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19th October 2023

Deputy Paul Murphy,
Dail Eireann,
Leinster House,
Kildare Street,
Dublin 2.
E-mail: paul.murphy@oireachtas.ie

Dear Deputy Murphy,

The Health Service Executive has been requested to reply directly to you in the context of the following parliamentary question, which was submitted to this department for response.

PQ: 43209/23

To ask the Minister for Health if he agrees that community psychiatric services need to be introduced for those who have a mild intellectual disability.

HSE Response

The role of the HSE is to provide a multi-disciplinary team approach which includes the provision of health and personal supports required by people with disabilities and incorporates Hospital, Primary Care and Community Services.

Many individuals, due to the complexity of their presentation, may have a primary diagnosis of intellectual disability or a co-morbid mental health component. In this context, it is important to note that the provision of supports and services cross a range of services.

The HSE funds a range of community services and supports to enable each individual with a disability, to achieve his or her full potential and maximise independence, including living as independently as possible. It would be important to ensure that we safeguard access to these services that are provided through other divisions and functions of the HSE, such as Primary Care, Mental Health, Older Persons Services etc.

Mental Health Services and People with Intellectual Disability (ID)

There are many people with an intellectual disability ID who have comorbidities that would come under the remit of Mental Health or Primary Care, such as ADHD, Korsakoff's syndrome; or Fragile X syndrome. There are also a number of genetic conditions or rare diseases that causes a range of developmental problems including learning disabilities and cognitive impairment that may receive services in different ways in different CHO Areas.



The number of people with mild or moderate co-existing/ comorbid mental illness is 25%, and if people with behavioural problems are included, which includes people with a severe learning disability, this means that up to 50% may experience a co-morbid illness and/or behavioural problems.

A Vision for Change recommends that specialist Mental Health Intellectual Disability (MHID) services are required for those with moderate or greater degrees of intellectual disability and co-morbid mental illness/behavioural problems. These individuals need to be responded to based on age related mental health service i.e. Child and Adolescent Intellectual Disability Mental Health Services (CAMHS-ID) and Adult MHID services.

In addition, approximately a third of those with mild learning disability who develop a co-morbid mental illness may be better served by specialist age related MHID services.

National Model of Service

People with intellectual disability should be able to access support from mental health services in the same way as the general population, within a framework which is multi-disciplinary and catchment area- based. Team members should have appropriate training and expertise, and teams should be suitably resourced.

To support achieving this, the HSE has developed a National Model of Service, which proposes a framework for providing specialist mental health services for people with an intellectual disability. It recognises the strengths of existing services while acknowledging the challenges that must be faced. It was developed following extensive consultation with clinicians, service users, families and service providers, and innovation and international best practice reviews. The document was led on by the offices of the National Mental Health of Intellectual Disability (MHID) Clinical Developmental Lead and Service Improvement Lead.

The primary aim of the model is to improve the mental health service experience and outcomes for people with an intellectual disability and their supporters. The model's main recommendations are:

1. Mental health services for people with intellectual disability should be provided by a specialist mental health of intellectual disability (MHID) team that is catchment area-based. The multidisciplinary MHID teams should be provided on the basis of two per 300,000 population for adults with intellectual disability.
2. These services should be distinct and separate from, but closely linked to, the multidisciplinary teams in Intellectual Disability Services, who provide a health and social care service for people with intellectual disability.
3. The core multidisciplinary team to deliver mental health services to adults with intellectual disability and a mental health problem and or challenging behaviour (where there is some suspicion of mental illness) should comprise key individuals from the disciplines of psychiatry, psychology, nursing, social work, occupational therapy (OT) and speech and language therapy (SaLT), in addition to an administrator.
4. The transition of care between child and adult MHID services is vital.
5. Model of service should be reviewed and updated where appropriate, within a two-year timeframe.
6. Although this model provides national guidance, it is not a prescriptive approach but rather a flexible guide. Teams should decide how best to encompass national standards, but also how to adopt the model as necessary, based on local requirements and geography.

Mental Health Intellectual Disability Team



An MHID team is a specialist adult mental health service specifically for adults with an intellectual disability. It is a multi-disciplinary team, with clinicians who have the appropriate training and experience to better assess and treat this population, taking into account their specific needs.

An MHID service is a distinct and separate service but aims to complement and be closely linked to, the services provided by primary care, disability services and community mental health teams, who provide health and social care services for people with intellectual disability.

Individuals living with mental illness are usually supported by the MHID team for limited periods of time to provide specialist mental health assessment and intervention. As the person's mental health improves the MHID team will plan discharge back to primary care with a recovery plan for staying well and how to access the team again if needed.

Over the last several years the HSE, in partnership with voluntary disability services, are continuing to establish MHID teams across the country, evolving this service in line with A Vision for Change (2006) and the more recent, Sharing the Vision, A Mental Health Policy for Everyone (2020), both of which were published as blueprints for future mental health services.

Childrens Services

The National Access Policy

The National Policy on Access to Services for Children & Young People with Disability & Developmental Delay ensures that children are directed to the appropriate service based on the complexity of their presenting needs i.e. Primary Care for non-complex functional difficulties and Children's Disability Network Teams for complex functional difficulties. Children with ASD may access supports from a Children's Disability Network Team or from Primary Care depending on the complexity of their needs.

Children's Disability Network Teams

91 Children's Disability Network Teams (CDNTs) are aligned to 96 Community Healthcare Networks (CHNs) across the country and are providing services and supports for children aged from birth to 18 years of age.

Regardless of the nature of their disability, where they live, or the school they attend, every child with complex needs and their families have access to the full range of family centred services and supports of their CDNT according to their individual needs. This includes universal, targeted and specialist supports, such as individual therapeutic intervention and access to specialist consultation and assessment when needed. Supports are provided as is feasible in the child's natural environments - their home, school and community.

Service Provision

The CDNTs are currently providing services and supports for 45,741 children and strategies and supports for urgent cases on the waitlist where staffing resources allow.

Children with complex needs and their families are offered evidence informed universal strategies and targeted supports based on individual needs and available staffing resources as part of their therapeutic programme. In addition, they may need individual one to one interventions at different stages of their development based on individual and emerging needs.

CDNTs, in line with national PDS policy, offers services based on the child's individual needs and family priorities as identified in the child's Individual Family Service Plan (IFSP) through a family centre practice model.



This model of service ensures that the supports provided are determined from family priorities, taking into account the factors relevant to each child. It recognises that each family has its own role, values, structures, beliefs and coping styles and it aims to strengthen families own abilities in dealing with their child's challenges. This approach is supported by national and international best practice.

Access to CAMHS for individuals with dual diagnosis

The HSE has established a joint working protocol between Primary Care, Disabilities, and CAMHS services with the aim to make the referral process between the three services easier for medical professionals and families to navigate.

When information indicates that there is more than one service that could best meet the child's needs, consultation should take place with the other service(s) to determine which is the most appropriate or whether a joint approach is indicated. Joint assessment may be indicated when presenting concerns or initial assessment indicates that there is a significant possibility of differential or co-morbid diagnosis of disability and/or mental health conditions.

In addition, the Integrated Children's Services Forum has been established to provide a formal, regular mechanism for services to meet and discuss individual children whose needs are not clear or who require some level of joint assessment or intervention and for whom direct consultation between the relevant services has not led to a decision on the best arrangement for the child.

The HSE regrets the gaps that remain in how children and young people can access support across health services when required. Wide experience shows that there are children and young people with complex clinical issues who do not fit neatly into one specific diagnostic criterion. Historically services have developed in differing ways leading to inequity and inconsistency. One aspect of this inconsistency is in joint case management of complex cases between Primary Care, Disability Services and CAMHS. The joint protocol between Primary Care, Disabilities and CAMHS has been designed to address this and work is ongoing to strengthen the connections between the two services.

The CDNT Roadmap for Service Improvement establishes a clear, robust governance structure at national level to drive the delivery of integrated Services between Disabilities, Primary Care, CAMHS and Tusla at local level, providing the critical building blocks for service integration for the benefit of children and families. Fundamental to this is the implementation of the Primary Care, Disabilities, CAMHS Joint Protocol and National Access Policy by Primary Care, Disabilities and CAMHS jointly for all children with disabilities.

Yours Sincerely,



**Mr Bernard O'Regan,
Head of Operations - Disability Services,
Community Operations**

