioning, which generally is in the IQ range 71 – 84 and the diagnosis of mental retardation is not warranted. The category , ‘not verified’, is included in the database as this group does have an intellectual disability but the level of disability has not been confirmed.

It is accepted that, where possible, I.Q. alone should not be the sole criterion for categorisation but should also include the dimension of the social functionality of the individual. **(MWHB, 1992: 1)**

Persons with a mild intellectual disability avail of generic services and will access specialised services where assessment of the individual indicates a specialised need that requires specialised health services. A number of conditions, of their own right, periodically referred to the disability services, including ADD, ADHD, Asperger’s Syndrome, Dyslexia and Dyspraxia do not fall intrinsically within these services. These conditions, where appropriate, will have their generic needs addressed by the mainstream services and will have their specialised needs addressed by appropriate specialist services within the Health Board or other agencies.

The 1st Annual Report of the National Intellectual Disability Database was produced in 1997, in respect of 1996 data. The data contained in the 2nd Annual Report, which will be published later in December 2000, will be incorporated into the detailed Action Plan on Intellectual Disability which will flow from the Strategy Statement and which will identify and outline the infrastructural, financial, staffing, training, and information technology resources required to give effect to the objectives of the Strategy Statement.

4.2. Statistics from Regional Database:

The Mid-Western Health Board's Intellectual Disability Database had a total of 2385 persons registered on its database, as of August 2000.

Note: Children with an intellectual disability in the (0 –4) range are currently under-represented in the Regional Database, due to current administrative difficulties. Using the national prevalence rate of 7.57 per 1,000 of the population would give a more accurate representation of the true picture for those in the (0 – 4) age group.

Table 1: Total Number of Persons on MWHB Regional Database: Age, Gender and Degree of Intellectual Disability (August, 2000).

Category	Not Verified		Borderline		Mild		Moderate		Severe		Profound		Total Male, Female		Total (Male + Female)
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M + F
Age Group (Years)															
0 – 4	10	15	0	2	21	11	11	7	2	0	0	0	44	35	79
5 – 14	5	3	5	2	156	89	72	56	13	23	4	3	1255	176	431
15 – 18	1	1	4	0	114	73	34	23	27	7	0	3	180	107	287
19 – 34	0	1	1	3	198	158	165	156	57	51	18	19	439	388	827
35 – 54	0	0	0	0	80	75	130	142	69	61	20	9	299	287	586
55 – 64	1	0	0	0	22	21	22	31	9	5	8	1	62	58	120
65 +	0	0	0	0	9	13	11	14	4	4	0	0	24	31	55
All Ages	17	20	10	7	600	440	445	429	181	151	50	35	1303	1082	2385

(Source: MWHB Regional Database, August 2000)

Age analysis of the data reveals that the age group (19 – 34) contains the largest number of clients, representing 35 % of the total; while the (35 –54) age group represents 25% of the total; and the (5 – 14) age group represents 18%. There are more in the (55+) age group (175) than in the (0 – 4) group (79).

Gender analysis of the data reveals that males dominate in the total number of all categories of disability (except the 'not verified' category) and the total numbers of all age groups (except the 65+ age group). Males dominate overall in the ratio of 1.21 :1.

Disability analysis of the data reveals that the 'mild' category (1,040) contains the largest number of clients, representing 44% of the total number. The 'moderate' category (874) represents 37% of the total; the 'severe' category (332) represents 14 % and the 'profound' category (85) represents 4%.

Table 2: Number of Persons with an Intellectual Disability, Clare County Catchment Area : Age and Degree of Intellectual Disability. (August, 2000).

Age Group (Years)	Not Verified	Borderline	Mild	Moderate	Severe	Profound	Total
0 - 4	9	1	5	4	1	0	20
5 - 14	2	3	70	42	9	3	129
15 - 18	0	2	49	18	6	0	75
19 - 34	0	0	69	88	14	2	173
35 - 54	0	0	19	60	19	4	102
55 - 64	0	0	7	12	6	1	26
65 +	0	0	2	8	5	0	15
All Ages	11	6	221	232	60	10	540

(Source: MWHB Regional Database, August 2000)

Age analysis of the data reveals that the age group (19 – 34) contains the largest number of clients, representing 32 % of the total; while the (5- 14) age group represents 24% of the total; and the (35 - 54) age group represents 18%. There are more in the (55+) age group (41) than in the (0 – 4) group (20).

Disability analysis of the data reveals that the 'moderate' category (232) contains the largest number of clients, representing 43% of the total number. The 'mild' category (221) represents 41% of the total; the 'severe' category (60) represents 11% and the 'profound' category (10) represents 2%.

Table 3: Number of Persons with an Intellectual Disability, Limerick County Catchment Area: Age and Degree of Intellectual Disability. (August, 2000).

Age Group (Years)	Not Verified	Borderline	Mild	Moderate	Severe	Profound	Total
0 - 4	7	0	11	4	0	0	22
5 - 14	2	2	136	35	15	3	193
15 - 18	0	2	107	19	9	0	137
19 - 34	0	1	179	138	50	18	386
35 - 54	0	0	78	132	73	19	302
55 - 64	0	0	19	32	6	8	65
65 +	0	0	13	14	3	0	30
Total	9	5	543	374	156	48	1135

(Source: MWHB Regional Database, August 2000)

Age analysis of the data reveals that the age group (19 – 34) contains the largest number of clients, representing 34 % of the total; while the (35 –54) age group represents 27% of the total; and the (5 – 14) age group represents 17%. There are more in the (55+) age group (95) than in the (0 – 4) group (22).

Disability analysis of the data reveals that the ‘mild’ category (543) contains the largest number of clients, representing 48% of the total number. The ‘moderate’ category (374) represents 33% of the total; the ‘severe’ category (156) represents 14 % and the ‘profound’ category (48) represents 4%.

Table 4: Number of Persons with an Intellectual Disability, Tipperary County Catchment Area : Age and Degree of Intellectual Disability (August 2000).

Age Group (Years)	Not Verified	Borderline	Mild	Moderate	Severe	Profound	Total
0 - 4	9	1	16	10	1	0	37
5 - 14	4	2	39	51	12	1	109
15 – 18	2	0	31	20	19	3	75
19 – 34	1	3	108	95	44	17	268
35 – 54	0	0	58	80	38	6	182
55 – 64	1	0	17	9	2	0	29
65 +	0	0	7	3	0	0	10
Total	17	6	276	268	116	27	710

(Source: MWHB Regional Database, August 2000)

Age analysis of the data reveals that the age group (19 – 34) contains the largest number of clients, representing 38 % of the total; while the (35 –54) age group represents 26% of the total; and the (5 – 14) age group represents 15%. There are more in the (55+) age group (39) than in the (0 – 4) group (37), though only by 2.

Disability analysis of the data reveals that the ‘mild’ category (276) contains the largest number of clients, representing 39% of the total number. The ‘moderate’ category (268) represents 37.7% of the total; the ‘severe’ category (116) represents 16.35 and the ‘profound’ category (27) represents 3.8%.

Table 5: Number of Persons with an Intellectual Disability from the Mid-West Region Receiving Services in Other Health Board Areas (September 2000).

Health Board/Authority	Number Receiving Services
Eastern Regional Health Authority	2
Midland Health Board	1
South Eastern Health Board	64
Southern Health Board	111
Western Health Board	5
Total	183

(Source: ERHA, MHB, SEHB, SHB & WHB Regional Databases, September 2000).

The Southern Health Board accounts for 60.5% of those receiving services outside the region, the South-Eastern for 35%, and the Western Health Board for 3%, the Eastern Regional Health Authority for 1% and the Midland Health Board for 0.5 %.

The vast majority of those accessing services within the South-Eastern Health Board area are attending special schools, special vocational training centres, sheltered work centres on a day basis while living at home. The vast majority of the 111 designated as receiving services in the Southern Health Board area are receiving services under the auspices of the Charleville and District Association for the Handicapped.

Chapter 5: The Continuum of Support

Structuring the range of services delivered to persons with an intellectual disability on the basis of a model of continuous support across the individual lifecycle offers the most appropriate means of identifying areas for change and improvement. The model posits a 'support continuum' structure to eliminate gaps in service delivery and ensure appropriate support at various points on the 'support continuum'. The components of the model are:

- ❑ **Preventative Support**
- ❑ **Anticipatory Support**
- ❑ **Home and Community Support**
- ❑ **Residential/Campus Support**

Gaps in provision or interventions affect the proper functioning of a continuous system of support. The objective of structuring services within a support continuum framework is to ensure relevant and timely assessment, intervention, support and day and residential service provision, in appropriate settings across the lifecycle and across conditions.

5.1. Preventative Support

The Health Board and Service Providers recognise that there are a range of preventative measures that can reduce the incidence of intellectual disability. The successful utilisation of Preventative Support would impact positively on the health and quality of life of all individuals in society.

1. *Stakeholder View:*

During the consultation process the stakeholders identified the following issues that required addressing:

- ❑ The Stakeholder process identified the need for greater emphasis on prevention, particularly among young or at-risk parents.
- ❑ There is a need for increased education in the areas of pre-conception and prenatal care.
- ❑ Health promotion, addressing nutrition and lifestyle issues, particularly in relation to smoking, alcohol and drug use has been highlighted as important in the prevention of intellectual disability.

2. Health Board and Service Provider's Position:

(a) Genetic Counselling:-

A Genetic Counselling Service has started at the Mid-Western Regional Hospital, which is serviced from the National Centre for Medical Genetics, Dublin. Four clinics per year are currently held at the hospital. Further development of this service will be encouraged.

(b) Antenatal and Postnatal Support:-

The research which indicates that leading a healthy lifestyle during pregnancy makes a significant impact on the health of children has promoted the Health Board to augment its interventions among young people who are at risk through its teenage pregnancy services and its child and family support services. The Health Board is particularly aware of the extra difficulties encountered by Young Parents. Programmes already established in this area that have input from Health Board staff include, the Teenage Pregnancy Prevention Programme, the Teen Parenting Programme (operated as part of the National Parent Support Programme) and the Social, Personal and Health Education Programme, operating in primary and secondary schools in the region.

(c) Immunisation Programmes:-

The National Childhood Primary Immunisation Programme is a key factor in the prevention of disabilities, including intellectual disability. The *Strategy Statement on Child Health* outlined a commitment to pursuing an uptake of this scheme of at least 95%, through a combination of parent education, follow-up arrangements for defaulters and special measures for areas of low uptake. The planned restructuring of the procedures for childhood immunisation uptake will augment current uptake levels. Enhanced education of parents on the relevance of availing of immunisation programmes will take place. The establishment by the Health Board of a Traveller Health Unit in September 1998, the appointment of a Primary Health Care Worker for Travellers in August 1999 and the creation of two posts of Community Worker for Travellers Health will result in improved levels of uptake among this group whose uptake had been historically low. (MWHB, 2000: 1).

(d) Health Education/Promotion Programmes:-

Persons with an intellectual disability require the same health education as the total population to ensure a healthy lifestyle throughout their lifespan. With increasing longevity among this population it is essential that all health maintenance strategies such as, healthy eating, physical activity and sensible lifestyle practices are established during teenage and adult years. Therefore, participation in generic population-based programmes, which have been adapted to the needs of this client group, may offer the greatest potential for health gain.

(e) Accidental Poisonings:-

A reduction in the number of accidents, including accidental poisoning and parasuicide, will lead to a reduction in the number of cases of acquired intellectual disability. In 1997 four hundred and fifty six admissions to hospitals throughout the

country of people resident in the Mid-West Region were due to poisoning by ingestion of psychiatric drugs and simple painkillers, such as aspirin and paracetamol (MWHB, 1999: 1) The Health Board's *Action Plan*, prepared in response to the Report of the National Task Force on Suicide, will spearhead the drive to reduce the incidence of suicide and parasuicide in the region. Measures outlined in the Action Plan to increase awareness and prevention include:

- the distribution of information leaflets
- media campaigns
- public poster displays
- promotion of the Samaritan's service
- development of the Health promoting Schools concept for students
- provision of information packs for Counselling Offices in colleges
- provision of an education programme by the Health Promotion Unit for students to reduce the risk factors of drug and alcoholism associated with suicide.

The Action Plan outlines a suite of developments in the mental health services (and related services) to reduce the incidence of suicide and parasuicide which are currently being implemented by the Project Co-Coordinator. Activities, focusing on prevention and training, are being coordinated in the voluntary sector and ongoing liaison with the local authorities on issues surrounding suicide is occurring. Training programmes for health care professionals in the region on issues relating to suicide and parasuicide are being implemented and specific resources have been provided to compile research on the issues. (MWHB, 1999: 2).

3. *Change Issues:*

- ◆ Further development of local genetic counselling service.
- ◆ Greater emphasis on preventative strategies in pre-conception, antenatal and perinatal services.
- ◆ Maximised uptake of Childhood Primary Immunisation Programme, in line with current best practice.
- ◆ Development and implementation of a comprehensive and coherent Health Education and Healthy Lifestyle programme for this client group by the MWHB Health Promotion Unit, in conjunction with the Service Providers.
- ◆ Reduction in levels of accidental poisoning in the region.

5.2 Anticipatory Support

Services and structures are required which anticipate the needs of persons with an intellectual disability in the region. By anticipating their needs proactive supports,

structures and service programmes can be planned and implemented in the light of the individual's needs.

1. Stakeholder View:

The stakeholders identified the following issues that needed to be addressed:

- ❑ The need for on-going assessment and review of service responses and modalities as central to the delivery of services.
- ❑ The establishment of a multi-disciplinary assessment team consisting of a range of medical, therapeutic service professionals and family support services was highlighted as a key priority.
- ❑ The deficit in information concerning service delivery.
- ❑ Stakeholders further identified a lack of co-ordination as the greatest difficulty associated with the service.
- ❑ The further development of the National Intellectual Disability Database is necessary to ensure its validity and comprehensiveness as a planning and forecasting tool.

2. Health Board and Service Provider's Position:

(a) Child Health Services:-

The Health Board screening programmes of the newborn and of early-childhood are aimed at ensuring early detection and prevention of conditions that may give rise to intellectual disability, if undetected. In accordance with the Health Board's *Strategy Statement on Child Health*, enhanced integration of children's services across the region will occur. **(MWHB, 1999: 3)**

(b) Regional Children's Diagnostic and Assessment Service:-

The development of a Regional Children's Diagnostic and Assessment Service for young people with complex developmental, intellectual, physical/sensory and psychosocial problems is proposed. The development of this service will enable the mainstreaming of diagnostic and assessment services for children with intellectual and physical/sensory disabilities. **(MWHB, 1999: 4)**

(c) Regional Database:-

It is essential to ensure that all persons with intellectual disability who require or who, in the future, will require a service are known to the Service Providers in their catchment area. The continued enhancement of the Regional Intellectual Disability

Database will occur, with development of the structure to facilitate more individualised information on each individual being a priority issue. Protocols for entry onto the Regional Database need to be clearly established. A National Database User Group, comprised of representatives of all the health boards, was established to provide feedback on the operation of the database. The Health Board and the Service Providers intend to establish a Regional Database Committee to oversee the functioning and development of the database.

(d) Information Provision:-

The Health Board have compiled a Directory of Services for Persons with Disabilities as part of its commitment to provide more information on service availability to persons with disabilities and their families. The Directory will be regularly updated. and will be provided in Braille and audio versions. The recent appointment of an Information Scientist to the Health Board's Disabilities Unit will facilitate the development of an information dissemination structure throughout the region which will meet the information needs of this client group and their families.

(e) Anticipatory Organisational Structures:-

The recent appointment of Area Managers for Disabilities and the development of Disability Care Groups is a direct response to recognition of anticipatory support structures both within the Health Board's services and across agency-provided services. County Intellectual Disabilities Advisory Committees will also be established within each County Catchment Area which will provide an important mechanism for the establishment of priorities and development of services for persons with an intellectual disability within the County Catchment Area and will provide an opportunity to develop services on a co-ordinated and partnership basis. The consolidation of such structures and their enhanced liaison with the Service Providers will be augmented, within the short and medium term, to enhance coordination of services, including services to the families of this client group.

(f) Counselling Nurses for Persons with Disabilities:-

The Counselling Nurses for Persons with Disabilities, the Public Health Nurses and the Area Medical Officers provide a central role in the acquisition of relevant information in relation to persons with intellectual disability who require or who, in the future, will require service provision. A Review of the role and functions of the Counselling Nurses will be undertaken as part of the initial implementation exercise of the Strategy Statement.

(g) Regional Advocacy Structures:-

As many persons receive services from agencies not directly linked to the Health Board or Service Providers during their lifetimes, it is necessary to develop a formal method of exchanging information, enhancing co-operation and defining roles and responsibilities between the Health Board, the Service Providers and these other agencies. These include the Department of Education and Science, the Department of the Environment and Local Government, the Department of Enterprise, Trade and Employment, the Department of Social, Community and Family Affairs and the Department of Justice, Equality and Law Reform.

As the recognition of the civil right of persons with disabilities to inclusion in all mainstream activities of our society grows the need for these formal linkages will become ever more acute. In line with the demand for mainstream inclusion there is the requirement to recognise the future needs of this client group with respect to the provision of accommodation and employment. This requires liaison with Local Housing Authorities, Community Housing Associations and employers and employment agencies on the part of the Health Board and the Service Providers. Disability advocacy structures will be established, involving the Director of Disabilities, the Area Managers, Service Providers and regional representatives from other government Departments and local bodies, which will address advocacy-related issues. The valuable advocacy role played by organisations of parents and friends of persons with an intellectual disability in the region will continue to be supported.

(h) Research Function:-

Dedicated research, with a regional remit, will facilitate the proactive translation of the regional data into valuable targeted information for planning purposes. The distillation of national and international data and information into regionally relevant information will further enhance this process. Compilation of dedicated research by staff of the Health Board and the Service Providers that will inform best practice in the region will be encouraged.

(i) Disability Awareness Training & Proofing:-

Disability awareness training can break down mistaken perceptions of persons with a disability and their needs. Frontline Health Board hospital and community staff should receive intellectual disability awareness training that addresses basic customer service needs and promotes enhanced skills in dealing with persons with an intellectual disability. A planned phased programme of intellectual disability awareness training for such staff will be implemented. In addition, the facilities and systems of all relevant Health Board services will receive disability proofing over the timescale of implementation of the Strategy Statement.

3. *Change Issues:*

- ◆ Enhanced coordination of Child Health Services.
- ◆ Development of Regional Children's Diagnostic and Assessment Service.
- ◆ More proactive use of the continuously updated Regional Intellectual Disability Database.
- ◆ Provision of continuously updated accessible information.
- ◆ Review of Counselling Nurses Role, involving all relevant stakeholders.
- ◆ Institution of formal linkages to facilitate liaison and advocacy with other statutory agencies, with particular emphasis on demarcation of roles and responsibilities with the Department of Education and Science.

- ◆ Development of research function.
- ◆ Development of intellectual disability awareness training programmes and implementation of disability proofing programme of facilities and systems.
- ◆ Co-ordination of all services necessary to ensure seamless delivery of anticipatory support.

5.3 Home and Community Support

The main aim of the disability services is to enable persons with intellectual disabilities to live lives of integrated, participative and inclusive citizenship within their own communities. The implementation of this aim is dependent on the effective provision of a range of services that can be adapted to individual needs across time.

1. Stakeholder View:

During the stakeholder consultation process, the stakeholders identified a number of issues that needed to be addressed:

- ❑ The inequitable distribution of services across geographic areas, in particular the Clare and Tipperary (NR) Areas.
- ❑ The inequality between persons linked directly to service providers and those cared for by families.
- ❑ The need for comprehensive Early Intervention Services.
- ❑ The need to provide family-centered services.
- ❑ It must be recognised that persons with intellectual disabilities have multiple needs and consequently multiple demands for different but complementary therapeutic modalities.
- ❑ Respite services, essential to the maximisation of families' ability to maintain persons with an intellectual disability within the home and community setting – particularly, crisis respite support.

2. Health Board and Service Provider's Position:

(a) Respective Roles of Health Board and Service Providers:-

The home and community services, of their nature, involve the maximum interaction with other services and groups and have a pivotal role in the development of

services for this client group. Priority will be given to clarifying the relationships between the Health Board and Service Providers, within the framework of *'Enhancing the Partnership, incorporating Widening the Partnership'*. The principles of accountability, equity, sustainability and independence are central to these relationships.

(b) Development of Localised Sector-Based Services:-

The perception may exist that undue prominence of service provision exists in the Limerick Area due to the historical siting of the main campuses of the Brothers and Daughters of Charity. The Health Board and Service Providers remain committed to the goal of providing a locally accessible service in all areas of the region. This will be progressively achieved through the continued development of home and community services that directly support families in their home and community setting. The development of an effective network of localised services, on a sector basis, will be a key element of the future focus of the delivery of services to this client group.

(c) Community Consultant Paediatricians:-

A key component of services to this client group, as identified by both stakeholders and the Health Board, is the appointment of Community Consultant Paediatricians, working in both a hospital and community setting, who would have a special interest in children with a disability.

(d) Early Intervention Services:-

An Early Intervention Team has been established by the Brothers of Charity, on a pilot basis, in West Limerick. This service is currently being evaluated by the Brothers of Charity, with initial findings to date being very positive, and it is anticipated that it will be extended to other areas of the Mid-West Region.

(e) Social Work Services:-

There is a requirement for ongoing support for individuals and their families, who have received a diagnosis of 'Intellectual Disability'. **(DOJE&LR, 1999: 2)**. Community support is provided by the General Practitioners or the Counselling Nurses for Disability Services. The valuable role which Social Workers can play in family support services throughout their lifespan to individuals and their families in the areas of client counselling, social assessment of family needs, information provision and advocacy is recognised and the Health Board and Service Providers will develop a Social Work infrastructure in each County Catchment Area dedicated to their needs.

(f) Support Provision to Families and Carers:-

The provision and coordination of services to the families and carers of persons with an intellectual disability is currently inadequate. The policy shift of services to community-based services requires a strengthening of the support base to these families. As resources are further channelled into community services the range and coordination of support services to families will be enhanced.

(g) Multidisciplinary Therapeutic Support:-

The Health Board and Service Providers recognise that multidisciplinary support within the community is an essential element of a comprehensive service. Multidisciplinary services, in this context, encompass Physiotherapy, Occupational Therapy and Speech and Language Therapy. These services aim to enhance the quality of life of individuals by addressing the communicational and functional difficulties that the individual encounters in their interaction with the environment. These services will be developed to meet the needs of the individuals as part of multidisciplinary teams that address the issues of specific groups within the intellectual disability sector. The level of need will determine the structure of the teams and some posts will be joint/collaborative posts between the Health Board and the Service Providers.

(h) Pre-School Service Provision:-

Children with an intellectual disability should ideally be integrated into mainstream pre-schools. A programme of sensitising mainstream pre-school providers to intellectual disability issues will be implemented jointly by the Pre-Schools Unit and the Service Providers. The needs of the individual child will determine the mix of specialist or mainstream pre-school service provision appropriate in each circumstance.

(i) Day Place Provision:-

The Mid-Western Health Board increased the number of Day Places for adults with Learning Disabilities by 79 in 2000. This is in keeping with the recommendations of '*A Strategy for Equality*' that day activity centres should be further developed nationwide on a permanent basis with appropriately trained staff and access to all modern and alternative therapies. **(DOE&LR, 1996:1)** The Mid-Western Health Board will support any Service Provider who includes a comprehensive range of therapies as part of their Service Provision for clients attending Day Services. Current Service Provision by the Board's service providers include personal development and life skills training. The policy of increasing the number of Day Places will continue in further years to meet the needs of this client group and all Day Services will be personalised to the needs of the individual with an intellectual disability. A programme of upgrading the physical standard of all existing Day facilities or relocating services to alternative facilities, as appropriate, will be pursued in order to continually comply with ongoing minimum standards.

(j) Respite Support Provision:-

The Health Board and the Service providers acknowledge the position of respite services as a key element of service provision. Respite support is seen as providing relief and personal development opportunities for the carer and the person requiring support. The Health Board and the Service Providers will respond, without undue delay, to this need in accordance with the national provision of resources to this aspect of service and will explore alternative models of respite support, in order to increase the flexibility of service provision.

3. *Change Issues:*

- ◆ Provision of a comprehensive range of therapy services and interventions at local sector level.
- ◆ Appointment of Community Consultant Paediatricians with a special interest in disability.
- ◆ Development and expansion of pilot Early Intervention Service to each Catchment Area.
- ◆ Development of Social Work Service in each Catchment Area.
- ◆ Enhanced support to families and carers.
- ◆ Further development of multidisciplinary therapy services.
- ◆ Enhanced provision of Day Services, together with provision of comprehensive range of therapy services.
- ◆ Flexi-time Day Support Services, inclusive of supported socialisation e.g. 12-16 hours per day.
- ◆ Continual compliance with minimum physical standards of facilities.
- ◆ Enhanced provision of Respite Services.

5.4 Residential / Campus Support

Current thinking favours the model that encompasses support in group homes or in individually managed accommodation as the ideal form of provision. Where home and community services are insufficient or no longer sufficient to meet assessed need campus services are provided. There is probably a direct link between the demand for residential services and the lack of available appropriate alternative responses. Traditionally these have been associated with the major institutions in the region i.e. Lisnagry, Bawnmore, and St. Anne's. Provision of support in a community-based setting is the goal aspired to by services in the region. There is a need to develop a range of responses in campus services to ensure an appropriate reflection of a person's abilities. These services must be designed to acknowledge the vulnerability of this client group but must also allow risk-taking by persons with an intellectual disability.

1. *Stakeholder View:*

The process of stakeholder consultation identified the following issues:

- ❑ The need to provide home and community services as a means of reducing the urgency of demand on residential service provision. In particular, they identified the need for the two approaches of 'Crisis Response' and 'Forward Planning' as key elements in this area.
- ❑ The ageing profile of carers and the increase dependency of clients signify the continued need for appropriate residential places.

2. *Health Board and Service Provider's Position:*

(a) Strategic Direction:-

The policy shift enunciated in '*Needs and Abilities*' of focusing resources and developments primarily in community settings will be actively pursued by the Health Board and the Service Providers, with the consequent scaling down of campus services in the region. In situations where persons with an intellectual disability, despite the availability of other services, are unable to continue residing in open accommodation or where community services are inadequately developed then the option of residential support must be continued.

(b) Development of Campus Services:-

Many services provided within the campus setting are similar to those provided in the Home and Community setting. These include Day Services, Therapy/Social Work Services and Respite Support. These services will be developed and personalised in tandem with the development of Day Services (as outlined in section 5.3.).

(c) Relocation of Persons Inappropriately Placed-

A process is currently in train to facilitate the transfer of 36 persons with an intellectual disability from St. Joseph's Hospital, Limerick to the Daughters of Charity Services campus at Lisnagry and to transfer those persons with an intellectual disability who are inappropriately placed in Our Lady's Hospital, Ennis to appropriate community settings. A plan will be formulated to direct a programme of development that will facilitate the transfer of the remaining residents at St. Joseph's Hospital who are inappropriately placed.

(d) Relocation of Less Dependent:-

Some of the residents in campus-based residential settings have a lower level of dependency than the majority of clients in these settings. A programme of transferring persons who are less dependent to community-based settings, with assistance from the Department of the Environment and Local Government's Voluntary Housing Scheme, will be developed.

(e) Older Persons with an Intellectual Disability:-

As with all older people, the aim of the Health Board's policies is to ensure a healthy active old age within a community setting, where possible. Where a person with an

intellectual disability who is in residential placement at that time reaches the age of 65 years s/he will be allowed to remain in a residential setting. Those who are not at the time in receipt of services at the age of 65 years will avail of the generic services for older people.

(f) Compliance with Minimum Standards for Facilities:-

A phased programme of upgrading the physical standard of all campus facilities will be pursued in order to continually comply with ongoing minimum standards. The likely enactment of the Children Bill, 1999 later in 2000 will amend the Child Care Act, 1991 so that it will now comprehend institutions for care and maintenance of children with physical or intellectual disabilities. Planned provision for the resource implications arising from this development will be developed.

(g) Contingency Planning:-

The Board and the Service Providers will formulate a “Crisis Response and Forward Planning Programme”, based in part on the data from the Regional Database, to reduce the uncertainty existing with regard to crisis and future placements.

3. *Change Issues:*

- ◆ Active pursuit of policy of focusing resources and developments in community settings, with consequent scaling down of campus services.
- ◆ Planned and innovative provision of residential places e. g part-time placements.
- ◆ Appropriate development of Day Services, within residential/campus settings.
- ◆ Relocation of persons inappropriately placed.
- ◆ Development of a programme for transferring the less dependent to community settings.
- ◆ Formulation of appropriate policies to cater for the needs of elderly persons with an intellectual disability.
- ◆ The development of “Crisis Response” and “Forward Planning” techniques, in order to reduce the incidence of crisis residential placements.
- ◆ Continual compliance with minimum physical standards for facilities.

Chapter 6: Discrete Issues

6.1 Persons with Autistic Spectrum Disorder

The Autistic Spectrum Disorder is a development disorder that persists throughout life. The generally accepted figure for the prevalence of the disorder is 4 cases per 10,000 births. If those presenting only some traits of autism are added to the cases of children with the full syndrome the prevalence may reach the number of 15 – 20 cases over 10,000 births. The disorder appears during the first thirty months of life and gives rise to various degrees of impairment of speech and communication, social skills and imagination. These symptoms are often accompanied by abnormal behaviour patterns, such as repetitive and stereotyped activities and interests, rocking movements and strange obsessions with certain objects or events. The degree of intelligence and range of abilities of persons with the Autistic Spectrum Disorder vary widely, though the vast majority have an associated intellectual deficiency. Few persons with Autistic Spectrum Disorder are capable of leading totally independent lives and most need significant help throughout their lives. **(ISA, 1996: 1).**

Early diagnosis is highly important to allow suitable programmes to be implemented, including supporting of parents and siblings in understanding and managing the many aspects of this complex disorder. **(MWHB, 1996: 1).**

The 1996 MWHB Working Party on Services to Persons with Autism endorsed and adopted the three general principles, outlined in the Department of Health's 1994 Report on Autism, which should underpin the treatment of persons with Autistic Spectrum Disorder :

- ❑ Where possible, the child should be treated and educated in the same setting as all other children i.e. in mainstream services.
- ❑ Where mainstreaming is not possible, specialised services should be provided.
- ❑ For either option, those involved in the child's or adult's education should have an awareness of the special nature of autism and should have the training to deal with the special demands it presents. Support from a variety of Consultants should be readily available to staff, as required. **(MWHB, 1996: 2).**

The families of persons presenting with Autistic Spectrum Disorder in the region have been keen to access Autism-specific programmes, staffed by appropriately trained personnel.

The Health Board and the Service Providers have undertaken to establish a full Regional Assessment & Diagnostic Team for persons with Autistic Spectrum Disorder in the region. However, the full impact of this service cannot be achieved until ongoing intervention and treatment services are available at Community Care catchment and sector level. The development and enhancement of catchment and sector-based services, including, therapeutic, psychological, social work and family

support services is a vital resource issue in developing a comprehensive response to this client group. The Health Board's *Strategy Statement on Child Health* stated a commitment to the undertaking of a needs assessment and implementation plan for children with emerging problems, to include Autistic Spectrum Disorder and other complex communication / behavioural disorders. (MWHB, 1999: 4)

A residential respite facility for persons presenting with Autistic Spectrum Disorder, developed in conjunction with RehabCare, was opened in July 2000 in Limerick and provides a holiday respite break for this client group in an environment away from their home environment and familiar surroundings. The facility caters primarily for those residing in the Limerick catchment area, with a regional remit for crisis respite support. Similar facilities will be developed in the Clare and Tipperary catchment areas. The facility whereby parents of children presenting with Autistic Spectrum Disorder can also reside with their children during the respite period is also being examined.

A senior Speech and Language Therapist, a senior Occupational Therapist and a Social Worker will be appointed in the immediate future as part of a Regional Assessment and Diagnostic Team for Autistic Spectrum Disorder. The full team will include a Senior Clinical Psychologist. It is envisaged that consultants in Child Psychiatry and Paediatrics will contribute to the work of the core diagnostic and assessment team. In addition, an Intervention Team for Autistic Spectrum Disorder will be developed in each County Catchment Area. Initially, a Senior Clinical Psychologist will be appointed in each Area, whose role will include the function of Coordinator of the Intervention Team. The Coordinators appointed will determine the composition of the individual Intervention Team.

The Coordinators of the Regional Assessment and Diagnostic Team and of the Community Care Catchment Intervention Teams for Autism will liaise with the Department of Education and Science inspectors and teachers and staff of the Department of Enterprise, Trade and Employment in meeting the inter-related health, education, training and employment needs of persons with Autistic Spectrum Disorder in the region.

6.2. Children with Acquired Intellectual Disability

Acquired intellectual disability, also known as traumatic or acquired brain injury, is an injury that results in damage to the brain as opposed to a developmental or neurological disorder. Typically those most affected are often young adults who sustain injuries in a traffic accident or a fall. The facts and figures of this population are not yet available but will be aided by the further development of national disability databases.

Many head injuries are mild and symptoms usually disappear over time with assistance from the appropriate services. Others are more severe resulting in long-term disability and the need for ongoing support. Advances in microsurgery have also meant that more people with head injuries survive. The majority of children return to some form of education following their physical recovery.(NWHB, 1999: 1).

Individuals may be affected in many ways with complications relating to movement, sensation, intellect or memory and social difficulties brought about by personality changes and regulatory disturbances. The location and severity of the injury to the brain ultimately affects the severity of the disability. The psychological strain on the family caring for the patient 24 hours a day, as well as the individual feeling redundant, contributes to a significant strain on the whole system.

The Department of Health and Children policy states that the term intellectual disability is applied only when the condition manifests itself before age 18. Once it is diagnosed the affected person is entitled to an intellectual disability service for their lifetime, provided that the diagnosis is not subsequently questioned. It sometimes happens that persons are admitted to intellectual disability services through assessment error. In such cases, their continued placement may be inappropriate. Brain impairment, of whatever origin, manifesting itself after age 18 is not currently considered to be within the remit of the intellectual disability services. The needs of persons of age 18 or over fall within services to persons with a physical or sensory disability and are addressed under that Strategy Statement.

The range of services required must therefore ensure that an effective and efficient system is in place for the transition from hospital into the community so that the level of therapy and support continues. The protocol of referring children with acquired intellectual disability previously referred to the National Rehabilitation Hospital back to the initial referring hospital and, when appropriate, into the community will be adhered to in the region. Patients and family have endorsed a wide range of services to be provided following discharge including for example, social work, speech and language therapy, physiotherapy, occupational therapy, respite support, education/training and psychological support in order to enable adjustment to the persons changed status. **(NRH, 2000: 1)**

The National Rehabilitation Hospital is to establish provincial advocacy groups to involve the brain-injured and their families and other interested parties, in the hope that the needs of the brain injured will become more widely known and appropriate services developed. The Mid-Western Health Board will support this advocacy process and cater for this client group through further appropriate development of comprehensive early intervention and children services within the intellectual disability services in each County Catchment Area, as part of its development of generic children's services. This will include the development of a multidisciplinary team (initially, in each catchment area) consisting of a psychologist, social worker, physiotherapist, speech & language therapist, psychiatric support, occupational therapist and further support in the home, through a home teacher. The level of respite support will also be increased to further support parents of children with an acquired brain injury.

6.3 Persons with a Mild Intellectual Disability

In most cases a person with a diagnosis of mild intellectual disability or general learning difficulty does not require a specialised health service and require a generic service response. Indeed, the majority of persons with a mild intellectual disability do

not wish to be associated with an intellectual disability agency for fear of any perceived stigma. Many people in this population function within mainstream society with little need to access any service but generally may require more educational inputs to ensure that their capabilities are maximised.

Challenging Behaviour in Persons with a Mild Intellectual Disability:

Challenging behaviours can be thought of both from the perspective of the individual with the behaviours and from the capacity of the services to manage the behaviour. The behaviours are challenging to the individual either because they are aggressive, disruptive or inappropriate in nature. This includes behaviour that may range from violent outbursts, obsessions, or to sexually deviant or inappropriate behaviour. The behaviours can also be thought of as challenging to the services because they strain the current service supports **(C& D A, 2000: 1)**.

In general, behaviour may be viewed as challenging if it satisfies one or more of the following criteria:

- the behaviour itself or its severity is seriously inappropriate given the individual's age and level of development;
- the behaviour is physically harmful to the individual or others;
- the behaviour constitutes a significant additional disability for the individual by interfering with the learning of new skills or by excluding a person from important learning opportunities; or
- the behaviour causes significant distress for the individual and impairs their quality of life to an unreasonable degree. **(BOC, 1999: 1)**.

Typically young adults fall within this category, which generally arises where a person does not have meaningful activities and opportunities to develop positive relationships with other people. Consequently, it is anticipated that as the quality and scope of services develop, the level of incidence should decrease **(DOH, 1990: 4)**.

The service response to date has been limited by resources and staff specifically trained to deal with challenging behaviour. This has led to instances where the individual must be placed outside the Health Board area to ensure either the protection of the individual and/or others. External placement of service users who present with challenging behaviours can ultimately lead to deskilling of service providers and carers.

There is a commitment to the development of a multi-disciplinary response that can be an intra- or inter-agency response to this issue, including the development of systematic responses. This will allow the identification of the condition, the development of prevention strategies and establishment of acute/long term interventions and training in coping strategies for families and service staff.

Two specific but interrelated approaches have been identified as the most appropriate and most effective methods of resolving the complex issue of challenging behaviour. These include a Community-based Specialist Team and an Assessment and Intervention Centre dedicated for this group of people. The

Community-based Specialist Team will allow those persons displaying challenging behaviour to remain in the community, to meet the person's individual needs within their own environment and not enter or return to institutional living. This would enable the individual to remain in his or her own home, attending local services and ensure social inclusion through a personalised programme. The team would be responsible for the prevention and management of challenging behaviours and work jointly with families, front line staff and service providers to develop successful interventions (**NEHB, 1999: 1**).

The Assessment and Intervention Centre will act as a safety net with the main objective being the rapid return to the community of those individuals referred to the centre. People with the most severe challenging behaviour will be referred to this unit for an agreed time-limited period of intense assessment and intervention. The Assessment and Intervention Centre will not be used as a containment unit or for long-term placements.

A regional Assessment and Intervention Centre is currently being developed by the Health Board and Service Providers on the Brothers of Charity campus at Bawnmore, Limerick. This will provide focused specialist interventions for this group of people and be a link point for Community-based Specialist Teams in each catchment area. The introduction of the first Community-based Specialist Team is underway in Clare on a pilot basis and will be expanded into each County Catchment Area. The provision of a high support group home in each catchment area is also proposed which would ensure that those who, because of their level of challenging behaviour and despite interventions by the specialist team, need more support than is available in a regular community group home. Opportunities for short-term respite are also envisaged.

The Health Board and the Service Providers will produce a comprehensive regional Policy Document on this issue, which will chart the progression of service development over the next five years.

6.4 Persons with Dual Disabilities

In many instances a person with a disability may have both a physical or sensory disability and an intellectual disability. In some cases there may also be multi-disabilities impacting on the full sphere of human functioning.

The basis for accessing a specialised service whether physical or intellectual is determined by the primary diagnosis - that is, the most predetermining condition of the disability. The setting most appropriate to the person's needs must also be considered. The primary diagnosis must therefore be used to inform the decision as to the most appropriate service. Generally those that have a moderate to severe intellectual disability, with a physical or sensory disability, would access services through an intellectual disability service provider. In the case of people with a mild intellectual disability their preference would be for a generic or physically orientated service.

Where a person does fall within the care of an intellectually disabled service the physical and sensory needs of the person will also be met by the same service. For

example, seating management may be critical for some people with an intellectual disability and hence they would have their seating and posture requirements also met. This may include the provision of aids and appliances and physical therapies to support the personalised programme of the individual.

An assessment of the resources provided to intellectual disability services is planned to ensure that appropriate services are provided and resource implications established. Clear protocols for management and referral will be developed, in conjunction with the Service Providers, for persons with a Dual Disability in the Mid-West Region.

6.5 Rehabilitative Training & Employment.

The provision of training and supported employment to persons with an intellectual disability has undergone a period of change. The *Report of the Commission on the Status of People with Disabilities* and the subsequent dissolution of the National Rehabilitation Board have directed the provision of vocational training and employment to mainstream service providers. Vocational training and employment services for people with a disability will be the remit of the Department of Enterprise, Trade and Employment, through FÁS. Within this new framework the emphasis will be on progression pathways to employment for persons with disabilities.

A specialised training service will remain for persons with an intellectual disability who do not have the skills or ability to access mainstream training or employment. This training will be rehabilitative/life skills focused which will give a foundation for further employment skills training and other options, including sheltered and supported employment. The Mid-Western Health Board will work collaboratively with intellectual and physical and sensory disability agencies within the region to maximise rehabilitative training and sheltered and supported employment opportunities. This may include consortium arrangements and direct service provision where a capacity for service provision does not exist.

The Health Board will produce a policy document in 2001 on the provision of Rehabilitative Training in the Mid-West Region.

6.6 Mental Health Needs of Persons with an Intellectual Disability

6.6.1 Introduction

A clearer understanding of the mental health needs of persons with an intellectual disability has arisen from recent developments in the provision of services to this client group. The provision of an enhanced level of day support and home support places, together with the development of a wide range of educational and training opportunities, has resulted in their much more visible presence in the community

bringing their needs to the attention of a wider audience. There is a consequent need for awareness of the possible behavioural difficulties and knowledge of the channels available for diagnosis and interventions on the part of both the professionals involved in supporting them and the public. Recent developments in the area of mental health services have also impacted on the issue of their mental health needs. The movement towards community-based psychiatric services has resulted in some marginalisation of this client group. Increasingly, they are perceived as not fitting into the general psychiatric services, while the existing intellectual disability services do not have a tradition of providing a comprehensive mental health service. (DOH, 1996:1)

6.6.2 Presenting Features of Mental Illness

Persons with an intellectual disability may display behaviours, which from time to time may appear strange or even threatening. Such behaviours, as such, are not manifestations of mental illness. Hence the practice has arisen of referring to ‘mental and behavioural disorders’ – a dichotomy which, though may not be scientifically sound, is useful in practice. In terms of presenting symptoms there can be an overlap between mental health problems and socially challenging behaviour among the intellectual disability population. This section focuses particularly on the mental health needs of the population. For a discourse on socially challenging behaviour among persons with a mild intellectual disability see **section 6. 3**.

All the usual mental illness and behaviour disorders occur in persons with an intellectual disability. However, it has been estimated that the lifetime prevalence of mental health problems in this client group is 50% compared with 10% in the general population. In respect of psychosis, the lifetime prevalence for those with a mild or moderate intellectual disability is 25% and those with a severe or profound disability is 50%. In respect of schizophrenia, the lifetime prevalence for persons with an intellectual disability is 3%, compared to 1% among the general population. Tending to affect the presentation of the illness are certain conditions, commonly associated with intellectual disability e.g. communication disorders, epilepsy, syndrome specific behaviours and co-existent autism. A range of special investigations should supplement the clinical diagnosis.

Categories of Disorder:

If a comprehensive service is to be provided for both children and adults all the clinical groupings, which have been identified, require addressing.

- *Adjustment and Emotional Problems in Persons with a Mild Intellectual Disability*
- *Behaviour Problems in Those with A More Severe Disability*
- *Acute Mental Illness*
- *Chronic Mental Illness*
- *Behaviour Problems Specifically Associated with Epilepsy and Gross Brain Impairment*

- *Offenders Who Are Intellectually Disabled:*
- *Mental Health Needs of Older People:*

Most of the above conditions may arise in children, adolescents or adults and, though adults numerically comprise more than two thirds of the intellectual disability population, the need for specialised attention to children is highly important. **(DOH, 1996: 2).**

6.6.3 Proposed Models of Service

The general principles governing the provision of a service to meet the mental health needs of persons with an intellectual disability are in line with the principles applicable to the generic intellectual disability services:

- ❖ Prevention, where possible
- ❖ Person-focused
- ❖ A comprehensive, locally-based service
- ❖ A multi-disciplinary team approach
- ❖ A seamless continuum of services
- ❖ A crisis intervention service
- ❖ Comprehensive staff training and support **(CEOG, 1996:1)**

The Mental Handicap Section of the Royal College of Psychiatrists (Irish Division), reporting on the psychiatric needs of persons with an intellectual disability, refers to a body of research that demonstrates that attempts to provide for the mental health needs of persons with an intellectual disability within generic psychiatric services have been unsuccessful. They further emphasised that special expertise and experience are needed for the diagnosis of mental health disorders in this client group in the face of uncommon presentation of symptoms, communication difficulties and, often, the absence of subjective complaints. The management of behaviour problems, many of which are unique to persons with an intellectual disability, requires specialised assessment and treatment techniques. Modification of the application of therapeutic interventions, including counselling and psychotherapy, is required to take account of intellectual and other limitations. The high frequency of side effects and unusual responses in persons with an intellectual disability necessitate the implementation of special treatment regimes and the careful monitoring of drug treatment. The existence of physical disabilities along with the intellectual disabilities, including epilepsy, which frequently complicates mental functioning, require consideration in the treatment, rehabilitation and aftercare of this client group. Staff competencies and skills are increased and the probability of effective and successful treatment is enhanced with specialised services. **(RCP, 1995:2)**

A specialised mental health service for persons with an intellectual disability and their families should contain the following as their main functions:

- ◆ Prevention of mental health and behaviour disorders
- ◆ Diagnosis and treatment of mental health and behaviour disorders

- ◆ Counselling, psychotherapy and support for families and other carers
- ◆ Diagnosis and treatment of physical /sexual/emotional abuse and neglect
- ◆ Provision of advice on the legal aspects of intellectual disabilities, including issues of consent (**RCP, 1995: 3**)

Different models of service are pertinent to the different sub-groups with mental health needs among the intellectual disability population:

1. *Adults with a Moderate, Severe or Profound Intellectual Disability:*

Out-patient Services: These services should be community-based, with good backup resources, including mental health outpatient facilities, domiciliary visits and staff allocation for home intervention in times of crisis. Multi-disciplinary specialist mental health teams consisting of a consultant psychiatrist, social worker, community nurse, psychologist, physiotherapist, speech therapist and occupational therapist should be provided in each service provider catchment area.

Acute In-Patient Services: A number of sub-regional community-based acute Mental Treatment Units, of high–support status, should be provided on greenfield sites to cater for this client group who experience acute or acute on chronic mental illness. These units should have a multidisciplinary team attached to them, on the lines of the community-based teams cited above. These units should be fully approved as ‘Approved Centres’, with the full legislative safeguards present in psychiatric hospitals, as outlined in the Mental Health Bill, 1999.

2. *Children and Adolescents with a Moderate, Severe or Profound Intellectual Disability:*

Out-patient Services: A parallel structure of community-based out-patient services will need to be put in place for children and adolescents among this client group, who will need a service distinct from that provided to adults.

Acute In-Patient Services: A number of sub-regional community-based Mental Treatment Units, along similar lines to the adult units, should be provided for this client group.

3. *Children and Adults with a Mild Intellectual Disability:*

The thrust of this Strategy Statement, with respect to services for person with a mild intellectual disability, has been that they avail of generic services and will access specialised services where assessment of the individual indicates a specialised need that requires specialised health services. The mental health needs of persons with a mild intellectual disability will catered for within the generic child/adolescent and adult mental health services. Persons with a borderline mild/moderate intellectual disability may be referred to the specialised mental health services, outlined at 1 and 2 above, depending on the individual case. Protocols for such referrals will be developed.

4. *Offenders with an Intellectual Disability:*

Persons with below average intellectual abilities, including those meeting in full the criteria for intellectual disability, are over-represented among those convicted of offences. It has been suggested (though not definitively established) that a

disproportionate number of persons with an intellectual disability commit crimes of arson and of a sexual nature. Most of this client group suspected or convicted of criminal offences have a mild intellectual disability and engage in property or acquisitive offences. Significant predisposing factors to the crimes are alcohol and drug abuse, mental ill-health and homelessness.

Mentally retarded offenders differ appreciably from other mentally disordered offenders, both in the nature and origins of their offending behaviour and their treatment needs. They consequently require specialised services. **(RCP, 1995: 4)** Specialist assessment can be critical in informing courts about the nature of the individual's disability and other relevant issues that throw light on the offence committed. Of particular value is forensic involvement with the individual when the offending behaviour occurred in the context of a serious mental health problem. Treatments, such as anger management and social measures to ensure appropriate support when living in the community may also be important. Specific treatments have been developed, which can be intensively delivered, to assist persons with intellectual disabilities who have been convicted of more serious crimes, such as sexual offences and arson.

The present reluctance of the Irish Courts to sentence any offender with a diagnosis of intellectual disability has increased the demand for community-based psychiatric services for this client group. **(RCP, 1995: 5)** The general principles that should inform provision of services to this client group include:

- ❑ Preventative measures which can be taken to reduce the degree of predisposing factors such as mental health problems, drug and alcohol abuse, homelessness and unemployment include appropriate assessment and treatment services and measures to improve housing and employment opportunities.
- ❑ Enhanced liaison between the Child Care & Family Support Services, the Disability Services and the Child & Adolescent Psychiatry Services in the region are required to develop appropriate preventative strategies for children and adolescents with an intellectual disability who are at risk of developing offending behaviour.
- ❑ Partnership between the criminal justice system and the forensic psychiatry service, currently being developed within the Mid-West Region, is required to ensure that the factors that have contributed to the offending behaviour can be brought to attention of the Court to inform sentencing.
- ❑ A service structure for persons with an intellectual disability convicted of serious offending behaviour who are referred to the health services for treatment in a secure setting requires development in the context of the emerging forensic psychiatry service in the region.

6.6.4 Action Plan

Although the service provision for the mental health needs of the intellectual disability population outlined above will involve drawing on existing staffing structures, the resource implications will be significant as much of the service

structure will need to be developed on a greenfield basis. The detail of staffing to population ratios, geographical location of units and other resource implications of the models of service provision outlined or implied in sub-sections 1 – 4 will be indicated in the costed Action Plan which will be compiled to give effect to the thrust of this Strategy Statement.

Chapter 7: The Strategy

7.1 Strategic Statement of Purpose and Intent

Cognisant of the need for development of services in accordance with the principles underpinning the *United Nations Standard Rules on the Equalisation of Opportunities for Persons with a Disability*;

Mindful of the three key principles underpinning the health services declared in the *National Health Strategy* of equity, quality of service and accountability and the concept of health and social gain;

Recognising the values underpinning service provision adopted in the Mid-Western Health Board's *Corporate Strategy* of Equity, Accessibility, Effectiveness, Efficiency, Appropriateness, Responsiveness, Dignity and Farsightedness;

Reaffirming the three guiding principles adopted by the *Commission on the Status of People with Disabilities* of Equality, Maximising Participation and Enabling Independence and Choice;

Recollecting the philosophy underlying the approach of 'Needs and Abilities' of the right of every person with an intellectual disability to as fulfilling and normal a life as possible;

Recalling the principles for partnership in services to persons with an intellectual disability declared in '*Enhancing the Partnership, incorporating Widening the Partnership*' that the arrangements for a new partnership be based on a recognition of the rights of this client group to quality services which respect their dignity, are provided within the least restrictive environment and aim at the greatest possible inclusion of persons with an intellectual disability in society;

Emphasising that parents, guardians, advocates and organisations of persons with an intellectual disability must be active partners with the Health Board and Service Providers in the planning and implementation of measures affecting their health and social wellbeing;

The Health Board and Service Providers affirm as the Strategic Statement of Purpose and Intent for persons with an intellectual disability in the region that:

The purpose of services for persons with an intellectual disability in the Mid-West region is to provide a 'person-centered' service of the highest quality to individuals with special needs that is the most appropriate to their needs. We aim to deliver services that provide our clients with the opportunity to live the life of their choice to their fullest potential within their home and community setting. We advocate and empower those availing of the services to participate and enjoy fully the rights and privileges available to society, focusing on the uniqueness of each person and his/her right to a dignified personalised life.

The strategic intent requires that the focus of the services be pivotally placed on the individual person with an intellectual disability and their families. The objective of the

services is to effect a continuous lifecycle model of service and social support through the provision of an integral 'continuum of support'. Flexibility in service provision will be required as the dictates of the changing internal and external environments determine the precise nature and mix of the elements of the support continuum. The ability of our services to respond to identified, targeted need will be a prime determinant of the effectiveness of the services.

Regular reviews and evaluations of services will be a feature of service planning and delivery. These structures will be informed by the canons of quality assurance, best-practice and evidence-based modes of service delivery.

7.2 Strategic Objectives

The Statement of Purpose and Intent is an expression of the strategic vision envisaged for the services to persons with an intellectual disability in the Mid-West Region. The Strategic Objectives of the Strategy, which bring a focus to the vision, are as follows:

Strategic Purpose and Intent:-

- ❑ Provision of 'person-centered' services of the highest quality to individuals with special needs that is the most appropriate to their needs.
- ❑ Provision of appropriate supports to, and within, the home and community setting of the person with an intellectual disability, so that as many as possible can remain in their environment.
- ❑ Ensuring that all adults with an intellectual disability, identified as in need of specialised health and personal social services, will receive their services in an integrated, appropriate setting.
- ❑ Ensuring that all those on waiting lists for day, respite or residential services, as identified by the database, will receive the service appropriate to their needs.
- ❑ Delivery of a continuous lifecycle model of service and social support through the provision of an integral 'continuum of support'.

Preventative Support:-

- ❑ Promotion of preventative strategies to reduce incidence of intellectual disability in the region.

Anticipatory Support:-

- ❑ Development of a Regional Children's Diagnostic and Assessment Service.
- ❑ Development of the internal and public advocacy role of the disability services.
- ❑ Disability proofing of all Health Board services and facilities.

- ❑ Forging effective linkages, developing coherent coordination and defining areas of responsibility with relevant government Departments, particularly the Department of Education and Science.

Home and Community Support:-

- ❑ Development of a comprehensive Early Intervention Service for children with an intellectual disability on a catchment area and sector basis.
- ❑ Further development of multidisciplinary therapy services.
- ❑ Enhanced provision of Day Services.
- ❑ Development of flexible, responsive respite services.
- ❑ Provision of enhanced support to families and carers.

Residential/Campus Support:-

- ❑ Active pursuit of policy of focusing resources and developments in community settings, with consequent scaling down of campus services in the medium/long-term.
- ❑ Ensuring that all persons with an intellectual disability who are inappropriately placed will be relocated to appropriate support settings.
- ❑ Formulation of appropriate policies to cater for the needs of elderly persons with an intellectual disability.

Discrete Issues:-

- ❑ Development of a full Regional Assessment and Diagnostic Team for persons with Autistic Spectrum Disorder.
- ❑ Development of Intervention Teams for persons with Autistic Spectrum Disorder in each catchment area.
- ❑ Development of residential respite facilities for persons with Autistic Spectrum Disorder in each catchment area.
- ❑ Appropriate development of a comprehensive early intervention and children's service for children with acquired intellectual disability within the intellectual disability services in each catchment area.
- ❑ Provision of appropriate multi-faceted, multi-agency interventions to those presenting with Challenging Behaviour to enable the individual to remain in their home and community setting, where possible.
- ❑ Enhancement of the quality of Rehabilitative Training service in the region.

- ❑ Development of community outpatient and acute inpatient, community-based mental health services for adults with a moderate, severe or profound intellectual disability within the intellectual disability services in each catchment area.
- ❑ Development of community outpatient and acute inpatient, community-based mental health services for children and adolescents with a moderate, severe or profound intellectual disability within the intellectual disability services in each catchment area.
- ❑ Development of services for offenders with an intellectual disability, within the context of the emerging forensic psychiatry service in the region.

Human Resource Function:-

- ❑ Development of effective staff recruitment and retention policies/structures and appropriate personal development programmes.

7.3 Values and Service Principles

The service principles outlined in *'Needs and Abilities'* of enabling those persons with an intellectual disability with the capability of living in the community to do so while providing residential places to those for whom this is not possible will underpin the strategic action designed to achieve health and social gain for persons with an intellectual disability. **(DOH, 1990: 5)**

These principles will be buttressed by the principles of equity, quality of service and accountability enshrined in the National Health Strategy, *'Shaping a Healthier Future'*. The values espoused in the Health Board's Corporate Strategy of accessibility, appropriateness, responsiveness and dignity will vigorously motivate service planners, managers and service providers.

Affirmative action will be directed towards realising the broader principles adopted by the Commission on the Status of People with Disabilities of equality, maximising the participation and enabling the independence and choice of this client group in the region.

The design of services along the continuum of support will facilitate the development of an holistic, continuous lifecycle model of service delivery that is person centred and appropriately supportive.

7.4 Organisation and Management

The Mid-Western Health Board is committed to intellectual disability service provision by the voluntary/community sector, with designated service providers accepting responsibility for the full complement of services in each catchment area. These services will encompass all services along the continuum of support.

The role of the Health Board will be, primarily, one of assessment of need, service planning/coordination, research, monitoring/evaluation, quality assurance and

promotion of services. The appointment of senior administrative, information and research and quality staff to the Disabilities Directorate will facilitate the development and enhancement of this role. Where a lack of expertise or capacity to provide a service exists within the voluntary/community sector the Health Board may become a direct service provider or invite other providers to deliver designated services until such capacity can be established.

The Intellectual Disability Services Consultative and Development Committees will continue to play a key partnership role in the overall management and planning of services in the region, involving representatives of the Health Board, Service Providers and parents/families of persons with an intellectual disability in the region. The completion of the appointment of the full complement of Area Managers will enable effective local coordination of services. The Disability Care Groups in each County Catchment Area, involving membership of the Senior Area Medical Officer, Area Manager for Disabilities, Area Counselling Nurse, Senior Community Paramedical Staff, a Senior Community Administrator and a senior representative of Rehabilitative Training Services, enable the coordinated and planned delivery of services in each Area.

The creation of County Intellectual Disability Advisory Committees will provide a mechanism for the prioritised, planned and coordinated development of services and will facilitate appropriate and adequate representation of local views from service providers and advocates. The future direction of services will pivot around catchment area and sector-based coordination and delivery of services.

7.5 Supporting Strategies

The implementation of this Strategy Statement will impact on staffing structures and levels, capital and revenue resources and information and communication policies. The pivotal supporting strategies are the People Strategy, the Resource Strategy and the Information Strategy.

The People Strategy:

The People Strategy acknowledges the function of the people employed by the Board and its partner agencies in effecting the objectives of this Strategy. The purpose of the People Strategy is to ensure convergence between the culture, structures, policies and procedures of the Board and its partner agencies and the motivation, commitment, performance and striving of their staff towards achievement of their Corporate Objectives in a learning environment which is conducive to change.

The central elements of the People Strategy involve:

- ❑ Aligning the management of human resources with the objectives of the Board and its partner agencies
- ❑ Acknowledging that people, throughout the organisations, are a strategic resource
- ❑ Developing appropriate structures, policies and procedures so that a constructive environment is created for staff of the Board and their partner organisations to contribute successfully to the attainment of Corporate Objectives
- ❑ Developing an equitable, caring organisational ethos for staff in learning organisations who are skilled at creating, acquiring and transferring new

knowledge and changing and adapting their behaviour to effect improvement in response to new knowledge and insights, in a continuous process. (MWHB, 1998: 1).

- ❑ Developing effective recruitment retention policies and structures in order to retain the employment of scarce grades
- ❑ Structuring appropriate personal development programmes to continually develop the competencies and knowledge base of staff.

The Resource Strategy:

The realisation of the central principles outlined in '*Needs and Abilities*' and the developments outlined in '*An Assessment of Need: 1997 – 2001*' and the updated data relating to the five year-period 1999 – 2003 (DOJE&LR, 1999: 3) will require significant capital and revenue investment to effect the desired improvement in the quality of life for this client group in the Mid-West Region. In order to address the issues arising within the Resource Strategy, the Board and Service Providers will compile a detailed costed Action Plan which will identify and outline the infrastructural, financial, staffing, training and information technology resources required to give effect to the objectives of the Strategy Statement. The Action Plan will embrace the developments prioritised in the National Development Plan over the period 2001 – 2006 for the region with respect to services for persons with an intellectual disability.

The Information Strategy:

The Health Board needs information for a variety of reasons, to facilitate operational decision-making; to carry out needs assessment; to undertake research and evaluation; to measure performance; to inform service planning and review so that client groups receive a quality service. The Health Board also generates information in a variety of ways, as reports, as assessments, as activities, as statistics and other key data. This information needs to be managed in terms of its collection, storage and eventual retrieval.

A minimum dataset is currently being developed within the Disabilities Directorate to facilitate the collection, in a standard format, of appropriate, accurate and relevant data on activities across all disciplines. Activity data is used to inform the operational management and strategic planning of services. Therefore, it is important that protocols and procedures are put in place to ensure that data is collected, checked, monitored and validated.

A computerised, patient-centred information system will also be developed to record activity data. This system will be capable of integrating with similar systems within the Health Board and among the voluntary agencies so as to provide a comprehensive overview of each client's use of services within the Mid-West region.

Development of the Regional Intellectual Disability Database will occur to facilitate the output of more personalised information on this client group within and from the region. To facilitate the monitoring and development of the database the Health Board and Service Providers will establish a Regional Database Committee in 2001.

The collection of appropriate, accurate and relevant activity data will ensure that the Health Board can make informed decisions in relation to service planning and policy formation. It will also facilitate more formal measures of performance based on activities and outcomes rather than waiting lists and waiting times.

As the Health Board is driven into much tighter levels of accountability, it is becoming increasingly important that healthcare professionals have access to accurate and relevant information in order to:

- ❑ Keep up-to-date with the latest developments in their field
- ❑ Facilitate assessments/diagnosis
- ❑ Undertake research
- ❑ Give advice and support

The recent appointment of an Information Scientist to the Health Board's Disabilities Directorate will ensure access to information on national and international best practice and alternative models of service delivery.

Chapter 8: Strategy Implementation and Review

Effective implementation of the Strategy Statement will require managed change at three functional levels; strategic, tactical and operational, together with planned periodic review of the effectiveness of the Strategy's operationalisation.

At the strategic level, enhanced implementation of the partnership structures outlined under the provisions of *'Enhancing the Partnership, incorporating Widening the Partnership'* will be required over the period of the Strategy Statement. The generation of cohesive, collaborative efforts between the Health Board and its partner agencies and between the partner agencies will characterise the nature of service delivery and development. The Health Board will be sensitive and responsive to the differences in history, values, community base and treatment modalities of the four Service Providers in the region. The structuring of services along the continuum of support will require a planned distribution of resources to ensure the objectives of the model are realised.

Tactical issues involve setting standards and monitoring their implementation. A suite of performance indicators will be developed for the services, based on the personal outcome measurement model and evidence-based approaches. Practices within the Health Board and its partner agencies, and at the interface between the Board and the agencies will be regularly reviewed to induce a seamless, comprehensive service to clients. Explicit criteria will be developed for entry to services in order to coherently define the boundaries of the services.

Operational issues are cited as ***'change issues' in Chapter 5, the 'Continuum of Support' and contained in the text of Chapter 6, 'Discrete Issues'***. Greater emphasis on preventative strategies in pre-conception, antenatal and perinatal services, together with improved coordination of child health services and increased emphasis on early detection will serve to enhance preventative support. There is a need to develop and implement coherent health education programmes for this client group within the region. Reduction in the levels of parasuicide that contribute to acquired intellectual disability is required. The development of regional diagnostic and assessment services is a key issue. Further development of the Regional Intellectual Disability Database is needed. The provision of continuously updated accessible information to families and guardians of persons with an intellectual disability is a consumer right. The development of the Health Board's internal and public advocacy role has acquired increased significance. The institution of formal linkages to facilitate liaison and advocacy with other statutory agencies is required to ensure a coordinated approach to service delivery.

The appointment of Community Paediatricians, with special interest in disabilities has been identified. The provision of a full range of interventions and therapeutic services at sector level will address the corporate values of accessibility and equity. There is a growing requirement to provide adequate day and respite services for this client group in accordance with principles outlined in *'Needs and Abilities'*. Enhanced support to families and carers will assume increasing importance as home and community services are further developed. The planned and innovative provision of

residential places for those in need of such places will be an ongoing requirement. The continued relocation of persons with an intellectual disability in the region who are inappropriately placed will be addressed. A programme of transferral of the less dependent to community settings will be required. A coherent regional programme of contingency planning requires development.

There is an urgent need for further development of assessment and diagnostic services, intervention services and respite facilities for persons with the Autistic Spectrum Disorder. Appropriate development of early intervention and children's services for children with acquired intellectual disability is required. The need for provision of multi-faceted and multi-agency interventions for those presenting with Challenging Behaviour has also been highlighted. Enhancement of the quality of Rehabilitative Training service in the region is required. There is a need to develop outpatient and acute inpatient mental health services for children/adolescents and adults with a moderate, severe or profound intellectual disability. Development of services for offenders with an intellectual disability needs to occur within the context of the emerging forensic psychiatry service in the region.

A half-yearly Review of the progress in implementing of the Strategy Statement will be held, which will involve senior management of the Disabilities Directorate and representatives of the Service Providers. Prior to the holding of the half-yearly reviews submissions will be sought from all stakeholders on their perceptions of the implementation process and summarised feedback from these submissions will inform deliberations at the Reviews.

Appendix 1:

Outline of Services Provided by Intellectual Disability Service Providers in Mid-West Region

(A) BROTHERS OF CHARITY:

The services provided by the Brothers of Charity are structured into the Assessment and Advisory Services, the Co. Limerick Services and the Co. Clare Services.

(1) Assessment and Advisory Services:

A multi-disciplinary team provides the following range of services:

- ❑ Assessment and Advisory Service for the Mid-Western Health Board
- ❑ Assessment and Advice on educational placement, support services to teachers and parents in various school settings
- ❑ Assessment and Advice for residential and day services and ongoing advice to parents and staff
- ❑ Individual or group counselling for adults with intellectual disability
- ❑ Staff training and development
- ❑ Holiday and respite schemes

An Assessment and Early Stimulation Service for children with developmental delay under 3 years of age, together with counselling support for their families is also provided.

Home Support:

Home Support Services are provided to people who are currently awaiting placement in services.

(2) Services Based in Bawnmore:

- ❖ Residential Centre for adults with moderate & severe / profound levels of intellectual disability at high supervision levels, requiring night cover.
- ❖ Comprehensive range of Day Activities catering for the varying needs and abilities of participants – mainly with low, moderate and severe intellectual disabilities.

(3) Limerick City Services:

- ◆ Two Community Workshops (Limerick City) for adults at moderate supervision level and provision of supported employment at one of the workshops.
- ◆ Adult Day Centre (Bawnmore) providing sheltered work to people in the mild / moderate range at low supervision levels.

- ◆ 1 Adult Community Home, at semi-independent level (Limerick City).
- ◆ 9 Adult Community Homes, at moderate supervision level -sleep over (Limerick City and surrounding area).
- ◆ 3 Adult Community Homes, at high supervision levels - sleep over (Limerick City and surrounding area).
- ◆ Community Home providing respite bed nights (Limerick City).

(4) Foynes Service:

- Residential Centre for children and young adults with severe / profound intellectual disabilities at very high supervision levels

(5) West Limerick Community Services:

- ❖ Community Workshop for adults providing a variety of training programmes tailored to meet individual needs. The three core activities of the workshop are activation, training and sheltered work. Supported employment is also provided. (Newcastlewest).
- ❖ 4 Adult Community Homes, at moderate supervision levels – sleep over . One house is also the base for a horticultural project. (Newcastlewest and West Limerick).
- ❖ Community respite home for adults, at moderate supervision level. (Newcastlewest).

(6) Ennis Community Services:

- ◆ Community Workshop for adults at moderate supervision level. This centre has a number of trainees on ESF and TOPS programmes. Supported employment is also provided. (Ennis).
- ◆ 1 Adult Community Home, at semi-independent level (Ennis).
- ◆ 6 Adult Community Homes, at moderate supervision levels – sleep over. (Ennis).
- ◆ 2 Adult Community Homes, at high supervision level – sleep over (Ennis).
- ◆ Day and Residential Service for adults with severe/profound intellectual disabilities (Ennis).
- ◆ 1 Community Home providing 5-day residential service for children, aged between 5 and 8, attending special school. Respite bed nights provided during summer nights. (Ennis)

(7) Kilrush Community Services:

- Community Workshop for adults, at moderate supervision level. (Kilrush)
- 2 Community Adult Homes, at moderate supervision levels – sleep over (Kilrush)

(8) Co. Clare Support Services:

Multi-disciplinary team providing the following:

- ❖ Assessment and Advisory Service for the Mid-Western Health Board.

- ❖ Assessment and Advice on educational placement, support services to teachers and parents in various school settings.
- ❖ Individual or group counselling for adults with intellectual disability.
- ❖ Staff training and programme development
- ❖ Holiday and Respite Schemes

An Assessment and Early Stimulation Service for children with developmental delay under 3 years of age, together with counselling support for their families is also provided.

Home Support Services are provided to people who are currently awaiting placement in services.

(B) CHARLEVILLE & DISTRICT ASSOCIATION FOR THE HANDICAPPED:

Charleville & District Association for the Handicapped has responsibility for the provision of services to persons with an intellectual disability in the geographic catchment area of North Cork and South Limerick. Services include the following:

❑ *Padre Pio Pre-School:*

Padre Pio pre-school was established in 1981 and is presently located in the main campus on Bakers Road, Charleville. It is opened 3 days per week. Padre Pio offers a specialised pre-school service to children to children with a developmental delay. Children may attend up to six year's of age, when, depending on assessment, they graduate to the appropriate school.

Depending on each individual child's needs, the Association endeavours to support children in a community pre-school or offer a mix of community pre-schools and the services of Padre Pio pre-school.

❑ *Holy Family School:*

Children, generally, enter the Holy Family School at 6 years of age and graduate at approximately 18 years. Children with moderate intellectual disabilities attend the school, while classes are also available for children with Autistic Spectrum Disorder and children with a severe / profound intellectual disability.

❑ *St. Joseph's Community Workshop:*

Under the umbrella of St. Joseph's Community Workshop, day and residential services are provided for adults with an intellectual disability.

Within St. Joseph's Community Workshop, sheltered employment and training is provided in areas of catering, industrial sewing, printing/trophy assembly, crafts and horticulture. Recent developments include the refurbishment of Glenside Garden Centre, production of jams (and other food products) under the label of 'An Seomra

Blasta' and production of greyhound covers / sheets for the greyhound industry, together with the further enhancement of crafts suitable for gifts etc.

Some people entering adult services participate in the TOPS training programme.

Day units for adults with special needs are located in Casa Maria and Assisi House, Charleville and Oakview, Kilmallock.

Residential facilities are available in Sancta Maria – Ballylanders, Teach Mhuire – Newmarket, Ardfern – Charleville and more recently in Dromina.

Hazelville, a retirement house for persons with disabilities was recently opened in Dromcollogher and provides day / residential and respite facilities.

❑ ***Respite Support / Home Support:***

The Association offers a Home Support Service for both children, adults and their families. Respite Support for adults is available in each residence while a house, dedicated to adults respite support was recently rented in Mallow, Co. Cork. Respite / shared support for children is available for three weeks during the summer and for 40 weekends during the year.

❑ ***Training & Development:***

The Association is committed to the recruitment and development of highly qualified staff in the provision of services.

❑ ***Multidisciplinary Team:***

The multidisciplinary team presently comprises of a Senior and Basic Grade Social Worker, Senior and Basic Grade Occupational Therapist, Physiotherapist, Music Therapist and a Speech and Language Therapist (on a sessional basis). Vacancies also exist presently for a Senior and Basic Grade Speech and Language Therapist.

❑ ***Sports & Recreation:***

The Association presently has a Sports & Recreation facilitator for adult services, while a Physical Education teacher is available to the pupils attending the Holy Family School. A multi-sensory room is presently being equipped and a toy and leisure library is also available. The Association is about to tender for provision of a dedicated respite / shared support unit for children and also the construction of shops / workshops in Charleville town. The development of sport and recreation facilities is also being finalised.

(C) DAUGHTERS OF CHARITY:

The Daughters of Charity Service provides a comprehensive service for adults and children with a moderate/severe intellectual disability. This service is provided to clients within a defined catchment area of the Mid-Western Health Board. The service is based primarily at St. Vincent's Centre, Lisnagry which is four miles from Limerick City, on the main Limerick/Dublin Road – near the village of Annacotty.

(1) EARLY SERVICES

- 2 – 6 years:** **Early Intervention** – 13 Priory Park, Clancy Strand, Limerick
 Pre-School/Montessori Class
 Sensory Stimulation
- 5 – 18 years:** **St. Vincent's School** – on campus at St. Vincent's Centre, Lisnagry
 Development Education Centre – on campus at St. Vincent's Centre, Lisnagry
 Development Education Centre – Dooradoyle, Limerick

(These services are supported by both the Department of Health and Children and the Department of Education and Science).

(2) ADULT SERVICES

2.1. TRAINING, ENTERPRISE AND EMPLOYMENT SERVICES:

- 18 years +:** **Vocational Training Centre – 3 year Training Programme** – on campus at St. Vincent's Centre, Lisnagry.
- Sheltered Employment:**
 Nagle House – on campus at St. Vincent's Centre, Lisnagry
 Tait Centre – Dominic St., Limerick
 Garvey Enterprise Centre – John St., Limerick

2.2. DAY ACTIVATION/SKILLS DEVELOPMENT:

St. Vincent's Centre, Lisnagry
Cappamore Community Centre, Cappamore, Co. Limerick

2.3. RETIREMENT PROGRAMME

St. Vincent's Centre, Lisnagry

(3) RESIDENTIAL SERVICES

3.1. RESIDENTIAL SERVICES AND RESPITE CARE:

All Ages: Full-time and part-time residential services and respite care is provided at the campus at St. Vincent's Centre, Lisnagry.

3.2. COMMUNITY RESIDENTIAL SERVICES:

Adults: Full-time and part-time residential services and respite care is provided in a community residential setting at houses based at:

Castletroy.
Rhebogue, Dublin Road.
Annacotty.
Mountshannon, Lisnagry.

(4) SCHOOL OF NURSING

In association with the University of Limerick, a diploma in mental handicap nursing is offered at St. Vincent's School of Nursing, Lisnagry. This three- year course is a pre-registration programme. An optional fourth year will allow students to undertake a Bachelor of Science (Nursing) Degree.

(5) SUPPORTED SERVICES PROVIDED

- Physiotherapy
- Swimming – hydrotherapy
- Physical Education
- Multi-Sensory Programme
- Multi-Disciplinary Team
- Pastoral & Chaplaincy Services
- Medical & Psychiatric Services
- Dental Care
- Chiropody
- Special Religious Education for Adults with Intellectual Disability (SPRED)

(D) ST. ANNE'S SERVICE

□ *Early Intervention:*

- Pre-school / school
- Support in Special Classes

□ *School:*

- Special School

(While St. Anne's Service has no direct responsibility for this service, staff are seconded to this location. Multi-therapeutic services are also arranged through St. Anne's Service).

□ ***Adult Day Services:***

- Day Activity Centres
- Resource Centres
- Pre-Vocational Training
- Work Experience
- Evening Classes
- Supported Work

□ ***Home Support:***

□ ***Residential Care:***

- Community Houses
- Campus-based
- Semi-Independent Living (Flat)

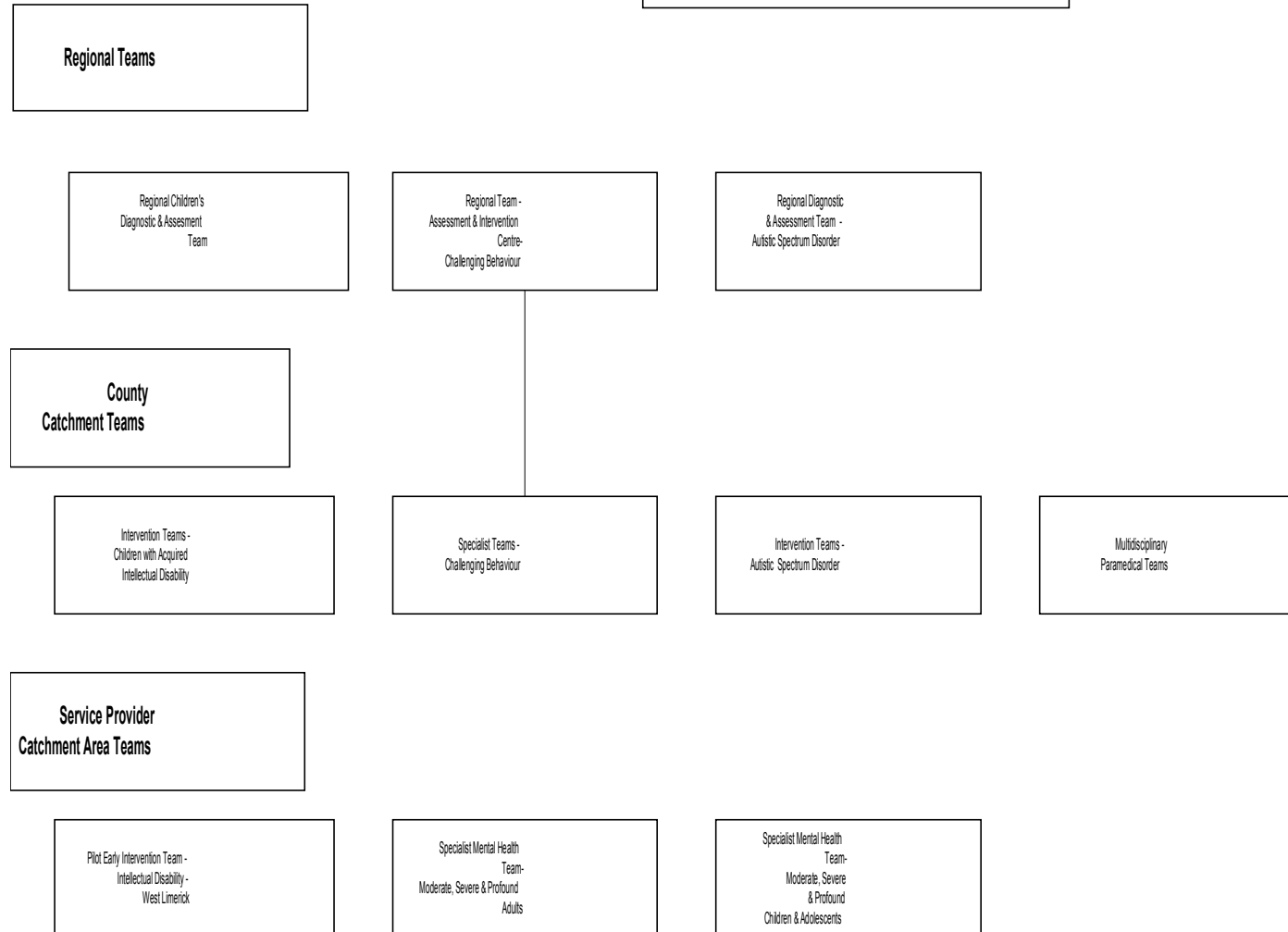
□ ***Professional Resource Services:***

- Psychology
- Speech and Language/ Communications
- Medical and Psychiatry
- Nursing
- Social Work
- Physiotherapy
- Chiropody
- Counselling
- Occupational Therapy

□ ***Alternative Approaches:***

- Reflexology
- Aromatherapy
- Massage
- Hydrotherapy
- Sensory Integration
- Multisensory Stimulation

**Appendix 2:
Organigram of Teams Cited
in Strategy Statement**



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