Report on services for the mentally handicapped (823 KB)

E A S T E R N H E A L T H B O A R D

REPORT ON SERVICES

FOR THE

MENTALLY HANDICAPPED

JULY, 1981

I N D E X

CONCLUSIONS AND RECOMMENDATIONS

Number of mentally handicapped persons receiving services in the Eastern Health Board area.

There are 5,191 mentally handicapped persons covering the 4 degrees of handicap receiving services in the Eastern Health Board area. (2.1)

Number of mildly mentally handicapped attending speical schools and classes

There are approximately 4,000 children who are mildly mentally handicapped attending speical schools and special classes attached to national schools within the Eastern Health Board area. It is estimated that 20/30% of these will seek some type of service during their lives. (2.2)

Mentally handicapped in psychiatric hospitals

(a) There are 150 mentally handicapped persons in the Board's psychiatric hospitals excluding St. Ita's Hospital. A separate service has been developed at St. Ita's. This caters for roughly 500 persons. (3.1)

(b) It is most desirable that residential accommodation for mentally handicapped in psychiatric hospitals be phased out. (3.2)

(c) To cope with the large number of mentally handicapped at present housed in psychiatric hospitals appropriate services should be provided. (3.3)

Division of services for residential purposes

Caring of mentally handicapped should be organised on three levels:

(a) total care
(b) general care
(c) supervisory care (3.4)

Mentally handicapped in non-mental handicap centres

(a) The needs of mentally handicapped in non-mental handicap centres should be studied and special programmes devised to cater for their needs. (3.6)

5 (b) There are 303 mentally handicapped persons considered to be in inappropriate settings (other than psychiatric hospitals). (3.7)

6. Community Based Services

(a) Mentally handicapped persons living in the community should be provided with day services based on the hospital. This service should be provided seven days per week. (3.7)

(b) There are inherent problems in returning patients to the community who have spent many years in residential care. These are outlined in the report. (3.9)

(c) It is generally accepted that the most suitable persons for a community based service are those who have never gone into residential care. (3.10)

7. Admission to residential care

It is generally thought that most persons in the profound range of mental handicap would not be kept at home after lO years of age. Similarly many persons in the severe range might be admitted to residential care at around 15 years of age, and most of the moderately handicapped at around the 30 year age mark. (3.14)

8. Mental Illness in the mentally handicapped

A minimum of 10 beds should be provided in the larger psychiatric hospitals for treatment of mental illness in the mentally handicapped. (4.1)

9. Disturbed mentally handicapped persons

There are between 100 - 150 disturbed mentally handicapped persons in the Board's area. These should be treated in units specially set up for the purpose. (5.1)

lO. Counting the handicapped

(a) Based on the criteria of the Report of the Working Party it is found that there are 4,551 persons in the moderate, severe and profound range. (6.1)

(b) Based on the same criteria it is found that there are 2,660 mentally handicapped persons in the moderate, severe and profound range in need of residential care (6.2)

10 (c) Based on the criteria quoted in the 1965 Report of the Commission of Inquiry on Mental Handicap the following are the estimated numbers of all degrees of mental handicap:-

7,000	mildly handicapped
1,850	moderately handicapped
450	severely and profoundly handicapped (6.4)

11 Developing co-operation between community care teams and the mental handicap services

Close co-operation is necessary between community care teams and the mental handicap service in such matters as counselling of parents, the establishing of a mental handicap record system and the identification of all mentally handicapped in the community. (7.1)

12 Projected figures for 1991

Based on projections established in the community care programme it is estimated that there will be:

2,945	moderately handicapped
2,025	severely handicapped
847	profoundly handicapped

by the year 1991. (Appendix D(i))

13 Provision of services by voluntary organisations

Voluntary organisations providing services for the handicapped should provide them on a global basis. (8.1)

14 Catchment Areas

With regard to existing catchment areas it is recognised that certain anomalies exist. A broad level of agreement on boundaries should be reached between the different voluntary organisations. (8.2)

15 Estimated number of mentally handicapped in need of residential care

(a) Applying the criteria supplied in the report of the Working Party it is estimated that there are 1,028 mentally handicapped persons in need of residential care. (9.11)

15 (b) There are roughly the same number of persons receiving services in the community who could be in residential care as there are persons in residential care who could be in the community. (9.12)

16 Provision of Hostels

(a) Of the number in residential care considered suitable to live in the community there is little possibility that most of these could return to their own families. This would mean embarking on a programme for hostel development. (9.13)

(b) Consideration would have to be given to the problems arising in providing accommodation as outlined in the report. (9.14)

17 Index to the mentally Handicapped

An index to the mentally handicapped started in 1979 should be developed so as to make it as comprehensive as possible. (10.3)

18 Future planning of Services

(a) Future planning of services should be based on community care areas with the following considered essential: (a) counselling, (b) pre-school facilities, (c) schoolgoing facilities, (d) adolescent development, (e) adult care.(11.1)

(b) Residential care should be planned so as to retain the profoundly handicapped at home until they reach about lO years of age and the severely handicapped up to about 15 years of age. (11.2)

(c) Residential care should be divided into total, general and supervisory care. (11.3)

19 Services Planned

(a) A total of approximately 570 additional residential places will be available to the Board within the next 4/5 years (12.1)

(b) Planning should begin for another 400 places. (12.1)

20 Counselling services for parents of newborn

A course on counselling of parents of newborn mentally handicapped commenced in 1980 and continued throughout the year. Further courses will be held in subsequent year. (13.0)

21 Emergency waiting list

(a) A waiting list of 400 emergency cases in need of residential care has been established. (14.1)

(b) An absolute priority list of 80 drawn from the emergency list has also been compiled. (14.1)

22 Future planning - residential care

In future planning residential care places should be provided on the basis of total care beds and general care beds. There should be a gradual phasing out of supervisory care beds in institutions. (15.1)

23 Parish hostels/Community homes

(a) Parish hostels should be established to cater for persons not requiring full residential care. Each parish community would endeavour to care for its own mentally handicapped in this hostel setting. (16.2)

(b) As this is an entirely new concept a pilot scheme might be considered. (16.4)

24 Adult fostering

(a) Consideration should be given to the introduction of an adult fostering service to cater for moderately handicapped as an extension to the community based services. (17.0)

(b) As this is an entirely new concept a pilot scheme is advisable. (17.0)

25 Proposals for immediate needs

(a) Day crisis centres which operate 7 days a week should be established. (18.1)

25 (b) There should be a minimum of four of these centres in the Eastern Health Board area with the possibility of a fifth centre located in the Kildare area. (18.4)

(c) It is recommended that a single unit be first established on a pilot basis. (18.4)

26 Provision for the treatment of physical illness in mentally handicapped persons.

A minimum of 10 neuro-psychiatric beds should be provided in each general hospital for the treatment of patients with physical illness. (19.2)

27 Genetic Counselling Service

The present genetic counselling service should be expanded. A family planning advice service should also be available to complement this facility. (20.2)

28 Baby sitting facilities

The provision of a babysitting service in each community area is most desirable. (21.0)

29 Recreation

It is noted that recreational facilities are being developed and that Special Olympics and National Indoor Games are held. It is most desirable that these activities in caring for the mentally handicapped are encouraged and expanded. (22.0)

30 Community Education Programmes

Community education programmes should be established, full use being made of all means of communication to disseminate information on the handicapped and to inform the public of services available. (23.0)

31 Research

(a) Consideration might be given to the establishment of an Institute of Mental Handicap funded from public resources with overall responsibility for the organisation of research as one of its responsibilities. (24.1)

31 (b) The NAMHI and all organisations concerned should be encouraged to sponsor research in the area of mental handicap. (24.2)

32 Autism

(a) Special consideration should be given to the needs of autistic patients in late adolescence requiring residential care. (25.1)

(b) Special consideration should be given to accommodating these patients in units related to the mental handicap service. (25.2)

(c) A solution will have to be found to the problem of the autistic child who fails to complete the primary education programme and on reaching 16 years of age, does not readily fit into existing programmes. (25.3)

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1.0 INTRODUCTION

1.1 The end of the Second World War brought improvements in social conditions and the awakening of the public conscience to the care and treatment of the mentally handicapped. With the success of various schemes there was a realisation that their potential was far greater than previously thought. This in turn brought about a greatly increased interest in the mentally handicapped.

1.2 Up to the 1920's mentally handicapped patients - if they were ever considered to be such - were put into mental hospitals or county homes and given care and sustenance and little else. At the turn of the century Stewart's Hospital was the only institution catering specially for the mentally handicapped.

1.3 At this stage it might be appropriate to define mental handicap. Mental handicap is sometimes wrongly confused with mental illness. Mental illness can strike anyone at any age: it usually responds to treatment and can often be cured. Mental handicap, on the other hand, is usually determined before or during birth or in the early weeks of life and affects a person's ability to learn or reason. It cannot be 'cured' in the same sense as an illness but the development of mentally handicapped people can often be improved by education, training and social care (and without such help may remain unnecessarily restricted). The 1965 Report of the Commission of Inquiry on Mental Handicap uses the term mentally handicapped to describe "those who, by reason of arrested or incomplete development of mind, have a marked lack of intelligence and, either temporarily or permanently, inadequate adaptation to their environment". Mentally handicapped persons are classified under four degrees of handicap, namely, mild, moderate, severe and profound. These are measured by reference to the intelligence quotient and adaptive behaviour. The lower the intelligence quotient the more severe the handicap.

1.4 Around the middle of the 1920's religious orders and voluntary organisations opened homes and schools for the mentally handicapped and in what is now the Eastern Health Board area the following entered into the field of providing services for the mentally handicapped: The Daughters of Charity, Order of St. John of God and the Sisters of Jesus and Mary. In 1956 the Association of Parents & Friends of the Mentally Handicapped was founded in Dublin to concentrate on the day care of the mentally handicapped in Dublin city and county, and today this association is known as St. Michael's House. Very recently this organisation has commenced providing residential services on a limited scale. Similarly in Co. Kildare the KARE Organisation is providing a wide range of services for this area.

1.5 The policy of successive governments, as far as the caring for the mentally handicapped is concerned was to provide financial support to these organisations. Provision of formal services for the mentally handicapped by Health Boards and their predecessors has, up to recent times, been relatively small by comparison.

1.6 For a number of reasons voluntary bodies are not able to meet the demand for additional places and the Department of Health and Health Boards are becoming increasingly involved in the direct building and staffing of new units. A number of these are at the advanced planning stage and building operations have commenced on two projects.

1.7 The setting up of a separate administration within the Health Board and the appointment of a Director of Mental Handicap has greatly facilitated the planning and development of the services for the mentally handicapped. The need to rationalise the services already available, to identify needs and to plan future services within the framework of a declared overall policy is necessary.

1.8 It might be pointed out that a committee comprising representatives of the voluntary bodies and the Board's staff has been in existence for a number of years.

Long before the concept of regional mental handicap committees was established the then Dublin Health Authority had set up such a body. One of the advantages of this committee from the point of view of the Health Board is that it is a forum where the views of both the voluntary bodies and of the Board are expressed and agreement reached. This has led to a closer and more harmonious arrangement in planning services for the mentally handicapped. This committee produced a report in April 1970 which up to now has been the guideline for the Board.

1.9 The objective of this report is to inform members of the Board of the present state of services for the mentally handicapped and the current needs in terms of numbers still requiring services. The report will also attempt to estimate the needs of the service to 1991 based on predictions of population increase. The criteria used will be those enunciated in the Report of a Working Party on Services for the Mentally Handicapped published by the Department of Health in February of last year.

1.10 While this report relies heavily on the findings of the Working Party Report it is realised that some conclusions in the latter are highly speculative and may be subject to revision in the light of further research.

1.11 The report will also examine the numbers considered to be in inappropriate settings and suggest means of overcoming the problem.

2.0 SERVICES AVAILABLE

2.1 In early 1980 a survey was made of all services available to the mentally handicapped in the Board's area. This has been revised and further information added so that comparison can be made with the findings in the Report already referred to. The following table is a summary of these services showing a breakdown of the four degrees of handicap. The figure for mildly handicapped has been included but the Report is concerned with provision of services for the other 3 categories. The full breakdown of this table is given in Appendix A(i - iv).

Table 1(a)
Number of mentally handicapped receiving services at 1.10,80

Type of Service	Degree of Handicap										
	CHILDREN					ADULTS					
	Mild	Mod	Sev	Prof	Total	Mild	Mod	Sev	Prof	Total	TOTAL
Residential	382	168	138	37	725	217	799	694	119	1,829	2,554
Hostel/Group Homes	---	17	---	--	17	14	61	2	---	77	94
Day Care	6	116	244	13	379	2	65	192	10	269	648
Special Schools	724	604	---	---	1,328	---	---	---	---	-----	1,328
Workshops	---	---	---	---	----	59	352	4	---	415	415
Training Centres	---	---	---	---	---	35	117	---	---	152	152
	1,112	905	382	50	2,449	327	1,394	892	129	2,742	5,191

2.2 There are also approximately 4,000 children who are mildiy mentally handicapped attending special schools and special classes attached to national schools within the Eastern Health Board area. It is estimated that 20 - 30% of these will seek some type of service during their lives.

2.3 The following is a summary showing the breakdown of the population in the moderate, severe and profound range by type of service provided.

Table 1 (b)

Total population (moderate, severe, profound)

Receiving Services

TYPE OF SERVICE	NUMBER
Residential	1,955
Hostels/Group Homes	80
Day Care	640
Special Schools	604
Workshops	356
Training Centres	117
	3,752

3.0 MENTALLY HANDICAPPED PERSONb IN OTHER INSTITUTIONS

3.1 The Report of the Working Party stresses the importance of the problem of mentally handicapped in inappropriate settings. It advises that no further admissions of mentally handicapped to psychiatric hospitals should take place. By far the greater number of mentally handicapped patients in inappropriate settings are not in psychiatric hospitals as is generally thought but in other places Appendix B gives in detail the location of mentally handicapped persons in inappropriate settings other than psychiatric hospitals.

Before discussing the mentally handicapped in psychiatric hospitals special consideration must be given to St. Ita's Hospital. There are roughly 500 mentally handicapped in the hospital. It is realised that the task of transferring such a large number to some other setting would be formidable. The opinion of the Director of Mental Handicap is that a comprehensive service ought to be provided and that this should be developed separately to the psychiatric service Consequently portion of the hospital has been dedesignated so that admissions need not take place under the MentaI Treatment Acts.

It is hoped to develop for the mentally nandicapped patients a range of services comparable with those obtainable elsewhere. Indeed considerable progress has already been made towards this ideaJ. Sixty percent of all mentally handicapped patients -ire now receiving therapy through a wide variety of programmes. For this reason the mentally handicapped patients at St. Ita's are not included in Table ^(a) below

Table 2(a)

Number of mentally handicapped in psychiatric hospitals

Excluding St. Ita's Hospital

Hospital	ADULTS Degree of Handicap				
	Mild	Mod	Sev	Prof	Total
St. Brendan's		120			120
St. Loman's	11				11
Newcastle	7	12			19
	18	132			150

3.2 Psychiatric hospitals are inappropriate settings for the mentally handicapped. It is felt however, that the position might be examined further because at the moment most psychiatric hospitals are providing a dual service i.e. firstly as treatment centres for acute and longterm psychiatric disturbances and secondly, providing residential accommodation for the mentally handicapped. It is most desirable that residential accommodation for mentally handicapped be gradually phased out and that no new admissions to general residential care or supervisory residential care should be allowed. For a definition of general residential and supervisory residential care see paragraph 3.4.

3.3 To transfer the large population of mentally handicapped presently housed in psychiatric hospitals would not be feasible. Therefore, it is recommended that services in these hospitals should be organised along lines similar to those in general hospitals i.e. on the campus of the psychiatric hospital. There would be services for acute psychiatric patients, long term psychiatric patients, psychiatric/geriatric patients and mentally handicapped patients. The connection between each of these services would be similar to that obtaining in general hospitals between the surgical, medical and paediatric wards etc. In other words one could not put a mentally handicapped person into a long term psychiatric section of the hospital.

3.4 The organisation of such a service could perhaps use as its model a service which has been developed at St. Ita's Hospital, Portrane. Services for the mentally handicapped are divided for residential purposes into (a) total care for those who are multiply handicapped and disturbed. (b) general care which would include the high severe and low moderately handicapped (c) supervisory care for those needing minimum supervision and who are training or preparing to go to a training hostel. There should be a training hostel attached to the service, possibly on the hospital grounds and long stay hostels should be provided in the community. The purpose would be to develop a system whereby the mentally handicapped could progress eventually to the community and be returned from the community immediately if their placement broke down.

3.5 The psychiatric hospital beds for general and supervisory care should be in the nature of residential hostel type accommodation. Each day the mentally handicapped would attend an independent day service run completely separately from the psychiatric hospital. This day service should include all the facilities of any good mental handicap service plus a day hospital to cope with illness or disturbance which might occur when the handicapped were at work.

3.6 The particular needs of the mentally handicapped in this type of setting would have to be studied. It would involve the setting up of specialised programmes to meet these varied needs. Ideally the day service should be a geographically separate facility to which the mentally handicapped would travel to each day.

3.7 The day service for the hospital patients should also take in mentally handicapped persons from the local community. The possibility of an extended day service should be looked at operating for about 12 hours per day for seven days per week. However, the attractiveness of such an idea might be outweighed by the many difficulties which it poses and these would have to be resolved before serious consideration could be given to any proposals of this nature. The concept of an extended day service is worthy of further investigation. The possibility of a pilot **service** might help to highlight the difficulties which would arise.

Table 2 (b)

Number of mentally handicapped in inappropriate settings other than psychiatric hospitals

CHILDREN				Degree of Handicap	ADULTS					
Mild	Mod	Sev	Prof	Total	Mild	Mod	Sev	Prof	Total	Total
8	4	22	---	34	226	37	5	1	269	303

It will be noted that there is a total of 453 persons misplaced (Tables 2 (a) and (b)) .

3.8 Table 7.6 of the Report of the Working Party gives percentages of moderately, severely and profoundly mentally handicapped persons in psychiatric hospitals and other accommodation who could be maintained in the community. By applying these percentages the following figures emerge of persons in inappropriate residential settings who might be capable of being maintained in the community.

	Psychiatric Hospitals	other Accommodation
Number in residence	132	69
Number suitable for community	30	23
Percentage suitable for community	22.6	33.6

3.9 Chapter 5 of the Report of the Working Party deals with the criteria for matching the mentally handicapped population to appropriate settings. While the report stresses the main determinant in deciding between residential and community settings as being the degree of handicap, a practical examination of the concepts has revealed difficulties which are not apparent:

1. It is often not possible to get those already in residential care to return to the community. In practical terms, the placing of persons who have spent years in institutions, in the community does not work.

2. Provision of suitable accommodation in a community setting may be as expensive as the provision of full residential care.

3. Hostels and Group Homes have to be kept to a limited number, otherwise they are unmanageable and the standard of care deteriorates.

4. Recruitment of suitable personnel such as house mothers to run hostels and homes is always very difficult.

3.10 It is generally accepted that the most suitable persons for a community based service are those who have never gone into residential care.

3.1 J. It should be emphasised that until recent times most of the work for the mentally handicapped was carried out in residential centres. A high standard prevailed and this has been one of the heartening features of the work for the mentally handicapped in this country. Recently however, more emphasis is being placed on the level of community care for the mentally handicapped.

3.12 Ideally this will lead to the implementation of the concept of comprehensive care where the best use of both community and residential facilities will be availed of for the benefit of the mentally handicapped and their families.

3.13 The aim must always be to ensure the highest quality of comprehensive care in whatever manner this is provided in keeping with the traditions mentioned earlier.

3.14 The desirability of keeping the mentally handicapped at home for as long as is possible has a wide acceptance but now it is generally thought that most persons in the profound range would not be kept at home after 10 years of age. Similarly, many persons in the severe range might be admitted to residential care at around 15 years of age, and most of the moderately handicapped around the 30 year age mark.

4.0 MENTAL ILLNESS IN THE MENTALLY HANDICAPPED

4.1 The psychiatric hospital section's function would be the treatment of mental illness in the mentally handicapped. It is suggested that the larger psychiatric hospital would have a set minimum number of beds - perhaps 10 available specially for the treatment of acute psychiatric illness in the mentally handicapped. Mentally handicapped persons who are psychiatrically ill would be admitted in the usual way and when their psychiatric illness was relieved would be discharged.

The provision of the crisis day centres mentioned later in the report would facilitate their discharge. Under no circumstances should persons admitted for the treatment of acute psychiatric illness be automatically transferred to long stay sections of psychiatric hospitals. Their names however, would be entered in the total care section of the central waiting list. (para. 14.0).

4.2 The mental handicap service would provide a consulting service to the psychiatric hospital in the treatment of acute psychiatric illness in the mentally handicapped but they would be the responsibility of the psychiatric hospital as long as they remained there as patients.

4.3 This concept is in line with the recommended procedure as outlined by the mental handicap section of the Royal College of Psychiatrists.

5.0 DISTURBED MENTALLY HANDICAPPED

5.1 In dealing with overall needs regard must be taken of a group of lOO - 150 mentally handicapped in the board's area who are seriously disturbed. The destructive effect of disturbed mentally handicapped can be out of all proportion to the numbers. Modern thinking stresses the need for the provision of special units to deal with these cases. It is generally agreed that these units should cater for only a small number of disturbed and that there should be a high patient/staff ratio. These units should be of two types:-

1. Those catering for short term cases attached to existing services where persons can be treated and returned to their centre or home.
2. Long term units catering for the chronically disturbed and attached to psychiatric hospitals or mental handicap centres with appropriate facilities.

5.2 The criteria for disturbance are not and cannot be strictly defined. Hence the difficulty in arriving at a precise evaluation of the numbers involved. But a consensus of opinion has indicated that there are between 100 - 150 disturbed mentally handicapped persons.

6 0 COUNTING THE HANDICAPPED

6.1 Our source of information is the 1979 Census of Population published in 1980 which gives a figure of 1,163,721 persons for the Eastern Health Board area. Applying the factors given in Table 4.2 of the Report of the Working Party the following are the numbers of mentally handicapped in the grades of moderately, severely and profoundly handicapped;

Total for 3 grades of handicap	4,551
Breakdown as between grades - moderate	2,305
severe	1,583
profound	663

Details of how these figures are computed are contained in Appendix C.

6.2 Chapter 5 of the Report of the Working Party discusses the criteria for matching the mentally handicapped population to appropriate settings. Table 5.1 sets out the percentages of persons in each category in need of residential care. These are as follows:-

In need of residential care:

Moderate	2,305 x 40% =	922
Severe	1,583 x 70% =	1,108
Profound	663 x 95% =	630
		2,660

By deduction the following numbers could probably remain in the community:

Moderate	1,383
Severe	475
Profound	33
	1,891

6.3 It is accepted practice that all severely and profoundly handicapped adults will require residential care. However, these percentages have been arrived at on the presumption that the younger severely and profoundly handicapped will be maintained at home up to a notional age of 15 years.

The Report of the Commission of Inquiry on Mental Handicap published in 1965 quoted figures given in the Lewis Survey carried out in Britain over a three and a half year period in the 1920's as follows:-

Mild	75%
Moderate	20%
Severe & Profound	5%

The mean prevalence rate for Britain as a whole was given as 8 per 1000. Taking the population of the Eastern Health Board as roughly 1.16 million this would give a figure of 9,280 who are mentally handicapped.

6.4 By applying these percentages and rounding up figures the following numbers in each category are obtained:

7,000	Mildly handicapped
1,850	Moderately handicapped
450	Severely & profoundly handicapped

6.5 As already indicated (paragraph l.l0) in the light of more up to date knowledge these figures may be an under estimation of the situation.

6.6 Assuming that the majority of the mildly handicapped adults will survive in open employment it brings the size of the problem down to more manageable proportions. Nevertheless, the mildly handicapped adults in the community present major problems for the general hospital services, the psychiatric services and the employment workforce.

7.0 COMMUNITY CARE AREAS

7.1 A close liaison is rapidly developing between the ten community care areas within the Board and the services for mentally handicapped provided by voluntary bodies and the Board itself. One of these developments has been the introduction by the Medico-Social Research Board of a Mental Handicap Index System which is maintained by the Health Board. It is imperative that this close working arrangement continues so that the efforts of each side would be integrated for the benefit of the mentally handicapped in the community.

The process of collecting data for this task has been greatly facilitated by Public Health Nurses attached to Community Care Areas.

7.2 Another development in this liaison has been the initiation of a Course on Counselling of Parents of mentally handicapped children. Nurses from each community care area and other health boards attend a full year course which consists of monthly day releases and three 1-week block sessions. This course is fully discussed later on in the report.

7.3 It is expected that there will be greater involvement in day services for the mentally handicapped by community care personnel as this liaison develops. A further breakdown of the figures for mentally handicapped in each community care area, based on the 1979 Census, is given be low.

Table 3 (a)

Number of mentally handicapped persons (mod,sev,prof) per l,OOQ pop. in each community care area 1979

C.C. Area	Pop. census 1979	Total 3.91	Mod 1.98	Sev 1.36	Prof 0.57
1	118,917	465	236	162	67
2	115,369	449	228	156	65
3	93,308	361	184	126	54
4	129,509	504	255	175	74
5	87,472	340	172	118	50
6	128,460	500	253	174	73
7	138,454	540	273	188	79
8	171,097	669	339	233	97
9	97,185	379	192	132	55
10	83,950	328	166	114	48
	1,163,721	4,538	2,298	1,578	662

7.4 It is felt that this information should be of benefit to each Community Care Director in helping him identify the mentally handicapped in his own area.

7.5 From information available to the Community Care Programme in relation to population growth within the health board area, Appendix D(i) of the report gives a projection of population for each community care area for 1991 and the expected number of mentally handicapped in the three grades, applying the same percentage factors.

7.6 Appendix D(ii) shows the actual expected increase in numbers of mentally handicapped in the three grades for each community care area.

8.0 CATCHMENT AREAS

8.1 There is general agreement between the voluntary organisations and the Health Board that an organisation undertaking to provide a service should do so on a global basis ie. it should endeavour to arrange the provision of a complete range of services for the particular area assigned to it. While this would be the ideal, the reality of the situation is very different. Services of the four main voluntary organisations have, up to recent times, developed independently throughout the Dublin city and county part of the Board's area.

8.2 It is not possible therefore to have closely defined catchment areas having regard to the services as they exist and their evolution. All that can be hoped for at present is that a broad level of agreement might be reached between these organisations so that scarce financial resources are employed to the best advantage.

8.3 The situation in Kildare and Wicklow with regard to mental handicap services is some what different. Services are evolving at a steady pace with the active co-operation of a number of voluntary organisations.

9.0 MEASURING THE GAP

9.1 As already indicated a total requirement of 2,660 places for moderately, severely and profoundly handicapped in residential care are required. This is offset by a figure of 2,156 places actually provided. The following table gives a more detailed picture of the position.

Table 4

	DEGREE OF HANDICAP									
	MODERATE			SEVERE			PROFOUND			
Settings	Places Required	Receiving Service	Shortfall	Places Required	Receiving Service	Shortfall	Places Required	Receiving Service	Shortfall	Total Shortfall
Residential	922	967)		1,108	832)		630	156)	473	
		)	128		)	303		)		904
Other Institutions	---	*173)		-----	*27)	---	---	1)	---	
Community	1,383	1,332	51	475	442	33	33	23	10	94
			179			336			483	998

^Psychiatric Hospitals & Other Non Mental Handicap

9.2 As in the Report of the Working Party there is an apparent near equalisation of the number of residential places available against the number required. But as explained in the Report there are three complicating factors, viz

(a) The number of mentally handicapped persons in unsuitable or inappropriate places

(b) Mentally handicapped persons in residential care who could live in the community.

(c) Mentally handicapped persons in the community who need residential care.

9.3 There is a further complication which relates especially to the Eastern Health Board situation.

(d) The number of mentally handicapped persons from other health board areas occupying places in centres in the Eastern Health Board area.

9.4 With regard to (a) a number of these mildly handicapped could be considered as being appropriately placed, but those in the moderate, severe and profound range should be accommodated elsewhere. Percentage factors of 61.1 for moderately handicapped and 25 for severely handicapped are given in the Report of the Working Party for those who could live in the community. If these are applied to the existing numbers we get the following:-

Table 5(a)

In inappropriate settings other than psychiatric hospitals	Mod 61.1%	Sev 25%	Prof 3.6%
Moderate 41 Severe 27 Profound 1	25	7	
	25	7	
	32		

Table 5 (b)

In Psychiatric Hospitals	Mild	Mod	Sev .	Prof.
	All	61.1%	25%	3.6%
Mild 18	18			
Moderate 132		81		
Severe Nil			---	
Profound Nil				---
	18	81		
	99			

9.5 To summarise, there are 453 mentally handicapped persons in inappropriate settings. 234 might be left as they are, 131 should be placed in the community and the remaining 88 must be placed in appropriate settings.

9.6 With regard to (b) the Report states that 61.1% of moderately handicapped in residential care could be maintained in the community; 25% of the severely handicapped population and 3.6% of the profoundly handicapped; Applying these percentages it is found that a total of 811 might be placed in the community, divided as follows:-

603 moderately handicapped

203 severely handicapped

5 profoundly handicapped

9.7 With regard to (c) table 7.8 of the Report of the Working Party gives percentages of persons in the community in need of residential care at some period in their life. These are as follows: 41% of moderately handicapped, 63.3% of severely handicapped and 95.9% of profoundly handicapped. The following table applies these percentages to those receiving services in the community.

Table 6 -
Percentage in the community who need residential care

Degree	Percentage No. in community	%	Number suitable
Moderate	1,332	41.0	546
Severe	442	63.3	279
Profound	23	95.9	22
	1,797		847

9.8 It should be noted that of the 1,797 persons receiving services in the community 847 of these are in need of residential care.

9.9 With regard to (d) there are an unspecified number of mentally handicapped persons from other health board areas receiving services in the Eastern Health Board. It is not the intention of the Board to seek to have these people returned to their own areas. However, it is expected that with the development of services in other health board areas there would be a big reduction in new admissions to residential care in the Eastern Health Board area from outside. It has not been possible to ascertain the number of such persons but this should be a factor for consideration in the future planning of the services in the Eastern Health Board area.

9.10 Bearing these points in mind the following adjustment to Table 4 should be madel

Table 7

	Degree of Handicap			
	Mod	Sev	Prof	Total
Shortfall of Res. places	128	303	473	904
ADD				
Persons in inappropriate settings who cannot live in the community	16	20	1	37
ADD				
Persons in psychiatric hospitals who cannot live in the community	51			51
	195	323	474	992
LESS				
Persons already in residential care who could live in the community	603	203	5	811
	-408	120	469	181
ADD				
Persons in the community in need of residential care	546	279	22	847
	138	399	491	1,028

9.11 This would indicate that there is a total of 1,028 mentally handicapped persons in need of residential care.

9.12 In relation to community services there are roughly the same number of persons receiving services in the community who could be in residential care as there are persons in residential care who could be in the community.

9.13 However, it has already been said that 811 persons in residential care could live in the community. This supposes that most of those would have no family ties, and could not return to living with their families. This would necessitate the provision of hostel or sheltered accommodation for these persons on their discharge and while the range of community services would be available to them this type of living accommodation would be needed. An indication of the problem of the provision of hostel places for this number is that 12 houses would be required in each community care area. The provision of such a large number involves very many practical difficulties.

9.14 Therefore as well as providing institutional places for 1,028 a considerable number of hostel places would also have to be provided.

10.0 INDEX TO THE MENTALLY HANDICAPPED

10.1 To plan services for the mentally handicapped on a realistic basis it is necessary to have agreed numbers in each mental handicap category. With a view to establishing these numbers a mental handicap index was set up in each community care area on January 1, 1979. Initially the index was meant to cover only mentally handicapped children diagnosed and whose date of birth was after January 1,1979.

10.2 In order to make the index viable it was decided that from January 1st 1981 to include all mentally handicapped. Voluntary bodies, community care teams and other contact sources are encouraged to make returns of all mentally handicapped who come to their knowledge from that date onwards.

10.3 A central index will be retained at the headquarters of the mental handicap service. This will contain the sum total of names on the community care indexes. It will be fully confidential and relatives of mentally handicapped will be encouraged to disclose particulars so as to make the index as comprehensive as possible.

11.0 PLANNING THE SERVICE

11.1 In planning the services it was felt from the health board's point of view that the actual planning should be done on the basis of a reasonable sized population. It was decided that as there were ten community care areas already in existence with their directors and full teams, it would be reasonable that the planning of the services should be based on these areas. On average, the population of each community care area is somewhere in the region of 120,000* Within each community care area access to the following services were considered to be essential:-

(a) counselling

(b) preschool day facilities

(i) preschool groups - if possible use should be made of preschool facilities for children of normal intelligence.

(ii) special care - these would be units catering for the moderately, severely and profoundly handicapped. Placement should be at the earliest age appropriate to the child and should build up gradually over the years. It is considered desirable that these SCU's might provide some placements for the moderately handicapped before going on to the special school. The presence of the pre-school child in the SCU for about a year before going on to National Special School is beneficial to all groups - making some activity and liveliness in the unit and showing some progress and new faces.

School going

(i) special classes in National schools

(ii) special schools for mildly handicapped

(iii) special schools for moderately handicapped

(iv) special care units for severely and profoundly handicapped.

adolescent

(i) mildly handicapped to receive second level education from NRB, ANCO or special training centres. It is realised that some mildly handicapped will leave primary school before the age of 14. These could be cateredfor by the provision of special classes in secondary schools or additional provision in the vocational education system.

(ii) moderately handicapped to attend special training centres for 2 years.

(iii) the severely and profoundly handicapped to be catered for in special care activation centres.

adult

(i) mildly handicapped to open employment

(ii) moderately handicapped to sheltered factories or sheltered workshops or sheltered employment

(iii) severely and profoundly handicapped to continue in special care activation centres.

11.2 Residential Care

It is to be hoped that residential care will be made available for those who are most in need as a matter or priority. An effort would be made to retain the profoundly handicapped at home by providing day services for them until they are approximately 10 years of age. The severely handicapped to be retained at home if possible until they are 15 years of age. The moderately handicapped to be retained at home until their parents are unable to look after them. By this time most moderately handicapped should be approximately 30 years of age.

11.3 In the area of caring for the handicapped the following descriptions will be used. (i) Total Care, (ii) General care, (iii) Supervisory care.

(i) Total Care

Total care would be for the low severe and profoundly mentally handicapped. This category .of patient would probably have an added handicap such as disturbed behaviour or difficulty with mobility. It would involve a high input of caring and a lesser input of training. The main part of the caring process would be done by nursing and caring staff.

(ii) General Care

This type of care is mainly for those handicapped who are in the high severe or low moderate range. These could with training, be able to look after their basic needs but would need supervision to ensure that proper standards of nutrition and hygiene were maintained. It would involve caring and training staff. The major input on the caring side would be from nursing personnel.

(iii) Supervisory Care

This would mainly be for high moderates and low mildly handicapped who could survive in hostel type of accommodation. There would be a low caring input and a high input from training staff.

Intensive Care

Another less permanent type of care might also be considered. In the area of mental handicap there is a need for an intensive care type setting. This would be similar to the type of intensive care given in general hospitals. There would be a major nursing input over a short period of time. It would involve continuous monitoring of those receiving this care. The type of situation where it could be used is in acute intensive physical or mental crisis. Normally those receiving intensive care could pass quickly into a total care situation and possibly progress from that to general and supervisory care.

11.4 The types of residential care and the staffing needed which have been briefly outlined above, will be examined in more detail in the following sections.

12.0 SERVICES PLANNED

12.1 The table below gives details of services already under construction or at various stages of planning. It should be noted that a total of 569 resident places will be available to the Board within the next 4/5 years. Planning for an additional 400 places to meet the needs outlined in this report should be undertaken without delay. Also, it is recommended that a scheme of hostels and sheltered living should be started with a view to having those mentally handicapped who are suitable accommodated in a community setting.

Table 8

Services under construction

or at planning stage

TYPE OF SERVICE	LOCATION	No. of PLACES	TOTAL
Residential	Peamount Hospital	20	
	St. Michael's House, Ballymun	139	
	Cheeverstown	130	
	EHB: Ballyboden	70	
	Loughlinstown	210	569
Hostel	K.A.R.E. Kildare Town	22	22
Junior Day Care	Stewart's Hospital	20	
	Cheeverstown	64	
	Loughlinstown	60	144
Adult Day Care	St. Michael's House, Belcamp.	70	
	Cheeverstown	90	
	Loughlinstown	60	220
Workshops	Sunbeam House	60	
	Cheeverstown	60	
	Loughlinstown	60	180
			1,135

13.0 COUNSELLING SERVICES FOR PARENTS OF NEW BORN

13.1 As mentioned earlier, in January 1980 the Eastern Health Board in response to a request from the Minister of Health set up a course to train counsellors of parents of new born mentally handicapped children. In an effort to help all the health boards in the country the training course was made available on a national basis .

13.2 The course was also intended to fulfil the Board's statutory obligation to provide a comprehensive service for the mentally handicapped. It would not be seen to duplicate any service already provided by a voluntary body but would be rather complementary.

13.3 From the point of view of the Eastern Health Board it was decided that the counselling service should be made available on the basis of each community care area. It was agreed initially that two persons should be trained in counselling from each area. From the personnel available it was considered that the most appropriate persons to undertake this training would be the nurses working in the community care programme. It was recognised that these nurses already had, in addition to their general training, experience in obstetrics and public health. It was recommended that those attending the course would have experience in working in the community over the last three years, so that they were already familiar with the practical counse lling of parents in the developmental field.

13.4 The course consists of an initial week in block, a day release course per month for 3 months followed by a second week in block then day-a-month releases followed by a third week in block and so on for the duration of the course which is 12 months. Through the services of a wide range of experts the course is designed to allay the anxieties of the parents of mentally handicapped children and to attempt to answer questions commonly put by parents, e.g. "what did I do wrong"? "what do I do now"? "what does the future hold"? In line with the modern approach to mental handicap the course utilises the expertise of psychiatrists, psychologists, social workers, speech therapists, occupational therapists, physiologists, recreation therapists, obstetricians, genetic counsellors, developmental paediatricians and expert counsellors.

14.0 WAITING LIST

14.1 In November 1977 it was decided with the agreement of the voluntary bodies that a composite waiting list be drawn up combining the existing lists of the Health Board and each voluntary body. This produced a figure of approximately 400 persons who had applied for and were considered in need of residential accommodation. Another figure of 80 was extracted from these 400 of persons considered to be in immediate need of residential care and through lack of it were causing severe problems to their parents and relatives by having to be kept at home.

14.2 Two surveys have recently been concluded by the Medico-Social Research Board of specific areas. As a result of these surveys it is now apparent that the number of 400 on the waiting list is a considerable understatement. Based on the information presently available and the trends as disclosed in these surveys it is clear that the number of places needed is probably in the order of 1,000 of which 700 would be for the moderately and low mildly handicapped and 300 for the severely and profoundly handicapped.

14.3 Although there is no immediate need for this greater number, our thinking will be that over a given number of years they will be required and should be planned for now and on the basis of the type of bed required i.e. total care, general care or supervisory care.

14.4 With this in mind it was decided to set up 3 waiting lists:

(i) a total care list

(ii) a general care list

(iii) a supervisory care list

The majority of those on the total care list would have to be cared for in a residential centre with the full range of facilities. Those on the general care list could be either placed in a residential centre or in a high dependency community home. Those on the supervisory care list who would be the larger number would be cared for in hostels or community homes.

The numbers given above take account of the fact that there are children in general and orthopaedic hospitals etc who should be placed in residential centres for handicapped. Their names will be added to the total care list.

14.5 However, it is not always possible to observe the strict order of priority on this emergency waiting list as vacancies do not often occur in suitable categories.

15.0 RESIDENTIAL CARE

15.1 All residential centres will be encouraged to look at their present population and to decide the number of total care, general care and supervisory care beds they have in their institution's. We would see a gradual phasing out of supervisory care beds and the encouragement of a policy already in existence of increasing the number of supervisory care beds in the community in the form of hostels. In only exceptional circumstances and on an experimental basis would we encourage an effort at providing hostel accommodation for total care and general care patients. Having agreed the numbers in each category the institutions would then be able to admit patients according to the type of bed available. This might eliminate the practice whereby persons not on the priority waiting list are admitted to residential care.

15.2 It must be borne in mind however, that voluntary organisations are national bodies and that dimension plays a significant role in the funding of these centres historically and traditionally. Many beds have been occupied by patients from outside the Eastern Health Board area and given the nature of the problem it is likely to remain like this for many years to come.

15.3 The problem of providing emergency beds might be alleviated by classifying the beds in this way and by trying where possible to transfer those in the supervisory care sections to hostel accommodation.

Obviously some of these beds with an appropriate increase in staff will provide total or general care and help relieve pressure on these waiting lists. It must be kept in mind that it is important for staffing to maintain definite ratios for total, general and supervisory care within an institution.

16.0 HOSTEL/COMMUNITY HOMES

16.1 It is recognised that many centres have established hostels. It is the aim that these hostels would become part of a widely based hostel system helping to keep a substantial number of the mentally handicapped in the community.

16.2 It is recognised that the setting up of hostels within the community sometimes causes concern within the particular community. It is felt that this could be overcome by arranging for the placement of the handicapped in hostels in their own locality.

16.3 It is therefore hoped that hostels might be established on a parish basis. A model for these community homes might be two semi-detached houses in each parish.

16.4 As this is an entirely new concept it would be advisable to consider a pilot scheme for this proposal.

16.5 The community home would also help to care for the mentally handicapped when their families could no longer care for them at home. It could provide holiday relief for families and help out where parents were finding it difficult to get baby sitters. If they wished to go out for a night parents might arrange to bring their handicapped children to the centre and for a small cost have them cared for until their return. These homes would be supervised by the main mental handicap organisation having responsibility for services in the community area.

Staffing of Community Homes

16.6 Each community home should be supervised by an appropriately trained person to ensure the proper running of the home.

The supervisor should endeavour to involve as many local groups and individuals as possible for the benefit of the residents.

16.7 Especially in rural areas where sufficient handicapped would not be available to fill a home the organising bodies might arrange for the twinning of a rural with an urban parish.

16.8 A benefit deriving from the home would be that for rural parishes those attending workshops and schools could live in the home on a 5-day week basis going to their own homes at weekends. An efficient means of transport to and from the home would have to be arranged.

16.9 Where children lived at home and where both parents were out at work, or in the case of a one parent family the child or adult could return from the school or workshop to the home each evening and be collected by the parent when he or she returned from work.

16.10 It is hoped that this system would help rationalise and use most effectively the limited funds available for the mentally handicapped service.

16.11 An adequate training programme should be organised for hostel supervisors

17.0 ADULT FOSTERING

As an extension to the community based services another possibility is the introduction of an adult fostering service as part of a general involvement in additional day care services. Although this is a very new concept in the caring of adult mentally handicapped it is felt that given the proper back-up services and sufficient finance a number of moderately handicapped could possibly be accommodated with relatives after the death of the parents. The cost of providing such a service would be considerably more than the DPMA at present paid to mentally handicapped persons living in the community and would need to cover food, additional heating and supervisory caring. In the long run it is felt that such a scheme might be more beneficial to the mentally handicapped persons receiving the service and would certainly be cheaper than the provision of hostels or group homes.

As this is a new concept it would be advisable that the scheme be commenced on a pilot basis.

18.0 PROPOSALS FOR IMMEDIATE NEEDS

18.1 It is recognised that a problem exists of finding residential places for the numbers of children and adults who are now in need of this facility. Even if maximum provision is made now to provide for these places it will be some years before the need is fully satisfied. The short term solution would appear to be in the provision of a greater number of day places. It is suggested therefore the setting up of crisis day centres. These could run parallel to the parish hostels.

18.2 Crisis day centres should be open all day long. They would cater for the disturbed mentally handicapped living at home. They would also admit mentally handicapped persons coming to live in the Board's area and who can not be immediately offered residential accommodation. They might also be used by the mentally handicapped in psychiatric hospitals. It would offer them appropriate activation in a mental handicap setting and help meet the objections of parent's and relations of having them in psychiatric hospitals.

18.3 They would cater for mentally handicapped persons who function normally for most of the time but present with behaviour problems on a short term basis and placement in a psychiatric hospital can not be arranged immediately. They would also provide day services where a child or adult has been allocated a place but where there is a delay in admission. This delay can vary from 2-3 days to 2-3 months.

18.4 There should be a minimum of 4 of these centres in the Eastern Health Board area. Two should be north and two south of the Liffey with the possibility of a fifth centre in Kildare , and would complement services already in existence. Their purpose would be to give maximum help to parents who are most in need and to provide this immediately and they should function in close association with the area psychiatric

Also where parents are desirous of keeping their child at home and need a flexible facility this type of unit would be very appropriate. To gain full advantage from such a unit it would be essential that adequate staffing and efficient transport facilities be laid on. Because of its implications it is recommended that a single unit be first established on a pilot basis.

19.0 GENERAL HOSPITALS

19.1 A solution should be sought to the treatment of physical illness in mentally handicapped persons within the general hospital service. Difficulty is often experienced in having mentally handicapped persons admitted to general hospitals. Other patients may not like them in the wards and are often afraid of them. With the sudden change they sometimes become disturbed and it is usually necessary to provide a special 24-hour nursing cover at considerable cost.

19.2 It is recommended that a minimum of 10 neuro-psychiatric beds be provided in all regional and general hospitals. This is stressed particularly at the present time when new hospitals are at the planning stage or are being built. These beds would facilitate the admission of mentally handicapped to general hospitals. A close integration of general and psychiatric beds would also be a decided advantage to the training of nurses. The staffing of the units would be a combination of general trained and mentally handicapped trained nurses. The mental handicap service would be expected to provide a consultant psychiatric service to these areas.

19.3 While we await the four new general hospitals each organisation providing services for the mentally handicapped should look for this facility in the hospital nearest to it. At the same time it is acknowledged that at least two of the newer hospitals in Dublin already have psychiatric units.

19.4 The general hospital beds would fulfil the fullowing functions:-

(a) treatment of acute illness in the mentally handicapped
(b) neurological investigation of difficult mentally handicapped patients
(c) profision of the most modern-dental care
(d) monitoring of epilepsy in the mentally handicapped.

20.0 GENETIC COUNSELLING

20.1 As people are becoming increasingly aware of hereditary factors in mental handicap, efforts should be made to expand the present genetic counselling service.

20.2 Each maternity hospital should have a genetic counselling service. A Family Planning Advice Service should also be available to complement this service.

20.3 Guide lines should be sought from the Genetic Counselling Service on the most appropriate type of cases for referral. These would be circulated to all the relevant health services.

21.0 BABY SITTING FACILITIES

21.1 In general parents of young children have great difficulty in finding suitable baby sitters. This is compounded where there is a mentally handicapped child in the family. It is recognised that the parents of the mentally handicapped have so many adjustments to make that if they fail to lead a normal social life the difficulties with the handicapped child may produce a major crisis. The provision of baby sitters with experience in mental handicap in each community area would be of enormous help. The service could be availed of not only by families but also by single parents.

21.2 The organisation of this service and the recruitment of staff might be the responsibility of the area mental handicap service. The service within the area would provide a short introductory course for these baby sitters.

21.3 It should be recognised that the baby sitting service may be needed right up until the mentally handicapped person is admitted to residential care as an adult. Therefore the introductory course should be broad-based.

21.4 The cost of this service would be met in the usual way that parents meet the cost of baby sitting for their other children. Where extreme financial difficulties arise the Health Board might provide this service on an occasional basis.

22.0 RECREATION

22.1 Up to recently the major effort in the field of mental handicap has been concentrated on education and occupation. Like the population in general it is found that the mentally handicapped have increased leisure time. A lot of thought has been given to the planning of recreational facilities to meet their needs in this regard and organisations on an international and national level have been set up.

The mentally handicapped are encouraged to take part in the Special Olympics, the National Indoor Games and representative events at lower levels as well as drama presentations. Both individual and team events are catered for.

Other passive and active pursuits are encouraged and groups are organised for such pastimes as camping, travelling abroad, attendance at sports events, swimming and many others suitable to the needs of the mentally handicapped.

A number of associations are active in the promotion of leisure time activities for the mentally handicapped. One such group are the A.R.C.H. clubs which have affiliated clubs in Ballyfermot, Dundrum, Tallaght and Blackrock, in the Eastern Health Board area. Specialist advice is usually available from the major mental handicap services in the area,

23.0 COMMUNITY EDUCATION PROGRAMMES

23.1 The knowledge of the general community about mental handicap is still very sketchy in spite of child education programmes. Efforts should be made to remedy this situation.

23.2 The body given the task of disseminating knowledge on health matters is the Health Education Bureau. In the mental handicap field the Bureau should be seen to carry out its statutory function in this regard. Community education programmes are of crucial importance as far as mental handicap is concerned and the Bureau should be given the responsibility of devising such programmes with the main aim of changing peoples[1] attitude towards mental handicap.

23.3 The Health Education Bureau since it has the money and resources available to it might make use of the many specialists in mental handicap. By building up a fund of knowledge and disseminating it through local mental handicap organisations a better understanding of the needs and problems of the mentally handicapped would be achieved. The Health Education Bureau should be guided by the specialists in this area who have the knowledge of the nature of mental handicap and of local conditions. A plan of integration of services of the health boards, the education services and its own role on a national basis should be put forward by the Bureau.

23.4 The Bureau might consider various modern methods of dissemination of knowledge on mental handicap by the production of booklets, tapes, video cassettes and films and the hiring of these to local interested groups. Spot advertisements on radio and television which are a feature of the Bureau in other health education fields would also be helpful.

24.0 RESEARCH

24.1 While services in Ireland are excellent, limited research has been done to date. Research carried out up to now has been funded mainly from private sources. There is a need for the provision of research funds from public resources, through a national statutory body such as an Institute of Mental Handicap which would have responsibility for certain aspects of mental handicap on the lines recommended in the Report of the Commission of Inquiry on Mental Handicap.

24.2 The National Association for Mental Handicap has a large, though by no means exclusive role to play in research and all organisations concerned with mental handicap should be encouraged to do some research work.

24.3 There are two types of research:

(i) scientific research of causations of mental handicap

(ii) evaluation of programmes

Professionals attached to the multidisciplinary teams should be encouraged to do research in both areas.

24.4 In keeping with developments in other countries departments of psychiatry in the universities should be encouraged to set up chairs in mental handicap. This development would add esteem and prestige to the whole field of mental handicap and greatly facilitate research.

25.0 AUTISM

25.1 Special consideration needs to be given to the position in regard to the development of services for autistic patients in late adolescence who require residential care and will continue to do so into adulthood, and who as children and young adolescents were cared for in special units for autistic children. The late adolescent presents a major problem because of inappropriate placement in either child or adult facilities.

25.2 The committee has reservations about the concept of a total care unit where these patients would continue to be cared for as a group. It is felt that consideration should be given to the possibility of their accommodation in small, special units related to the mental handicap services, with hostel places for those suitable for such placement.

25.3 Similarly, it will be necessary to seek solutions to the problems of the autistic child who, for various reasons, cannot fully participate in the primary education programme and who leaves before its completion. There is also the problem of the child who on reaching 16 years of age does not readily fit into the existing training programmes.

A P P E N D I C E S

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Appendix A (i)

Services Available

RESIDENTIAL	DEGREE OF HANDICAP										
	CHILDREN					ADULTS					
Centre	M	Mod	S	P	Total	M	Mod	Sev	P.	Total	TOTAL
Daughters of Charity											
St. Joseph's, Clonsilla	--	--	--	--	--	--	179	90	--	269	269
St. Vincent's Navan Rd	--	50	40	--	90	--	70	212	--	282	372
Holy Angles, Glenmaroon	124	--	--	--	124	--	--	--	--	--	124
St. Teresa's, Blackrock	92	--	--	--	92	--	--	--	--	--	92
Order of St. John of God											
St. Augustine's (Blackrock)	160	--	--	--	160	--	--	--	--	--	160
St. Raphael's, Celbridge	--	73	24	5	102	--	122	17	1	140	242
Stewart's Hospital	--	32	19	17	68	16	22	67	115	220	288
Sunshine Home	1	4	9	15	29	--	--	--	---	---	29
Srs. of Charity of J.&M											
Moore Abbey	--	--	--	--	--	32	108	24	2	166	166
Peacehaven	--	--	--	--	--	--	10	--	--	10	10
Peamount Hospital	--	--	--	--	--	30	141	53	1	225	225
Marino Clinic, Bray	--	--	10	--	10	--	--	--	--	--	10
Sunbeam House, Bray	3	--	--	--	3	5	5	1	--	11	14
Sleepy Hollow	--	--	2	--	2	--	--	--	--	--	2
EHB St. Joseph's, Portrane	--	8	32	--	40	70	142	208	--	420	460
St. Michael's, Ballymun	2	1	2	--	5	4	--	2	--	6	11
St. Mary's, Baldoyle	--	--	--	--	--	60	--	20	--	80	80
	382	168	138	37	725	217	799	694	119	1,829	2554

Contd/ Appendix A (i)

CENTRE	DEGREE OF HANDICAP										
	CHILDREN					ADULTS					
	M	Mod	S	P	Total	M	Mod	S	P	Total	Total
Hostel /Group Homes											
Daughters of Charity Service											
Navan Road							22			22	22
Order of St. John of God :											
Dunmore House							7	2		9	9
Islandbridge						12	6			18	18
Stewart's Hospital	—	17	--	--	17	2	26		--	28	45
* St. Michael's House:											
Grangemore - 10 adults											
Artane - 2 adults											
Templeogue - 6adults											
	—	17	--	—	17	14	61	2	—	77	94

* Figures included in Adult Day Care Facilities

APPENDIX A (ii)

Services available

DAY CARE	DEGREE OF HANDICAP					
	CHILDREN					
Junior	M	Mod	S	P	Total	TOTAL
Daughters of Charity						
St. Vincent's, Navan Road	---	4	19	---	23	23
Order of St. John of God						
Dunmore House	5	38	21	3	67	67
Islandbridge	---	19	42	10	71	71
St. Raphael's, Celbridge	---	--	10	--	10	10
St. Michael's House (Developmental Day centres)						
St. Annes, Kilmacud	---	10	37	--	47	47
Grange Park Grove, Raheny	---	12	39	--	51	51
Ballymun Road	---	10	34	--	44	44
Co. Kildare Association						
St. Anne's	1	16	13	---	30	30
Co. Wicklow Association						
St. Catherine's, Newcastle	---	7	27	---	34	34
Stewart's Hospital	---	---	2	---	2	2
	6	116	244	13	379	379
Adult	ADULTS					
Daughters of Charity						
St. Vincent's Navan Road	---	---	3	---	3	3
Order of St. John of God						
Islandbridge	---	16	10	---	26	26
Dunmore House, Glenageary	2	21	13	6	42	42
Stewart's Hospital	---	11	3	---	14	14
St. Michael's House						
Ballygall Road, Finglas	---	--	85	---	85	85
Rathfarnham Castle	---	--	66	---	66	66
St. Anne's, Kilmacud	---	--	10	4	14	14
Kildare Association - Valetta House	---	17	2	--	19	19
	2	65	192	10	269	269

APPENDIX A (iii)
Services Available

SPECIAL SCHOOLS	CHILDREN			
	DEGREE OF HANDICAP			
	M	Mod	Total	TOTAL
Order of St. John of God				
Islandbridge	---	95	95	95
Dunmore House, Glenageary	1	20	21	21
St. Raphael's, Celbridge	---	25	25	25
St. Augustine's	90	--	90	90
ST. Michael's House				
Ballymun Road	---	106	106	106
Grosvenor Road	---	94	94	94
Raheny	---	101	101	101
Phibsboro	---	11	11	11
Co. Kildare Association				
St. Mark's, Newbridge	121	--	121	121
St. Anne's , Curragh	---	69	69	69
Special Classes - Athy	16	--	16	16
" " - Edenderry	16	--	16	16
Co. Wicklow Association				
St. Catherine's, Newcastle	--	42	42	42
Scoil Chiarain	188			188
St. John's School, St. Augustine St D. 8	135	---	135	135
Daughters of Charity: Navan Road (day pupils	--	36	36	36
Holy Angels, Glenmaroon(day pupils)	80	--	80	80
Sunbeam House	60	--	60	60
Stewart's Hospital (day pupils)	--	5	5	5
Carlow Association				
St. Joseph's, Baltinglass(from EHB area)	17	---	17	17
	724	604	1,328	1,328

N.B. There are also approximately 4,000 children who are mildly mentally handicapped attending special schools and special classes attached to national schools within the Eastern Health Board area.

Appendix A(i v)
Services Available

	ADULT			
	DEGREE OF HANDICAP			
WCRKSHOFS	M.	Mod.	Total	TOTAL
Cherry Group - Ballyfermot	22	80	(3 severe) 105	105
Order of St. John of God * Dunmore House (40 places) St. Raphael's, Celbridge	--	37	37	37
St. Michael's House Goatstown (Pottery Unit)	–	30	30	30
Ballygall Road, Finglas	–	51	51	51
Templeogue (long stay)	–	56	56	56
Charles Street (Long stay)	–	45	45	45
Kildare Association	—	19	19	19
Sunbeam House, Bray	22	15	(1 severe 38	38
Fingal Association, Portrano	15	7	22	22
Moore Abbey , Monasterevan	--	12	12	12
	59	352	416T	415
TRAINING CENTRES				
Daughters of Charity St. Vincent's, Navan Rd. (Day attenders)	--	48	48	48
Stewart's Hospital : Mill Lane	12	22	34	34
St. Michael's House Ballymun	23	47	70	70
	35	117	152	152

Figures included in Adult Dav Facilities

APPENDIX B

Mentally handicapped persons in inappropriate settings
Other than
psychiatric hospitals

	CHILDREN					ADULTS					
	Degree of Handicap					Degree of Handicap					
CENTRE	M.	Mod	S.	P.	Total	M	Mod	S.	P.	Total	TOTAL
Clontarf Ortho. Hosp.	--	--	--	--	--	--	- -	3	--	3	3
Hampstead Hospital	--	--	--	--	--	--	--	2	--	2	2
Harcourt St. Hospital	--	--	1	--	1	--	--	--	--	--	1
St. James' Hospital	--	--	--	--	--	--	--	--	1	1	1
Childrens Hosp, Crumlin	--	--	8	--	8	--	--	--	--	--	8
St. Patrick's Home (Navan Road)	7	3	10	--	20	--	--	--	--	--	20
Madonna House	1	1	3	--	5	--	--	--	--	--	5
Our Lady of Charity Gloucester Street	--	---	--	--	--	76	10	--	--	86	86
High Park Convent Drumcondra	--	--	--	--	--	70	7	--	--	77	77
Irish Sisters of Charity Donnybrook	--	--	--	--	--	80	20	--	--	100	100
	8	4	22	--	34	226	37	5	1	269	303

APPENDIX C

1	Number of mentally handicapped (mod, sev, prof) in Eastern Health Board area based on 1979 census of population (1,163,721), taking the factor of 3.91 per 1,000 of population. (Table 4.2:page 13) i.e. 1,164 x 3.91	4,551
	Breakdown of degree of mental handicap (Table 4.2) 1,164 x 1.98 (moderate) = 2,305) 1,164 x 1.36 (severe) = 1,583) 4,551 1,164 x 0.57 (profound) = 663)	
2	In need of residential care (Table 5.1:page 17) 'Moderate 2,305 x 40% = 922) Severe 1,583 x 70% = 1,108) Profound 663 x 95% = 630)	2 ,660
3	Capable of remaining in the community Moderate 1,383) Severe 475) Profound 33)	1,891

Appendix D (i)

Number of mentally handicapped persons (mod, sev, prof) per 1,0Q0 pop. in each community care area 1991

PROJECTED FIGURES

C.C. Area	Projected population 1991	Total 3.91	Mod 1.98	Sev 1.36	Prof 0.57
1	128,578	504	255	175	74
2	126,569	497	251	173	73
3	97,708	383	194	133	56
4	184,509	723	366	252	105
5	162,872	637	323	222	92
6	209,790	821	416	286	119
7	142,254	555	281	193	81
8	203,504	798	404	278	116
9	130,000	508	257	177	74
10	100,000	391	198	136	57
	1,485,784	5,817	2,945	2,025	847

Appendix D (ii)

Projected Figures

Increase in number of mentally handicapped persons to be cared for in 1991

C.C. Area	Total	Mod	Sev	Prof
1	39	19	13	7
2	48	23	17	8
3	19	10	7	2
4	219	111	77	31
5	297	151	104	42
6	321	163	112	46
7	15	8	5	2
8	129	65	45	19
9	129	65	45	19
10	63	32	22	9
	1,297	647	447	185