HSE MID WEST COMMUNITY HEALTHCARE

Mental Health | Older Persons | Disabilities
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Model of Service for the Young Adult Disability Team CHO 3

Young Adult Disability Steering Group

HSE Mid West Community Healthcare

2022

Document Title	Model of Service for the Young Adult Disability Team, HSE Mid West Community Healthcare
Version Number	V1.2
Approved by:	The Young Adult Disability Team Steering Group
Approval Date:	05/05/2022
Revision Date:	05/05/2023

Front Cover Image

Horse - by Emma Griffin (top left)

Liver Bird - by David Bello (top right)

Controller - by Paul Lyons (bottom left)

Scrambler - by Andrew McAuley (bottom right)

These artworks are mid-size sculptures made from recycled materials and hand painted by recent school-leavers as part of the RT programme at HSE Dulick Centre, Ennis, Co. Clare. The image of the butterfly was chosen by the group as a vehicle for the idea of transition.

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Acknowledgements

The Young Adult Disability Team wish to sincerely thank the Young People attending HSE-funded Adult Day Services who generously shared their knowledge and experience with the team as part of the Model of Service development process.

The team is indebted to our colleagues involved in the establishment of Young Adult Disability Teams in other areas, who also shared their valuable knowledge and experience with us.

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As part of a broader stakeholder engagement process, the team also met with individuals from a number of relevant agencies and services such as: Dochas Mid-West Autism Support Limerick, St Gabriel's Foundation, Brothers of Charity Services

Limerick / Clare, and HSE Mid West Community Healthcare Children's Disability Network Teams.

Purpose

The purpose of this document is to outline the Model of Service of the HSE Mid West Young Adult Disability Team, which aims to improve the experiences of Young People transitioning from child disability services to adult focused disability services in the Mid West region i.e., Clare, Limerick and North Tipperary.

This specialist multidisciplinary team (MDT) for Young People with disabilities is provided by the HSE Mid West Young Adult Disability Team (Senior Clinical Psychologist and Staff Grade Occupational Therapist presently).

The Model of Service is designed to be a guide for individuals, families, service providers, and professionals, in conjunction with the Easy Read Information Leaflet.

The Model of Service proposed here was informed by a number of sources and further iterations will be strengthened by further engagement with key stakeholders:

- National and international disability, mental health, and healthcare policy.
- Consultation with service users, family members, carers, day service providers, clinicians, clinician managers, disability managers, voluntary agencies, child disability services, children's disability network teams, family support services.
- Current evidence base and best practice review.

Context

643,131 individuals were recorded as having a disability in Ireland (CSO, 2016) or 13.5% of the population. 66,611 of those recorded identified as having an Intellectual Disability. 28,388 people were registered on the National Intellectual Disability Database in 2017, and of those 2,390 lived in HSE Mid West Community Healthcare.

In 2020, the National Ability Supports System (NASS) reported that 26,644 individuals accessed Day Services in Ireland, and of that group 96% lived with their primary caregiver. 3,804 individuals nationally are identified as having a primary diagnosis of Autism, 16% of those are aged 18-24 years. 56% of individuals with a

primary diagnosis of Autism accessed Day Services in 2020 and 63% accessed specialist supports (NASS, 2020). The range of support needs for individuals accessing day services in Ireland is diverse and requires flexibility in terms of service delivery.

Furthermore, the Department of Health projects a substantial increase in the need for both residential and adult day services for individuals with disabilities in Ireland between 2020 and 2032 based on the high birth rates of the early 2000's. In particular, more young adults with disabilities require day opportunities or day service places, and more adults will require therapeutic interventions (DoH, 2020).

In parallel, disability services in Ireland are undergoing a significant change process. These changes are being driven by some key legislation and policy documents including:

- Transforming Lives – Value for Money and Policy Review of Disability Services in Ireland (Department of Health, 2012)
- Time to Move on from Congregated Settings: A Strategy for Community Inclusion (HSE, 2011)
- New Directions– Review of HSE Day Services and Implementation Plan for people with disabilities (HSE, 2012)
- Progressing Disability Services for Children and Young People 0-18 years
- A Vision for Change: Report of the Expert Group on Mental Health Policy (Department of Health and Children, 2006)
- Sharing the Vision: A Mental Health Policy for Everyone (DoH, 2020)
- Assisted Decision Making (Capacity) Act, 2015
- Ratification by Ireland of the United Nations Convention on the Rights of People with Disability in April 2018

Some of the key changes underway include:

- The movement of people with disabilities from living in congregated settings to living in dispersed housing in local communities with individualised support designed to meet individual needs. Increasingly, some people with disabilities are making a further transition to living alone.
- The development of services and supports that can respond to the unique and diverse individual needs through a person-centred approach.

- The development of decision supports whereby decisions are no longer taken in the best interest of the person but the person is supported to make decisions for themselves in accordance with their own will and preferences.

'New Directions: Interim Standards for New Directions, Services and Supports for Adults with Disabilities' (2015), proposes an approach to the provision of adult services which is based on the principles of person-centeredness, community inclusion, active citizenship and high-quality service provision. The New Directions Interim Standards require service providers and key stakeholders to involve people with disabilities in the design, delivery, monitoring and evaluation of the services and supports provided.

The Value for Money and Policy Review of Disability Services (Department of Health, 2012) proposes a shift in focus that is pre-dominantly group-based service delivery towards a model of person-centred and individually chosen supports. These supports embed the person in their natural support system and wider community, accessing mainstream and disability services and supports appropriate to need.

Building on this, the National Framework for Person Centred Planning in Services for Persons with a Disability aims to inform and guide how person-centred planning is carried out across services for individuals with a disability. In accordance with the Interim Standards 1.5:

> *Each person has a personal plan that includes the services and supports to be provided to them to achieve a good quality of life and to realise their goals.*

Specialist Multidisciplinary team support aims to inform, consolidate and support the further development of the Young Person's personal plan.

For many young people their goals relate to having valued roles within their community or having life experiences similar to that of their peers. People with disabilities leave education earlier and are less likely to have completed primary, secondary, and third level education than their peers (Department of Social Protection, 2016). Adults with disabilities are twice as likely to be outside the labour force as the general public (CSO, 2016). The Economic and Social Research Institute (ESRI) highlight a strong link between disability, joblessness, and risk of poverty, and consequently that employability is a safeguard for people with disability against experiencing poverty in their working years or retirement. In 2015, the Irish government launched a national ten-year strategy to increase the number of people with disabilities in employment. A key action of the 'Comprehensive Employment

Strategy for People with Disabilities' is to enhance education, training and pathways into work for young adults with disabilities. A practise used to good effect in other countries is that in the final three years of schooling, Individual Education Plans become Individual Transition Plans. The importance of supporting young people through this pivotal period of transition is acknowledged and the establishment of Young Adult Disability Teams reflects a motivation to provide the appropriate support. This transition, from child to adult focused disability services also marks a significant change in terms of how services are provided to individuals with disabilities.

HSE Mid West Community Healthcare Service Landscape

Children's Disability Network Teams (CDNT) within HSE Mid West Community Healthcare provide services to children with complex developmental difficulties and their families residing in Clare, Limerick, and North Tipperary. Each CDNT has a Children's Disability Network Manager. HSE Mid West Community Healthcare is a mix of rural and urban populations served by 7 teams. Additionally, each CDNT uses the HSE-owned Children's Disability Management Information System (MIS) to record and update each child's family-centred plan. CNDT catchment areas have been reconfigured to align with Community Health Networks (CHN).

Each CDNT in HSE Mid West Community Healthcare is listed below together with the Lead Agencies identified as of 19th April 2021:

Clare CDNT CHN 1 and CHN 3 HSE

North Tipperary CDNT CHN 2 Enable Ireland

West Limerick CDNT CHN 4 Brothers of Charity

East Limerick CDNT CHN 5 Daughters of Charity

Treehouse CDNT CHN 6 St Gabriel's Foundation

South City CDNT CHN 7 St Gabriel's Foundation

Blackberry Park CDNT CHN 8 Enable Ireland

Exemptions to the above home-based access to CDNT have been agreed for children attending three Special Schools in the Limerick City area, with access to CDNT based on school address for these children and their families.

Exemptions to Home Based Access to CDNT:

- St Vincent's School, Lisnagry, East Limerick CDNT
- St Gabriels's School, Dooradoyle, Treehouse CDNT
- Catherine McAuley's School, Limerick Blackberry Park CDNT

Children with non-complex developmental difficulties residing in Clare, Limerick, and North Tipperary access their healthcare needs through HSE primary care services (Psychology, Occupational Therapy, Speech and Language Therapy, Physiotherapy). Children with disabilities warranting input from two or more professionals due to significant impairment in functioning due to their disability access clinical input from their Children's Disability Network Team. Children accessing disability services identified as also requiring intervention due to a moderate to severe mental health disorder may also access Child and Adolescent Mental Health Services (CAMHS) or Child and Adolescent Mental Health Intellectual Disability (CAMHS ID) services as appropriate. Children most frequently attend a mainstream school, a supported classroom within a mainstream school or a special school. Their school may also access the support of the National Educational Psychology Service.

Prior to leaving school, an occupational guidance advisor will be in contact with the young person and their family to discuss post-school options and to complete the profiling process. The HSE Occupational Guidance Service helps people with a disability to find a training option or support service that is suited to their needs.

The school leaver's needs may be met by a:

- HSE-funded rehabilitative training programme
- HSE-funded adult day service
- Mainstream education or training services

The HSE provides rehabilitative training and adult day services for people aged 18 and over with Intellectual disabilities, Autism, complex physical and sensory (deaf/hard of hearing or blind/visual impairment) disabilities and mental health difficulties. Rehabilitative Training programmes are training courses funded by the HSE to develop life skills, social skills, and basic work skills, and courses usually last from two to four years. These courses can be a stepping stone to more mainstream education or training options.

Adult day services are HSE funded programmes to assist people to make choices and plans and to be an active, independent member of the community. Service

providers have individual service entry criteria and deliver varying degrees of supports to people with a very diverse set of needs, wishes and aspirations. Ideally, referrals should be made to the HSE at least 13 months in advance of the person leaving school and students can be referred from age 16 for future planning purposes. Some school leavers will transition to day services where they will have access to clinical or therapeutic interventions. A number of those school leavers with complex needs will transition to HSE/HSE-funded Adult day services where clinical supports have not been provided for but are necessary to support the young person to reach their full potential.

In the Mid-West Community Healthcare Area, disability services are delivered through a combination of HSE direct provision and via partnership arrangements with Section 38 & 39 or private providers e.g. Brothers of Charity (Limerick & Clare), Avista, Irish Wheelchair Association (IWA), Enable Ireland, Rehab Care, Acquired Brain Injury, Resilience, Headway, Nua healthcare etc. 1,345 Adult Day Service places were provided with supports across 95 locations in the Mid-West in 2020.

Day services for adults with disabilities will have an annual intake of School Leavers and Rehabilitative Training leavers and some of the services have provision for Multidisciplinary team input within their organisation to support the young person to transition and adapt to adult services. However, there is a sizeable cohort of Young People who transition to HSE/HSE-funded adult day services in HSE Mid West Community Healthcare that do not currently have access to multidisciplinary team supports.

In addition, there is currently no HSE Community Adult Disability Clinical Team in operation for those previously accessing the Children's Disability Network Teams to transition to upon turning 18 years of age in HSE Mid West. Consequently, young adults who receive support from the Young Adult Disability Team will not have access to an Adult Disability Clinical Team when they are discharged. There is also no HSE Mental Health Intellectual Disability Team in operation in CHO3 at present, should an adult with an intellectual disability present with a mental health difficulty requiring a specialist mental health team. It is well established that mental health difficulties are 3 to 4 times more common in people with an Intellectual Disability than in the general population (Sheehan et al., 2015). It is therefore reasonable to predict that a sizeable cohort will require specialist mental health input in this area. Individuals with non-complex needs or whose needs have to-date been most

appropriately met in primary care services will continue to access services at primary care level.

In order to address the equity of access issue for this group, the Young Adult Disability Team will focus its resources initially on meeting the needs of young people attending or due to transition to HSE/HSE-funded Day Services that do not have provision for access to a multidisciplinary team. In services that do not have access to a multidisciplinary team, the Young Adult Disability Team can be requested to assist by providing service-level or direct input to support the young person, their families and/or the service provider during this period of transition. The extent to which the team are adequately meeting the needs of this group and the team's capacity to extend access to a broader group will be reviewed at 3 monthly intervals within the parameters of the Young Adult Disability Steering Group (YADSG) meetings. Where needs outside of this cohort are identified, a proposal will be brought to the steering group to request the additional clinical, administrative and accommodation resources required to amend the eligibility criteria of the team to serve a broader population.

Table 1. Tiered care accessed by children and adults with disabilities

Tier 4 **Specialist Mental Health in Intellectual Disability (MHID) Service** In-patient treatment / therapeutic respite (Severe acute mental health difficulties requiring specialist in-patient treatment)
Tier 3 **Mental Health in Intellectual Disability (MHID)** and/or **Young Adult Disability Team** MHID / CAMHS ID: Specialist multidisciplinary mental health teams designed to meet the needs of individuals with intellectual disabilities experiencing a moderate to severe mental health difficulty requiring a community-based multidisciplinary mental health team. YADT: Specialist Young Adult Disability Team designed to support young adults with complex needs transitioning from child disability services to adult-focused day services.

Tier 2
Children's Disability Network Teams (CDNT) / Adult Disability Team

Children's Disability Network Teams designed to provide clinical input (assessment and intervention) to children with complex needs and resulting functional impairment in two or more areas resulting from their disability.

Adult Disability Teams (Intellectual Disability / Physical and Sensory / Autism Spectrum Disorder (ASD)) designed to meet the needs of adults with complex needs and functional impairment resulting from their disability.

Tier 1
Primary Care

GP / Primary care Team is accessed by all; those presenting with non-complex needs access specific disciplines within their primary care team and/or network i.e. public health nursing, primary care speech and language therapy, physiotherapy, psychology, occupational therapy.

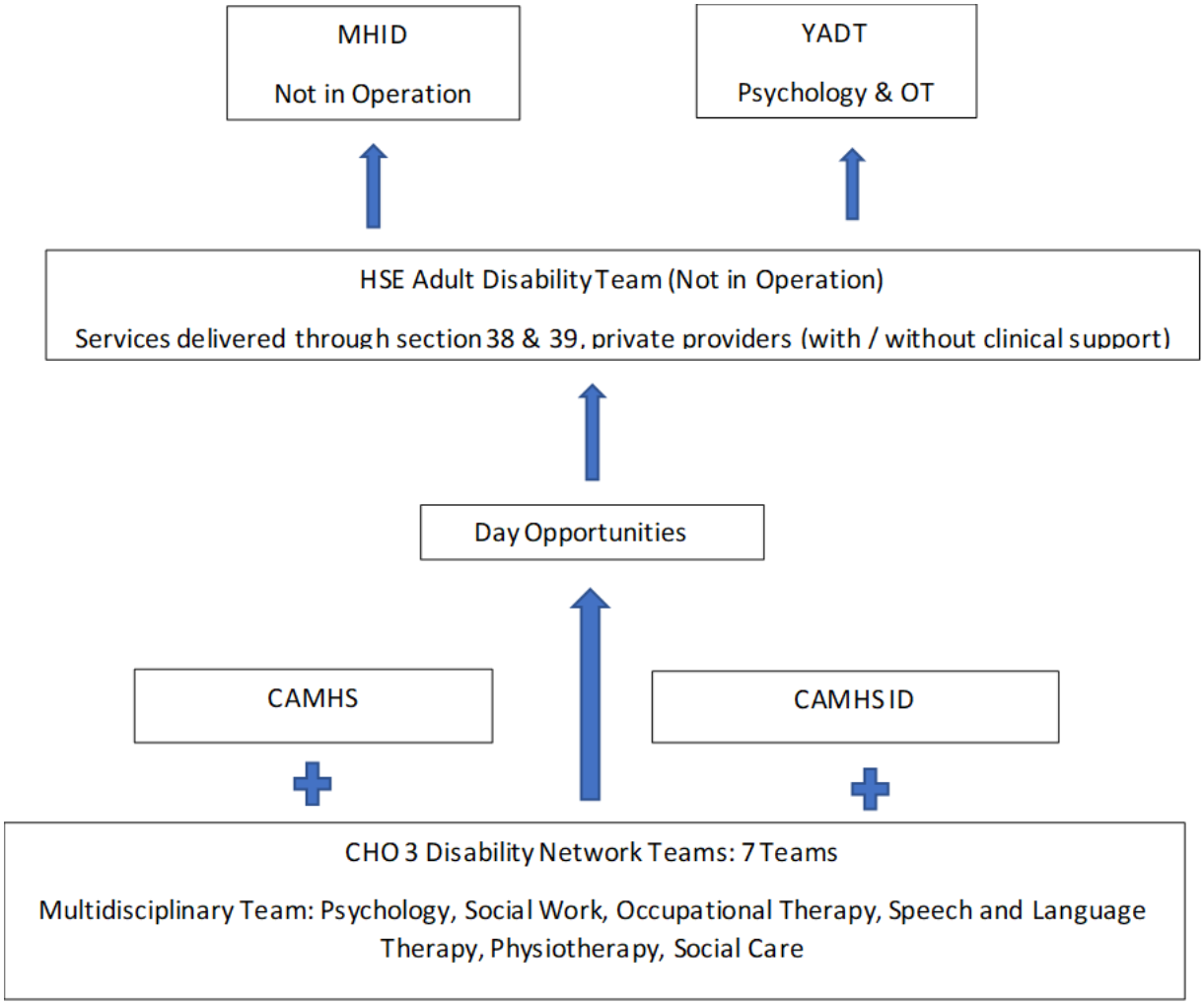

Figure 1: Clinical Supports for Individuals with Disabilities transitioning from Child to Adult Services in HSE Mid West Community Healthcare.

Team Principles

The design and development of this team is in accordance with the New Directions Interim Standards for Services and Supports for Adults with Disabilities. The principles are to:

1. Provide person-centred services and supports that are tailored to individual need

2. Provide person-centred services and supports that promote community inclusion and active citizenship
3. Provide person-centred services and supports that promote independence and a good quality of life for people using them
4. Promote and uphold the equal rights of adults with disabilities
5. Promote and improve the health and development of each person
6. Provide safe services and supports that promote positive risk management
7. Provide effective governance arrangements with clear leadership, management and lines of accountability
8. Plan and use resources effectively
9. Deliver responsive and consistent services based on evidence and good practice

Person-Centeredness

The HSE, in its commitment to enabling cultures of person-centeredness throughout the system, adopts the following description of person-centeredness:

"*an approach to practice established through the formation and fostering of healthful relationships between all providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development"*

(Adapted from McCormack & McCance, 2016:3[1]).

In accordance with Standard 2.2 *People are meaningfully involved in the planning, design, delivery, monitoring and evaluation of services and supports,* the team will actively engage young people, their families and service providers in the design, development and review of the service. An important aspect of this is embedding standard outcome measures (SOMs) within service provision to ensure that the team are focused on supporting the Young Person to meet their goals and that this is monitored and evaluated as standard practise.

Human Rights

The United Nations Convention on the Rights of Persons with Disabilities (CRPD), which was ratified by Ireland in 2018 commits to ensuring the right of people with a disability to the highest attainable standard of health, without discrimination. The purpose of the Convention is to promote, protect and ensure the full and equal

enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. Under the convention, persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. Article 24 of the United Nations Convention on the Rights of the Child (ratified by Ireland in 1992) specifies that the 'State shall recognise the rights of the child to the enjoyment of the highest attainable standard of health and the facilities for the treatment and rehabilitation of health.

Community Inclusion

In line with the National Framework for Person Centred Planning in Services for Individuals with a Disability, the team seeks to strengthen relationships between the individual and community members.

One of the strategies used to involve informal support in person-centred planning is through circles of support.

A circle of support is a natural arrangement that involves a group of friends, family – immediate and extended, and sometimes staff or clinicians coming together to support an individual, assisting them to identify things they would like to achieve or alter in their life and then putting in place supports to make this happen. Every circle is different because of the uniqueness of the goals of the individual and the unique contribution of the circle members. Circles of support can be a key factor in enabling individuals to live well in their communities. The team will seek to support, empower and provide additional input to the individual's circle of support to help the young person to achieve their goals.

Guiding Framework

The team will be guided by O'Brien's Five Valued Experiences (2006): belonging, respect, shared spaces, contribution, and choice. It is proposed that these five valued experiences are necessary for everyone to live a happy and meaningful life. However, those with disabilities may have access barriers to these experiences and additional enablers and supports may be needed to ensure full access. The Young Adult Team will work collaboratively with the young person, their families and day service providers to support belonging, respect, shared spaces, contribution and

choice. As HSE Employees, team members are informed and guided by the HSE Core Values: Care, Compassion, Trust and Learning.

Developmental Stage

A primary drive of adolescence and of early adulthood is to achieve greater independence and to consciously individuate from parents, siblings and peers. The drive for autonomy is a key aspect of this stage as the young person moves from being primarily supported by their parents to gaining more mentorship and guidance from community members and extended family. Through the development of a broader range of life skills the young person begins to gradually assimilate more into the broader community. Individuals with disabilities are subject to the same drives but may experience barriers to achieving greater independence or may require individualised supports, flexibility, and creativity in order to achieve greater autonomy.

Erikson's Theory of Psychosocial development (1968) proposed that the primary developmental task of adolescence is to form a new, more complex identity. Identity is what allows a young person to bring together the different parts of themselves – their experiences, beliefs, values and aspirations – into a coherent whole. It guides their choices, and behaviour, confirms their commitments, and motivates them to behave in a way that is consistent with the way they think of themselves and what matters to them. The young person will work at refining a sense of self by testing roles and then integrating them to form a single identity. The resolution of this is dependent to an extent on the opportunities the young person has, to test out different and valued roles.

In Young Adulthood, the young person strives to form close relationships and to gain capacity for intimacy. The resolution of this task requires opportunities and supports to develop close and intimate relationships.

Engaging Young People

In addition to informal discussions with adults currently attending HSE-funded day services, two formal service user engagement events were held as part of the Model of Service Development process. The purpose of the events was to better understand the experiences of those who had transitioned from school aged services to adult-focused services and to identify the challenges, supports, strengths and

opportunities experienced. A secondary purpose was to help establish a service user forum with whom the team could consult to inform service provision going forward.

The adults in attendance at the service user forums were invited to share their experiences of moving to adult day services and to reflect on what was good about the change, what was difficult, what helped, who helped, and how other young people might be supported during the transition.

Service user feedback is summarised below and presented across four main themes.

Information

‘I like to know’

Service users spoke about the importance of receiving timely information and described how this reduced any anxiety they were experiencing. They discussed three main times where this was important:

1. Finding out what course or training centre they would be attending. When the appropriate course or training centre was identified, young people often sought information from multiple sources e.g. online, other young people, information leaflet. For many, the earlier they accessed this information the better prepared they were for the change.
2. Filling out the form sent to them from the training centre allowed individuals to share information which most found helpful. This reduced service user anxiety about for example medication concerns and provided an opportunity to make centre staff aware of their individual needs and capacities.
3. Contact and information sharing between their school and day service was seen as a potential opportunity to share more information. Some service users felt that more contact between their school and the training centre would have further supported their transition.

Relationships

‘I meet new people’

Most service users spoke about the opportunity to meet new people and described this as a significant benefit of the transition. Some service users came to their training centre with friends from school which they reported as being a positive aspect. For others, opportunities to meet other young people, particularly those who were also new to the centre, was very important in helping them to become comfortable there.

'I met with people from the centre'

Many service users talked about meeting with someone from the centre such as the service manager before starting and described this as very helpful.
One individual noted their reluctance to attend a service for individuals with disabilities as they did not view themselves as having a disability. Opportunities to meet with staff from the centre and to sample courses that the centre had to offer helped.

'I met with my keyworker'

Service users noted that they knew they could go to their keyworker when they needed help. They noted that being able to meet with their keyworker a lot at the beginning was important, and being able to meet with their keyworker and visit the centre at a time that was less busy was very important.

'Getting to try new things'

Keyworkers often helped service users to try new skills or explore new areas of interest and also encouraged the further development of established skills.

Setting

Service users described coming into the centre to sample activities before attending on an ongoing basis. The majority reported that they liked being able to have a 'trial run' and at a quiet time when their keyworker was on hand if they needed support.

Having a locker with a key and being able to store belongings in a safe place when coming into the centre was important for some service users.

Orientation: Many service users discussed coming into a central space in the mornings to meet with others, orientate themselves, get organised, and look at their timetable before going to their first class or activity. This was important in reducing any worry or confusion and gave an opportunity to ask for help or to be directed towards the appropriate room.
Service users spoke about the importance of their individualised timetable in helping them to know where to go and what was coming next.

Transport

The majority of service users discussed transport. For most, the transition to a training centre or day service also required a change in how they travelled daily. Service users reported using the bus, walking, getting a taxi, and being driven by their parents as the main types of transport they used. For many, the change to another form of transport was very significant and represented another important transition.

Standards

The Young Adult Team will adopt the standards of *New Directions: Interim Standards for New Directions, Services and Supports for Adults with Disabilities.* This team and its development will also take cognisance of HIQA as the Independent Health Information and Quality Authority.

All team members will have completed statutory training in line with up-to-date legislation. This will be reviewed regularly and in line with national guidance. All team members will have completed up-to-date Children's First, General Data Protection Regulation, and National Standards for Adult Safeguarding: Putting the standards into practice training. The Team will comply with relevant sections of the Assisted Decision Making Act (2015), the Disability Act (2005) and will be cognisant of the role of the Health Information and Quality Authority (HIQA) as the Independent Health Information and Quality Authority.

Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures (2014), applies to all HSE and HSE funded services and outlines a number of principles to promote the welfare of vulnerable people and safeguard them from abuse. The Young Adult Team as HSE employees supporting individuals accessing HSE/HSE-funded day services, are bound by and committed to implementing this policy.

Aims and Scope

Key aims and scope of the HSE Mid West Community Healthcare Young Adult Disability Team:

1. To provide multidisciplinary support to Young People (school leavers) attending or due to attend HSE/HSE-funded Adult Day Services that do not have provision for access to multidisciplinary team input in HSE Mid West Community Healthcare.
2. To support the young person referred to the team to achieve their goals within a person-centred framework.

The aims and scope of the team will be reviewed by the steering group (YADSG) and any broadening of the scope will be contingent on the provision of the resources required on the team to provide a safe and accessible service.

Criteria for Referral to the Young Adult Disability Team:

- The Young Person attends or has accepted a place in a HSE/HSE-funded Adult Day Service within HSE Mid West Community Healthcare that does not have provision for access to a multidisciplinary team.
- The Young Person has or is due to leave school in 2022 or thereafter. *
- The individual presents with complex needs that would not be more appropriately addressed within the uni-disciplinary or multidisciplinary framework of Primary Care Services. Evidence of this is provided through the use of the profiling tool completed by the Occupational Guidance Advisor / Day Opportunities Officer.
- The Young Person left school within the last 3 years.*

- The Day Service that the Young Person attends or is due to attend does not have provision for multidisciplinary team support as part of their Service Level Agreement.

*As an interim measure and reflective of the impact of the COVID-19 Pandemic, young people who left school between 2020 and 2022 and have accepted a place in a HSE-funded Adult Day Service within HSE Mid West that does not have provision for access to a multidisciplinary team, and who meet all other referral criteria may be referred to the Young Adult Disability Team. This measure will be reviewed within the parameters of the steering group meetings.

Following review of the referral criteria and the number of referrals to the team over an initial 3 month period, the inclusion of Rehabilitative Training Leavers as eligible for referral will be proposed to the YAD Steering Group for approval.

Any change to team referral criteria will be proposed, reviewed and agreed by the YAD Steering Group and will be contingent on the team being sufficiently resourced to operate safely and accessibly. An extension to the length of time in which an individual will have access to the Young Adult Disability Team (i.e. greater than 3 years post leaving school) may be proposed and reviewed by the YAD Steering Group as required and will reflect the resources and capacity of the team.

In the absence of an adult disability team or MHID Team to discharge adults to following input received from the team, it is foreseen that an extension of service may need to be considered on an individual basis. A proposed extension of service provision in such individual circumstances will require YAD Steering Group approval. Such extensions will need to be carefully reviewed in the context of team resources in order to reduce the risk of service inaccessibility to school leavers resulting from any delayed discharge.

Referral Pathway

- Referrals will be accepted from the Occupational Guidance Advisor / Day Opportunities Officer, Day Service Manager, Disability Case Manager in collaboration with the Young Person, their family and their keyworker (as appropriate).
- A completed referral form (Appendix 1), a copy of the young person's profiling tool (Appendix 2), and a copy of the young person's Person Centred / Family Centred / Individualised Plan will be needed to process the referral. Additional guidance and resources for completing a PCP are

available at
https://www.hse.ie/eng/services/list/4/disability/newdirections/person-centred-planning-framework-implementation.html

- Referrals will primarily be made by email to the YADT to support the development of a paperless service and new referrals will be discussed fortnightly at the team referrals meeting.
- EReferrals will be processed in line with GDPR guidance and with the team's Standard Operating Procedure for the management of eReferrals (Appendix 3).
- New referrals will be discussed at the team referrals meeting and the suitability of the referral will be agreed based on referral criteria and the information made available. Further information may be sought at this stage.
- Following discussion and agreement, accepted referrals will be prioritised according to need based on the information available and the team's prioritisation policy.
- An appropriate keyworker from the MDT will be allocated based on the individual's need and on the competencies of the disciplines available on the team. An initial triage appointment may be required to clarify the individual goals and needs of the Young Person.
- An episode of evidence-based care will be provided to support the Young Person to meet their individual goals and mindful of the need to provide the least intrusive but most effective intervention at each of the levels described in figure 4.
- Following an episode of care the Young Person's person-centred plan will be updated or reviewed to incorporate the interventions provided as appropriate. The extent to which the goals set at referral stage were met through involvement with the team will be recorded in consultation with the young person.
- A summary of input report will be provided by the team or individual professional who facilitated the intervention as required. A copy of this report will be made available to the Young Person, the Service Provider and the Family (as appropriate).
- The case may be re-opened in future following appropriate re-referral to the team.

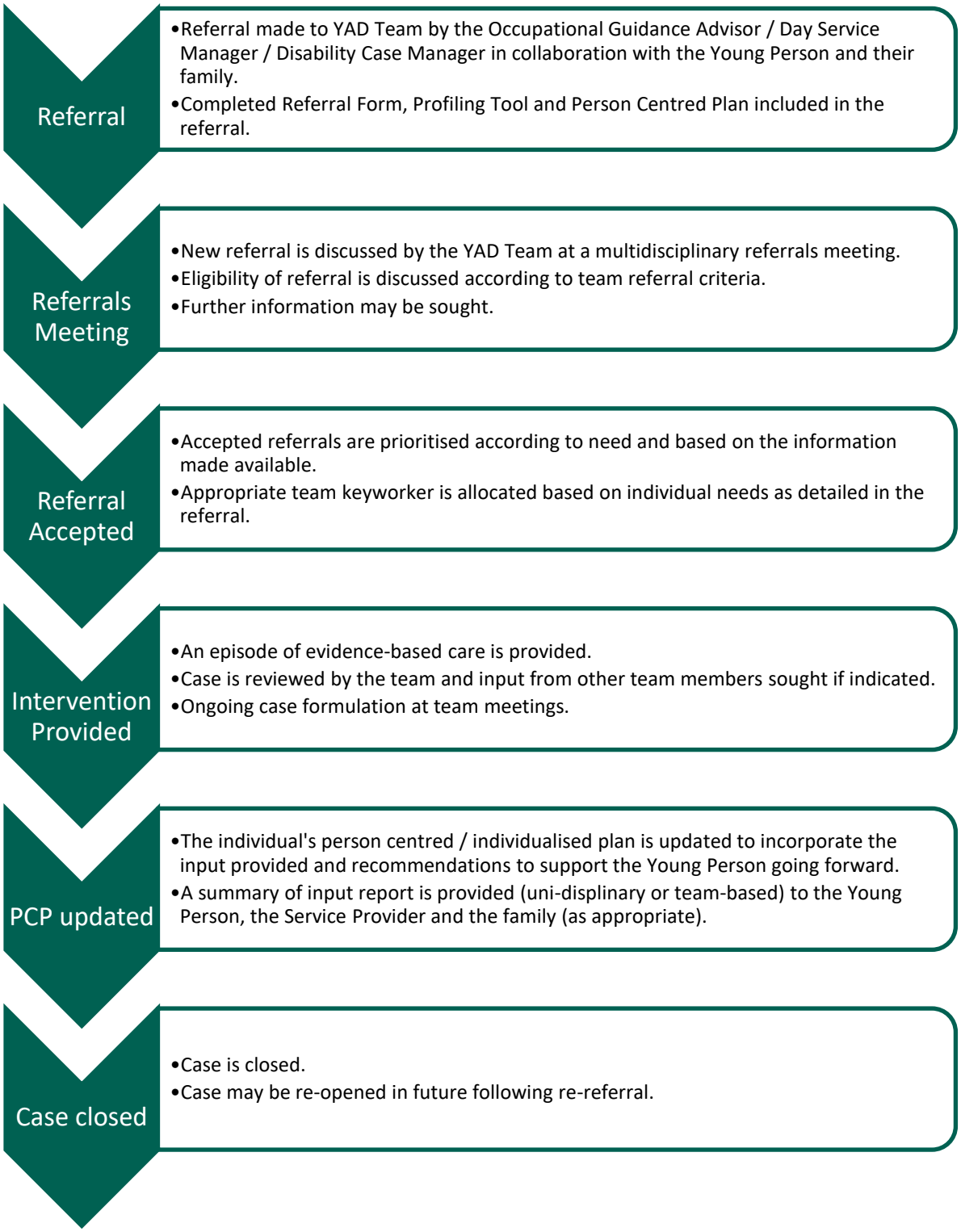

Figure 2: Young Adult Disability Team Referral Pathway

Model of Service Provision

The team will aim to empower, support and strengthen natural support structures. Safe, evidence-based interventions will be provided at the least intrusive level that allows the provision of effective services. The team may provide input at various levels of the person's Circle of Support. For example, the team may provide consultation to the young person's service provider to meet the emotional needs of the individual, the team may need to conduct an assessment and work with the service provider to develop a comprehensive behaviour support plan or individual team members may meet with the young person or their family to provide direct one-to-one intervention. The input provided in each instance will be structured around the person and respectful and supportive of the individual's Circle of Support.

Currently, Children's Disability Network Teams in HSE Mid West Community Healthcare have implemented the Family Centred Model of Practice (FCP) and utilise this process to support families to identify their goals and support needs. Families accessing CDNTs in HSE Mid West were introduced to this model of practice and Family Support Plans are now central to the recording of data on the Management Information System. The Young Adult Team will follow and progress this model utilising a person-centred planning approach to reflect the developmental stage and transition of the young people accessing the team.

Figure 3: Circle of Support

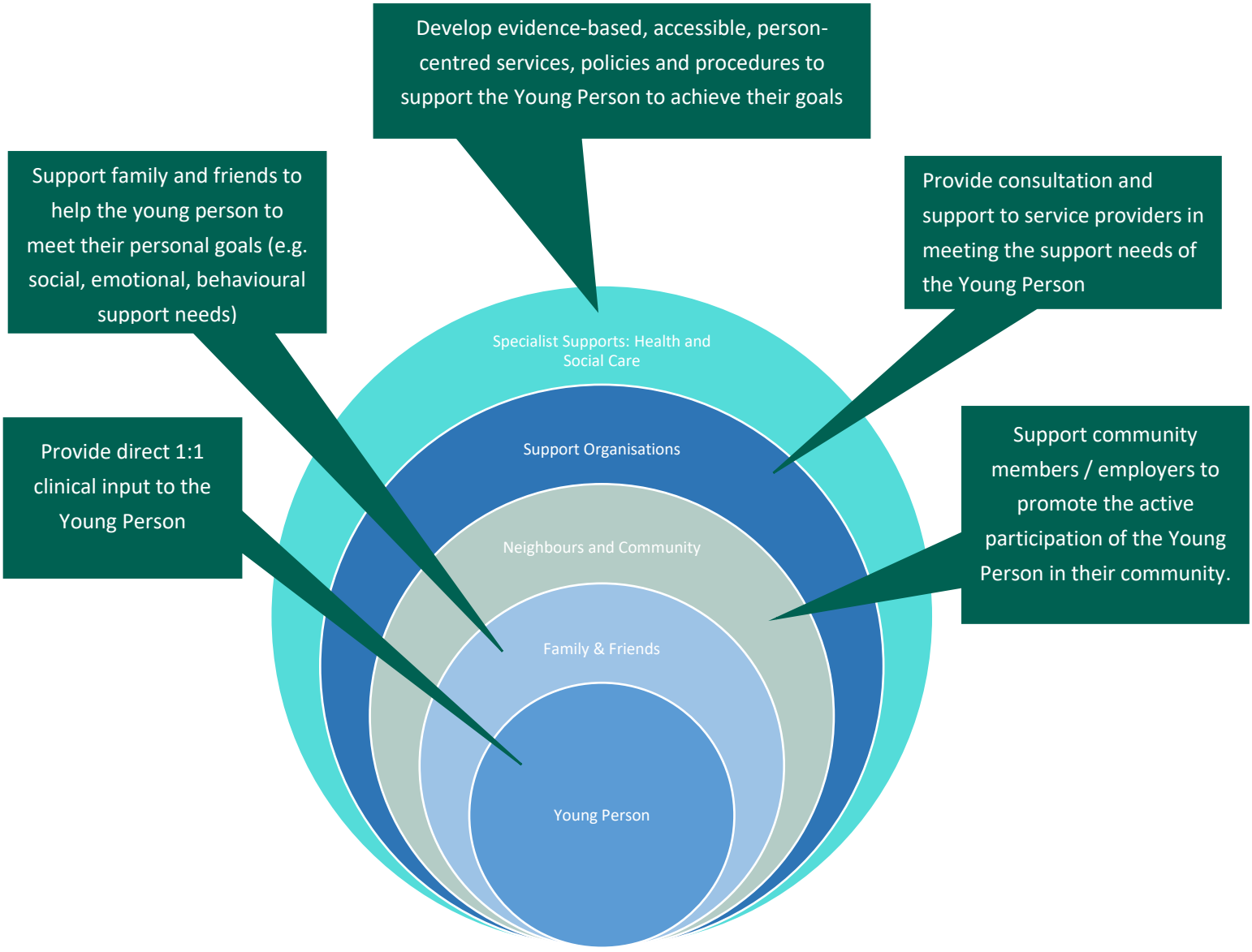

Figure 4. Circle of Support and the Young Adult Disability Team

Stepped Care

The MDT will be mindful of the need for services to make available interventions at the least intensive level which clinically meets the needs of the Young Person. Stepped Care is a system of delivering and monitoring interventions, so that the most effective yet least resource intensive treatment is delivered to individuals first; only 'stepping up' to intensive/specialist services as clinically required. In some cases, following review if clinically indicated interventions will be stepped up to the next most appropriate tier of the model. At the top of the stepped care model is individualised Psychological or Occupational Therapy brief interventions. In addition to the input provided on the team, it may also be necessary to refer to a specialist mental health team (e.g. Mental Health Intellectual Disability or Adult Mental Health Team). Equally, following receipt of an episode of care, or following receipt of referral, it may be most appropriate for the Young Person's needs to be met within Primary Care Services.

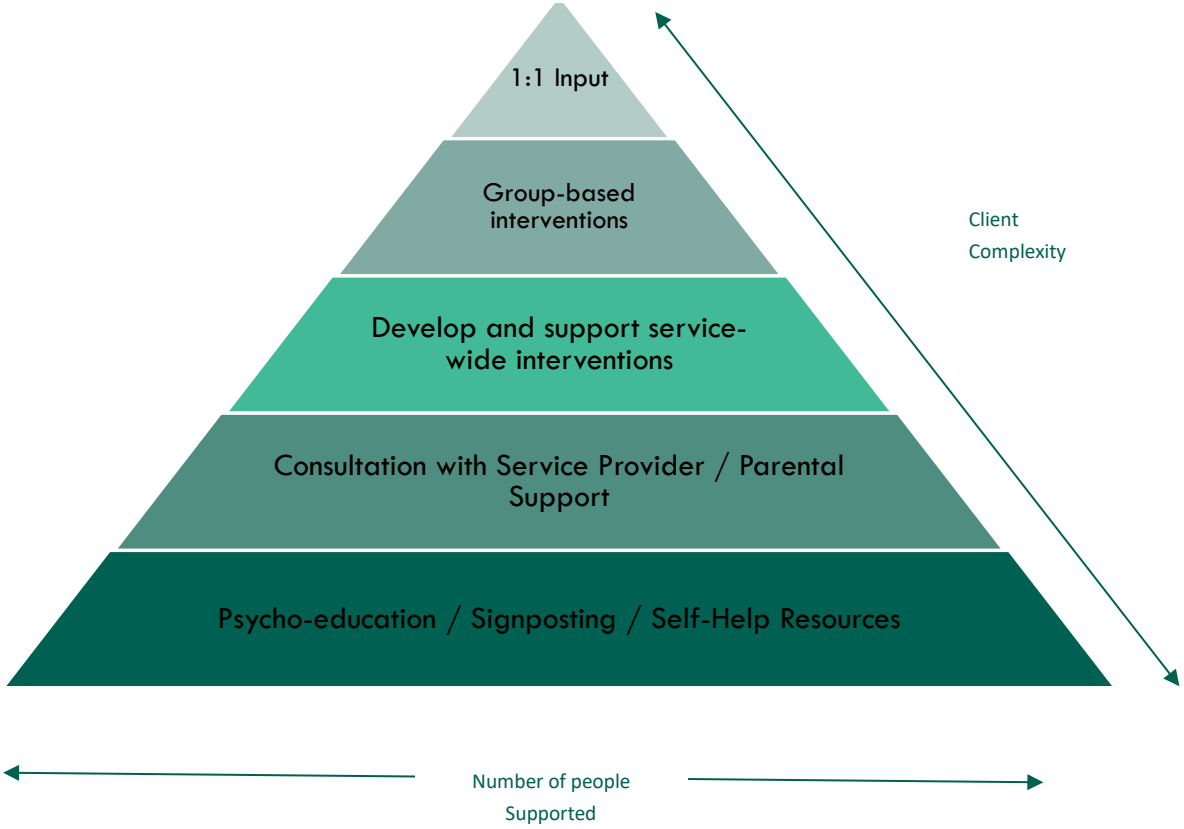

Figure 5: Stepped care model example

Trauma-informed

It is important that the Young Adult Disability Team delivers trauma informed services. This means that services are delivered recognising that individual's lives may be impacted upon by the presence of trauma symptoms. Trauma informed care is not intended to treat symptoms or issues related to particular trauma but rather to provide support services in a way that is accessible and appropriate to those who may have experienced trauma. This is implemented so as to reduce the possibility of triggering or exacerbating trauma symptoms or re-traumatizing individuals (Buffalo Centre for Social Research, 2021)

Cultural Competence

Sensitivity to cultural differences is entwined in the systems of service delivery which should be compatible with individual values and goals.
Each individual's unique cultural differences and diversity should be recognised. The uniqueness will inform the partnership in service delivery with the individual and their day service provider. The culture of each organisation needs to be acknowledged and appropriate aspects integrated within the culture of service provision from the School Leavers MDT.

Episodes of Care

In line with evidence based and evidence informed practice, services will be delivered through periods of active input targeting a particular person centred and functional goal. Consistent with the process used within CDNTs in the Mid West, the young person will be asked to identify specific goals which they wish to work on during the course of their engagement or active input with the team. The period of active input, when an individual would be open to the service and receiving intervention directly or indirectly, will be episodic in nature and initiated through a referral. The extent to which the goals identified at referral stage were met through the period of active input will be recorded and used to inform discharge.

The Young Adult Disability Team will work in partnership with stakeholders and the wider community to support and develop services and activities that achieve mutually beneficial outcomes which will involve universal and targeted approaches to service delivery as well as intensive/ individualised supports when needed by the young person and those who support them.

Clinical input will aim to complement and enhance rather than substitute primary supports, care or health services providing existing supports to the young person. The Young Adult Disability Team will aim to empower the young person and those who support them with tools, strategies, knowledge, skills and resources which will benefit the young person and will be transferable and applicable to other situations and goals where possible.

Initial Team Roles

Discipline	WTE
Senior Psychologist (Recruited) (0.5 WTE Clinical Psychology and 0.5 WTE Clinical lead role)	1.0 WTE
Occupational Therapist (Recruited)	1.0 WTE
Behaviour Therapist/Assistant Psychologist (Not recruited)	1.0 WTE
Total WTE	3.0 WTE

Current Team Member's Roles and Responsibilities

The Occupational Therapist will:

- Be responsible for assessment, planning, implementation, and review of treatment / intervention programmes for service users according to service standards.
- Manage own caseload in accordance with the needs of the post.
- Collaborate with service users, family, carers and other staff in treatment / intervention planning and in the provision of support and advice.
- Plan discharge or transition of the service user between services as appropriate.
- Document all assessments, treatment plans, progress notes, reports and discharge summaries in accordance with local service and professional standards.
- Communicate verbally and / or in writing results of assessments, treatment / intervention programmes and recommendations to the team and relevant others in accordance with service policy.
- Participate in teams as appropriate, communicating and working in co-operation with other team members.

- Attend clinics, review meetings, team meetings, case conferences, ward rounds etc. as designated by Senior Occupational Therapist / Occupational Therapist Manager.
- Arrange and carry out duties in a timely manner within settings appropriate to service users' needs and in line with local policy / guidelines.
- Maintain quality standards of practice and participate in quality assurance and clinical audit as appropriate.
- Seek advice and assistance from his / her supervisor / manager with any assigned cases or issues that prove to be beyond the scope of his / her professional competence in line with principles of best practice and clinical governance.
- Maintain professional standards in relation to confidentiality, ethics and legislation.
- Operate within the scope of Irish Occupational Therapy practice and in accordance with local guidelines.
- As a mandated person under the Children First Act 2015 you will have a legal obligation to report child protection concerns at or above a defined threshold to Tusla and to assist, if requested, in assessing a concern which has been the subject of a mandated report.

Senior Psychologist

The senior psychologist will provide a professional psychology service as part of a specialist multidisciplinary disability team providing supports to young adults as they transition from school age services to adult focused services. The Senior Psychologist will also act as Clinical Lead of the Young Adult Disability Team, a role that will require 0.5 WTE allocation. Therefore, the Senior Psychologist will work at 0.5 WTE capacity of the approved 1 WTE Senior Psychologist post while undertaking 0.5 Clinical Lead role.

The Senior Psychologist will:

- Be responsible for the delivery of professional psychology services within the team.
- Provide psychological assessments for the client group based upon the appropriate use, interpretation and integration of data from a variety of sources including psychological tests, self-report measures, direct and indirect observation and interviews with clients, family members and/or carers.

- Formulate and implement plans for psychological therapeutic intervention or management based on an appropriate conceptual framework, working in home and clinical settings as appropriate.
- Provide clinical supervision to other Psychology staff members and doctoral students as required.
- Exercise autonomous professional responsibility for the assessment, treatment and discharge of clients whose challenges are appropriately addressed using psychologically based intervention.
- Contribute a psychological perspective to case planning, formulation and multi-agency case working, and review and call multi-professional meetings when appropriate.
- Provide professional reports detailing psychological assessment and intervention in accordance with professional standards.
- Work within the limits of professional competence in line with principles of best practice, professional conduct and clinical governance.
- Represent and advocate for the psychological needs of the young people accessing the team.
- Work in and promote an ethical and professional manner at all times.
- Undertake a Key Worker role as appropriate within the team.

Research & Evaluation

- Utilise evidence-based literature and research to support effective practice.
- Conduct service evaluation research, embedding standard outcome measures within service provision, and provide such information as required by the steering group for the purpose of service monitoring and evaluation.
- Publish research outcomes in professionally recognised journals and share information on outcomes at professional conferences where appropriate.

Education & Training

- Provide post-graduate teaching and training to professional postgraduates including Doctoral Psychology trainees who form an important part of the psychology workforce within disability services.

- Provide supervision to the work of non-psychologists in the delivery of psychological interventions as appropriate.
- Provide psychological training, advice and consultation to staff from health and other agencies in areas relevant to direct clinical work and to psychology service provision.
- Provide professional and clinical supervision to trainee psychologists.
- Provide supervision as appropriate on running group-based intervention groups for other professions.

Clinical Lead (0.5 WTE)

The purpose of the clinical lead role is to achieve the best clinical outcomes and experience for young people accessing the Young Adult Disability Team within the available resources for the team. The work of the Clinical Lead will be aligned with national policy and health strategy. The Senior Psychologist will be required to provide overall clinical leadership for the team in addition to providing clinical input.

Clinical / Professional:

- Responsible and authority for clinical effectiveness and outcomes ensuring quality and safety systems are in place within the resources available.
- Lead clinical practise development of the team and oversee research activity to drive quality improvement.
- Ensure meaningful and effective service user engagement in service development, review and oversight.
- Lead the design, development and execution of the Model of Service for the Young Adult Disability Team.
- Identify service development priorities, protocol and procedural priorities, and prepare business cases in consultation with the Day Opportunities Manager when resource needs are identified.
- Attend YAD steering group meetings as a steering group member.
- Work closely with colleagues in primary care, child and adult disability services, mental health, and acute care services to ensure an integrated response for young people referred to the team.

- Participate in the recruitment of permanent, temporary and locum staff as required.
- Build professional networks to remain up-to-date and influence local and national service provision in this area.
- Manage and co-ordinate the work of the team in consultation with the Day Services Manager by providing clinical leadership in relation to the acceptance of referrals, prioritisation, provision of evidence-based service and discharge.
- Assign duties and responsibilities as appropriate to ensure effective and efficient service delivery.
- Support the maintenance of appropriate service user records and statistics in accordance with HSE requirements and local guidelines, Freedom of Information Act, Data Protection Acts and other relevant legislation.
- Provide service reports or data regarding service activities as required.
- Contribute to the development and implementation of information sharing protocols, audit systems, referral pathways and integrated care arrangements.
- Contribute to or undertake project management including audit and service evaluation with colleagues within the team to inform and develop service provision.
- Contribute to policy development, service planning and budgetary control in conjunction with the day opportunities manager and relevant others.
- Communicate with relevant stakeholders, referrers and agencies regarding the remit of the team and negotiate shared care agreements with services as appropriate.
- Assist in ensuring that the team makes the most efficient and effective use of developments in IT.
- Maintain professional standards with regard to service user and data confidentiality.
- Monitor and guide the operation of the team to ensure that practices and protocols are in line with the agreed Model of Service.
- Monitor and evaluate service quality through routine collation of data and auditing service practices against national quality standards.

Assistant Psychologist / Behaviour Therapist

Work under the supervision of the senior psychologist to utilise psychological theory, research and evidence-based interventions in order to support young people referred to the team to achieve their individual goals.

Under the direct supervision of a professionally qualified Psychologist, the Assistant Psychologist will:

Clinical / Professional:

- Inform team-wide case discussion and formulation by providing a psychological perspective of a young person's presenting difficulty.
- Work collaboratively with other disciplines to provide comprehensive multidisciplinary intervention to enable young people to achieve their goals.
- Work within the parameters of the team Model of Service.
- Complete and maintain updated certification of statutory training, along with other training requirements as outlined by the senior psychologist and / or the day opportunities coordinator.
- Work as a member of the YAT multidisciplinary team.
- Take on a keyworker role within the team where appropriate.
- Prepare professional reports to an appropriate standard and communicate promptly and in an appropriate manner with young people and their families.
- Work within the limits of their own professional competence.
- Work in compliance with professional guidelines e.g. Psychological Society of Ireland's (PSI) Code of Ethics, National and Area Health Service Executive (HSE) guidelines (e.g., Children First: National Guidance for the Protection and Welfare of Children, 2011), local policies, protocols and guidelines, current legislation (e.g. Data Protection Act (2003).
- In line with the Model of service, screen referrals and contact service users to obtain further information or offer initial appointments as appropriate.
- Contribute to prescribed triage assessments of service users using standardised semi-structured interviews; formal psychometric instruments; and direct observation.
- Provide reports of clinical input as required in accordance with required standards.

- Integrate assessment findings to inform clinical case formulations. Where appropriate, and in line with evidence-based practice deliver a range of evidence-based interventions to service users.
- Undertake prescribed supportive work with carers, family members, health staff and other professionals.
- Assist the Senior Psychologist and other team members in the process of referring service users onto other services where needed.
- Offer consultation services to referrers, including the provision of pre-referral advice. Promote the work of the team by providing relevant information to various stakeholders (e.g., the general public, referrers, day service staff)
- Assist the team in the process of providing training to other health care staff.
- Promote a culture that values equality, diversity and respect in the workplace.
- Participate in scheduled formal supervision and seek informal additional supervision when required.
- Maintain appropriate service user records, databases and statistics in accordance with HSE requirements and local guidelines, Freedom of Information Act, Data Protection Acts and other relevant legislation.
- Produce information leaflets, webinar's, therapeutic resources and carry out other tasks necessary to the efficient running of the team.

Research & Evaluation

- Undertake and participate in research to inform person-centred service provision.
- Undertake and conduct audits of key performance indicators to monitor the quality of service delivery.
- Collect service user and service performance data for the purposes of service evaluations.

Multidisciplinary Team Working

There are two well-established models of multidisciplinary team working within this area of service provision i.e. the keyworker model and the case management model. The keyworker model is predominantly used within community mental health teams. The model is presented here as an example of how to structure and carry-out multidisciplinary team working. A description is provided as outlined in Multidisciplinary Team Working from Theory to Practice (Mental Health Commission, 2006)

Description of the Keyworker model with triage at point of referral

The keyworker model has been in use for some time in Ireland and in the UK, it incorporates triage at the point of referral. Keyworkers are the prime therapist for each service user and can come from any of the professional disciplines. In exercising this role, keyworkers coordinate and lead the care plan and serve as the service user's and carers' main access point to the team. Every individual in receipt of care has a keyworker. Their primary role is to deliver and manage care to service users.

A shared management structure operates in this model, with three key roles, that of clinical lead, team coordinator and business manager. The clinical leader of the team exercises a broad range of functions. These include ensuring probity of team functioning, achieving team cohesion and providing vision and direction for service development. These functions can only be served in a setting of genuine respect between different professionals on the team and in the sharing of decision-making. A close working relationship between the team leader, team co-ordinator and team manager is critical to the successful functioning of the team. The team co-ordinator manages the team's clinical business. The team coordinators serve as a single point of access to the team, a function that brings them into close relationships with referrers and other referring agencies.

The team coordinator has responsibility for monitoring the workloads of all team members and taking a lead role in auditing team activity. They have responsibility for keeping team members informed of relevant clinical matters and team activities. They have particular responsibility for liaising closely with the clinical team leader and liaising with other services and with groups and agencies in the wider community. The business manager is responsible for all the administrative tasks associated with ensuring the smooth running of the multidisciplinary community mental health team. This person has responsibility for managing the budget and related administrative functions. They also have a role in enabling audit, review and monitoring functions, and ensuring that support systems to enable this are in place, such as IT systems and administrative support staff.

The current compliment of professionals on the Young Adult Disability team does not allow for the full realisation of the roles described in this model. However, as the clinical caseload increases and the staffing resources on the team increase, it is

proposed that the team adopt the team working model and roles as described above (discussed further in Projected Personnel Needs).

Keyworker Model

Following acceptance of a referral to the team, each service user will be allocated a keyworker from within the team. Key workers are allocated in a manner that relates to the primary focus of the intervention and also in line with the training and skills of team members. Throughout the service user's episode of care, the key worker will work collaboratively with the service user in some of the following ways:

- Be the main point of contact of the service user and their family with the team.
- Coordinate all stages of the service user's journey during their episode of care with the young adult's team.
- Work in partnership with service users and their family to inform them of each stage of their journey.

Management and Governance Structures

- The HSE is the employer for the approved team posts.
- The team will report directly and will be under the line management of the Day Opportunities Manager, HSE Mid West.
- The Senior Psychologist's reporting relationship for clinical governance and clinical supervision will be to the Psychology Head of Discipline.
- The Occupational Therapist's reporting relationship for clinical governance and clinical supervision will be to the Occupational Therapist Manager in Primary Care. Head of Discipline. Mr. Mahesh Dayalan – Occupational Therapist Manager in North Tipperary East Limerick Services has kindly agreed to provide this support.
- The team's functioning will be reviewed by the YAD Steering Group and any substantial changes to the Model of Service, referral criteria, team personnel, team structure or reporting relationships will be subject to approval of this Steering Group.
- The clinical work of the team will be led by the senior psychologist who will be the clinical lead and the line manager both operationally and professionally of the Assistant Psychologist / Behaviour Therapist and other approved psychology staff.

- All team members will access clinical supervision from within their profession and in accordance with the requirements of their respective professional bodies and / or CORU.

Clinical Governance

The 'International Framework: Good Governance in the Public Sector' suggests a number of high-level governance principles which should underpin the governance arrangements in public sector organisations. The YAD Steering Group will have responsibility for monitoring the overall progress of the team, ensuring that the team is operating within scope and directing overall staffing and operation of the team.

- The Steering Group will oversee the set up and establishment of the new team.
- The team will report to the Day Opportunities Manager operationally.
- The aims, scope, model of service and overall functioning of the team will be reviewed by the Steering Group.
- Membership of the Steering Group will be reviewed and added to as agreed at steering group meetings. Initial composition will include:

    - Disability Manager
    - Day Opportunities Manager
    - Occupational Guidance Adviser
    - Service User Representative
    - Principal Psychology Manager Limerick
    - Occupational Therapist Manager, North Tipperary East Limerick
    - Senior Psychologist / Clinical Lead

Terms of reference of the Steering Group to include:

- Sign off on the operational policies, procedures, protocol and guidelines (PPPG)'s developed for the team/service
- Ongoing review of the service
- Agree and review the Key Performance Indicators for the service
- Review the operations of the team and make recommendation in relation to enhancement and performance.

A central responsibility of the multidisciplinary team is the implementation of systems of clinical governance. Clinical activity will be monitored and will focus in as much as is practicable on outcomes, and objective measurement instruments will be used in achieving this. The Young Adult Team will make such data available for the review of the steering group in accordance with the YAD Steering Group Terms of Reference.

Key Performance Indicators (KPIs)

In line with the person-centred approach of the team and the principles of New Directions, Key Performance Indicators will seek to measure the impact of engagement with the team on a Young Person's Quality of Life, and the extent to which the person's own goals were met through their involvement with the team. Therefore, Standardised Outcome Measures (SOMs) designed to assess Quality of Life and a person's goals will be implemented as standard practise at baseline (referral) and pre discharge to evaluate the efficacy of interventions provided. These measures will be used to evaluate the impact of the service over a one year period.

Standard Outcome Measures / Quality Indicators

Quality of Life Measure**:** Adapted version of the World Health Organisation Quality of Life Brief Measure (WHOQOL – BREF)

Personal Goals**:** Collaborative goal setting has been adopted by the Children's Network Disability Teams in HSE MID WEST COMMUNITY HEALTHCARE. To promote consistency and ease of use a similar goal-setting structure will be used to establish and review the goals of each young person who accesses the Young Adult Team. Personal goals will be identified at referral stage, reviewed throughout engagement with the team and formally recorded again pre-discharge,

Person Centred Planning input: MDT member involvement in supporting the development, review or inclusion of recommendations in an individual's Person Centred / Personal Plan will be recorded. Episodes of care may highlight support needs or future goals may need to be included, in consultation with the young person in their person centred plan.

Team Activity / Caseload (monthly):

- No. of individual face-to-face assessment / intervention sessions
- No of face-to-face group-based intervention sessions

- No of individual telehealth assessment / intervention sessions
- No of family-based assessment / intervention sessions
- No of consultations with keyworkers / service provider staff
- No of consultations with other agencies / schools / family
- No of sessions allocated to service-wide interventions / staff supports / training
- No of professional assessment / intervention reports completed

Team Responsiveness (recorded monthly)

- No of Young People referred to the team by a service provider
- No of cases opened
- No of cases closed
- No of episodes of care provided
- No of Young People on the Waiting List
- Longest wait-time on the WL
- Average time for YP on the WL from referral to receiving intervention.

Team Activity and Team Responsiveness KPI's will be recorded monthly and will take account of team staffing levels and leave arrangements. The extent of detail provided and frequency of recording will be reviewed regularly. Given the need for professionals on the team to prioritise clinical work in light of current staffing on the team, administrative support will be required to support completion of up-to-date KPI's for the team.

Initially, and reflective of the lack of dedicated administrative support or protected time allocated to the role of project co-ordination the team will prioritise the recording of Team Responsiveness Data. Upon review by the steering group and following the allocation of sufficient resources to this task, the additional KPI's proposed above will be recorded.

Supervision

Support and supervision is a process to provide a regular opportunity for the professional to review and reflect on organisational and professional and clinical functioning. It is a partnership to establish, maintain and/or elevate the level of an individual's performance within services. It is the responsibility of all staff and his/her manager/s to actively participate in this process.

A clear reporting relationship will be identified in the supervision agreement for each team member.

- Supervision is provided within the team member's own discipline
- Senior grades will provide supervision for staff grades as appropriate and in line with each discipline's code of practise.
- Supervision should take place in a regular, planned and structured manner.
- Support and supervision is a confidential process, however issues arising may need to be addressed elsewhere.
- Supervision may involve clarifying any personal issues that may be affecting work performance but is not intended as personal counselling and other avenues are available within the employing organization.
- Reflection and feedback are key components for both participants in the process.
- The supervision meeting should follow a set framework. Issues raised by either party may need to be addressed following the meeting and this process should be planned.
- A supervision record is completed during each meeting which both parties agree, sign, and a copy of this record is kept.
- A supervision file for each individual staff member must be kept in accordance with confidentiality policy.

Team Accommodation

The team will support individuals to develop valued roles within their community. Premises and facilities in which the team conduct their work will be accessible and designed to support the delivery of community-focused, high quality, person-centred and safe services. Ability to travel, access to public transport and the geographical location of the individual will be taken into account.

The Interim Standards for New Directions, services and supports for Adults with Disabilities outlines:

Standard 2.12 Premises and facilities are designed to support the delivery of community-focused, high quality, person-centred, and safe services and supports.

The team will provide services as appropriate and in agreement with the Young Person in a separate community-based clinical space away from their Day Service where possible. Where it is more acceptable or feasible for the YP, team members will meet with the YP / family members / staff in a separate room in their day service. A room will be made available to the team by the Service Manager. The location of clinical work will be based on the individual needs of the Young Person. In order to access community-based interventions provided by the team it may be necessary for additional supports to be put in place such as transport or staffing support. Additional supports will need to be arranged with the Day Service provider in advance of the appointment.

All Young Adult Team members will require access to a desk / computer / phone and internet access in order to carry out their duties. The ability to utilise a clinical space separate to rooms available in day services will reduce travel time for clinicians and potentially improve efficiency of the team (see Appendix 6 Challenges and Enablers identified by established YADT).

Team Location & Logistics

- The team will provide a service across the entire CHO Mid West area.
- It is envisaged that the team base will be a Limerick City location.
- Team members may utilise clinical and administration space within HSE Disability services and day services as appropriate and in agreement with the day opportunities manager and day service manager as appropriate.
- The team base will include both administration space and accessible clinical space for assessment and intervention.
- When members of the MDT travel to provider organisations, a suitable room will be provided for meeting client and/or staff training.

Projected Personnel Needs

Senior Speech and Language Therapist 1 WTE

Service providers in this area have identified a significant need in the current cohort of young people to access Speech and Language Therapy, a discipline that families in this area are primarily accessing privately currently. Young people referred to the YADT will be transitioning from CDNTs where they previously had access to Speech and Language Therapy input prior to leaving school. Given that the profile of school leavers in this area indicates a high proportion of individuals with a diagnosis of ASD,

the social communication needs of young people transitioning to HSE day services is likely to be substantial.

Administration Support – Grade IV 1 WTE

Administration support is necessary for the operation of the team. This has been identified as an immediate need in order to commence safe and effective provision of clinical services and is an established and much-needed role in the YADTs currently in operation (see Appendix 1 staffing on YATs). This role will be required in order to:

- ensure safe recording and updating of client data
- communicate promptly with families, professionals and services regarding referrals / appointments / interventions / service-wide resources / discharge
- update information systems in-line with national standards
- maximise the clinical time of team members by carrying out administrative tasks required for effective team functioning

0.5 Senior Psychologist Post

- 0.5 WTE of the approved Senior Psychologist post is currently allocated to the role of Clinical Lead for the team.

The aim of the Young Adult Team is to provide comprehensive multidisciplinary interventions to address the range of needs of the service user. The team will aim to achieve this through the resources available on the team. Any broadening of referral criteria or increase in individuals being referred to the team will require an increase in the roles on the team to include those identified in the Mental Health Commission's Multidisciplinary working document (2006).

The key administrative and clinical functions required to ensure good governance and efficient use of clinical resources include:

1. *Clinical leadership – a lead clinician will articulate the collective vision of the team and ensure clinical probity.*

2. *Team Co-ordination – The team co-ordinator's functions should include the administration and triage of referrals in consultation with the clinical lead and the team, managing waiting lists, organisation of team meetings, liaising with referrers and other agencies or services.*

3. *Practice Management – Administrative functions of the team such as budgeting, auditing, data collection and evaluation, IT and systems management should be carried out by the practice manager.*

Non-pay budget

The team will require access to a team budget to facilitate the cost of:

1. assessment measures
2. access to journal articles / books / client resources
3. stationery
4. therapeutic equipment and materials
5. professional training
6. information systems access and support
7. equipment to support an accessible clinical environment

The non-pay resource needs of the team will be reviewed by the team and brought to the Steering Group for consideration and approval.

Additional Approved YADT Documentation:

1. Steering Group Terms of Reference
2. Safeguarding Statement
3. Referral and Easy Read Consent Form
4. Standard Consent Form
5. eReferral Standardised Operating Procedure
6. Easy Read Information Leaflet

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Young Adult Disability Team Referral Form

Criteria for Referral to the Young Adult Disability Team

- The Young Person attends or has accepted a place in a HSE-funded Adult Day Service in HSE Mid West Community Healthcare.
- The Young Person has or is due to leave school in 2022 or thereafter.
- The Young Person presents with complex needs that would not be more appropriately addressed within the uni-disciplinary or multidisciplinary framework of Primary Care Services.
- The Young Person left school within the last 3 years.
- The Day Service that the Young Person attends or is due to attend does not have provision for multidisciplinary team support as part of their Service Level Agreement.

Please tick to indicate that the young person meets criteria for referral as described above:

Tick box here ☐

Date of Referral: **Referrer Name:**

Referrer Occupation: **Referrer Contact Details:**

YOUNG ADULT'S PERSONAL DETAILS	
Surname:	**First Name:**
Gender:	**Date of Birth:**
Address: **Eircode:**	
Family contact phone number:	**Young Adult contact phone number:**
Family Email address:	**Young Adult email address:**

Country of Birth:	**First Language:** **Other languages spoken at home:**
School	
Name of School: **Contact Details:** **Year School Completed / Due to Complete:** **School Principal:** **Name of Year Head or school personnel with most knowledge / experience with the young person:**	
REASONS FOR REFERRAL	
What are the main concerns and priorities for the person and their family? **What would the person like support with?**	1. 2. 3.
Are there any supports/strategies already in place to support this identified need? Please detail.	

What outcomes does the person hope to get from this referral?	

OTHER COMMUNITY HEALTHCARE SERVICES **List all other services currently involved or waitlisted /previously involved with the young person.**	
Has the young person previously attended the Children's Network Disability team or other school age clinical teams? **Please provide details of team**	**Primary Care:** **Speech & Language Therapy** ☐ **Occupational Therapy** ☐ **Physiotherapy** ☐ **Psychology** ☐ **Other (please give details)** ☐
Mental Health Service ☐	**Tusla** ☐
Other (Please give details) ☐	
DAY SERVICE DETAILS	
Day Service Name:	**Keyworker Contact Name:**

Specific Day service Location/Address:	**Key Worker phone number/email:**
Manager/Contact Person of Day Service:	**Manager phone number/email address:**
MEDICAL HISTORY (Attach any relevant Medical Reports)	
General Practitioner (Name, address, contact number):	
Relevant Medical History/Surgical Intervention:	
NEURODIVERSITY / DIAGNOSES	
Has the young person received any professional diagnoses indicating an Intellectual Disability, Autism, Sensory Impairment or others? Please Describe and attach relevant reports.	
Current Medications:	
Allergies/Adverse medication events:	
Current investigations (Is the young person currently undergoing any health investigations or assessment?):	

SOCIAL CIRCUMSTANCES
Relevant family and social history, for example; family health or housing difficulties, financial or employment problems, bereavement or other stressors.
Please identify the strengths / interests and capacities that would be helpful for the team to be aware of when working collaboratively with this young person, their family and service provider:
Please provide any additional information here:

Please email your referral together with each of the documents listed below to: YADT@hse.ie

1. Completed YADT referral and appropriate consent form
2. Copy of the Occupational Guidance Profiling Tool
3. Copy of the Young Person's Person Centred Plan / Family Centred Plan / Individualised Plan
4. Copies of all relevant Professional Reports

Please password protect any documents which include identifying information before sending. Please avoid using identifying client health information in the body of the email.

Profiling Tool 2022

Profiling Details

Person's ID:	
Service/School Name:	
Name:	
D.O.B.:	
Profiler:	
Others Present at Meeting:	
Date:	

Was the interview conducted remotely &/or in-person?	
Attend Anywhere	**Yes / No**
In person	**Yes / No**

Was the purpose of the tool explained to the service user?	
Yes	**No**

What areas of your life do you most enjoy or value?	
Details of where the person lives: **Does the person live in the family home (either partially or wholly)?**	
Yes	**No**

Part 1 - Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL)

ADL/IADL scale

(use scale below, base answers on a typical week)

0 = Fully Independent	NO support required from another person. May use equipment, adaptations, telecare, etc.
1 = Largely Independent	The person is largely independent in the activities of daily living. They might need minimal support OCCASIONALLY.
2 = Partial Independence	The person has limited independence: OFTEN requires prompting or coaching to undertake activities of daily living or accessing the community.
3 = Limited Independence	ALWAYS OR NEARLY ALWAYS requires SUPERVISION, prompting or assistance to undertake activities of daily living or accessing the community (other must be present).
4 = High Support Needs	The person requires extensive full physical support to complete the activities of daily living. Requires activity to be undertaken by ONE other.
5 = Very High Support Needs	The person requires extensive full physical support to complete the activities of daily living. Requires activity to be undertaken by TWO OR MORE people.

Record current situation, taking into account the effect of equipment, adaptations or telecare already in place.

Comments recommended for scores, in particular 3 or higher

Question	Score	Comment
Eating/Drinking (0-5)		
Dressing (0-5)		
Maintaining personal appearance (e.g. shaving) (0-5)		
Washing whole body (e.g. taking bath, shower) (0-5)		

Using the toilet/managing continence (0-5)		
Staying comfortable (e.g. in a bed or chair) (0-5)		
Preparing drink/snacks (0-4)		
Housework (0-4)		
Keeping occupied (0-5)		
Getting out and about (0-5)		
Keeping appointments (0-5)		
Life planning/management (0-4)		
Anxiety (0-4)		
Sensory Processing challenges (0-4)		
Ability to understand others (comprehension) (0-4)		
Verbal ability (0-4)		

Part 2 – Medical

Section A – Exceptional Medical Needs

Comments recommended for scores, required for scores 4 or 5

Level	Description	Tick box	Comments
0 = Fully Independent	NO medical needs.		
1 = Largely Independent	The person is independent in medical needs but may need OCCASIONAL support.		
2 = Partial Independence	Prompting or coaching to support medical needs.		
3 = Limited Independence	Needs one or two others to support medical needs (e.g. 2 SNAs) but the medical need does not require daily nursing/medical supervision.		
4 = High Support Needs	The person requires daily MEDICAL/NURSING SUPPORT to meet medical/nursing needs. SUPPORT MUST BE PROVIDED BY ONE MEDICALLY TRAINED STAFF MEMBER.		

5 = Very High Support Needs	The person requires daily medical/nursing support to meet medical needs. SUPPORT MUST BE PROVIDED by TWO OR MORE MEDICALLY TRAINED STAFF.		

Section B – Interpretation

Level	**Tick Box**	**Comments**
None		
Irish Sign Language		
Lámh		
Other		

Section C – Seizures

Have seizures been exhibited on at least one of the last three days?	**Yes**		**No**	

Part 3 – Behaviour & Vulnerability

Comments recommended for scores, required for scores 3 or 4

Level	Description	Tick box	Comments
0 = No Difficulties	No apparent difficulties		
1 = Mild	Occasional behavioural problems that are out of the ordinary, causing concern to others. May be socially unacceptable or mildly self-harmful but insufficiently severe or frequent to substantially reduce social acceptance. Occasional concerns relating to vulnerability resulting from issues with independent travel,internet etc		
2 = Moderate	Behaviour(s) sufficiently frequent and severe to cause concern to others and/or reduce level of acceptance in social situations. Moderate concerns relating to vulnerability resulting from issues with independent travel,internet etc		
3 = Severe	Frequency and/or severity of behaviour causes serious concern. History of incidents involving actual harm to self, others or property as well as serious near misses. Behaviour seriously limits acceptance in ordinary social situations. Severe concerns relating to vulnerability due to history of difficulties, near misses etc.		

4 = Very Severe	This person exhibits behaviour that challenges (aggression, self-harm) to an extent that it is of constant, severe and prominent concern. This person has a history of serious actual harm to self or others or property. Continuous or near-continuous supervision or observation on a 1:1 basis is needed. Very severe concerns in relation to vulnerability, history of very serious incidences resulting in harm to self, others etc.		

Part 4 – Summary

Person's ID

Establish for Everyone

Information Sources –prior to Profiling will have requested information (tick all that apply)	Service User & Family	
	School/Education	
	RT Service	
	Psychology	
	Psychiatry	
	Behaviour Therapy	
	Speech & Language	
	Physiotherapy	
	Occupational Therapy	
	None Available	
	Other – Please Specify	
Disability (tick all that apply)	Autistic Spectrum Disorder	
	Head Injury	
	Hearing	
	Visual	
	Mental Health	

	Physical	
	Intellectual Disability:	
	Mild	
	Moderate	
	Severe/Profound	
	Not Specified	
	Specific Learning Difficulty	
	Other - Please Specify	
Is the service user receiving schooling? (circle the option which applies)	Special school Special class in mainstream Mainstream Other Unable or unwilling to attend school Not applicable	

Profiler Signature: _____ Date: _____

Young Adults Disability Team Standard Operating Procedure for the management of the Email Referral System

Purpose:

The Young Adult Disability Team recognises the need for an accessible, responsive, and transparent procedure for the administration of new referrals to the team. As outlined in the YADT Model of Service, the team is committed to establishing a paperless service. An effective e-referral system ensures a close relationship between all levels of health systems and helps to ensure service users receive the best possible care and support.

When compared to other more common referral methods such as FAX/postal, an email referral system can offer some of the following advantages:

- Reduce the risk of General Data Protection Regulation breaches.
- Environmentally and financially more sustainable means of communication.
- Increased speed of receipt of and response to referral.
- Reduce the level of administrative support required to process new referrals.
- A confirmation receipt of email can be provided automatically and immediately, explaining that new referrals are discussed at team meetings held on a fortnightly basis.
- The process will streamline administrative processes and ensure good communication with the referrer.

Referral Pathway:

As per the YADT Model of Service, referrals will be received from Occupational Guidance Advisors / Day Service Managers and Disability Case Managers in consultation with the Young Person, their family and keyworker as appropriate. Referrers are asked to email the appropriate documents in a password protected manner and to submit an additional email with password details. Referrers are asked to avoid using identifying / personal information in the body of the email.

Referrals to the team must include copies of the following password protected documents:

1. Completed YADT Referral and Consent Form
2. Copy of the Young Person's Family Centred Plan / Person Centred Plan / Individualised Plan
3. Copy of the Occupational Guidance Profiling Tool
4. Copies of relevant professional reports (e.g. Psychology, Occupational Therapy, Speech and Language Therapy).

To receive referrals, an email address has been established yadt@hse.ie which can be accessed by all clinicians on the team. Once a referral/email is sent to the YADT email address, the referrer will receive a return generic email to acknowledge receipt of the email. Clinicians will meet fortnightly to review and triage emails received. Referrers will then be contacted by a member of the team to inform them of the outcome. Following allocation of a new case to a keyworker on the team, that professional will become the main point of contact for referrers and other professionals with the team regarding that case.

Security

1. Only Young Adult Disability Team members will have access to the email account.
2. Team members will not share login credentials with anyone outside of the team.
3. Login to the team email account will only occur using HSE devices.
4. Team members will avoid storing login details in the same location.
5. Referrers will be asked to password protect all referral documents and to send an additional email with passwords. Referrers will be asked to avoid using identifying information in the body of the email.

Data Protection and Confidentiality

1. HSE and GDPR Data Protection policies outline strict guidelines on emailing patient identifiable information. A secure HSE email account is used to receive e-Referrals. Password protected documents will be used for sending any patient identifiable clinical information to the team. Otherwise, a patient should not be identifiable in an email or in any associated attachments.

Young Adult Disability Team members agree to implement HSE Personal Data Protection Policy. Of relevance to the eReferral system, the team are committed to upholding the following sections of the HSE Personal Data Protection Policy:

6.3 Processing of Special Categories of Personal Data

Special categories of data are defined by the GDPR and include data such as racial or ethnic origin, religious or philosophical beliefs, genetic data, biometric data, health data, sex life details and sexual orientation.

The processing of special categories of personal data shall be lawful where it is necessary:

(a) for the purposes of preventative or occupational medicine,

(b) for the assessment of the working capacity of an employee,

(c) for medical diagnosis,

(d) for the provision of medical care, treatment or social care,

(e) for the management of health or social care systems and services, or

(f) pursuant to a contract with a health professional.

Processing is lawful where it is undertaken by or under the responsibility of—

(a) a health practitioner, or
(b) a person who in the circumstances owes a duty of confidentiality to the data subject that is equivalent to that which would exist if that person were a health practitioner. For example the outpatient clinic secretary, Emergency Department Receptionist, Primary Care Centre Staff etc.

If the processing of data is not covered by the categories above the HSE will require explicit consent from the data subject.

6.4 Processing of Personal Data

1. The processing is necessary in order to protect the vital interests of the person (referred to as the data subject in Data Protection language). This would apply in emergency situations such as in the Emergency Department when unconscious, sharing information with other emergency services for rescue or relocation in storms etc.

2. The processing is necessary for a task carried out in the public interest or in the exercise of official authority vested in the controller; for the HSE this official authority is vested in us through the Health Act 2004 (as amended).

3. Processing of personal data is permitted where is necessary for the performance of a contract to which the data subject is party or in order to take steps at the request of the data subject prior to entering into a contract.

6.5 Data Storage Limitation Policy

The HSE should erase any personal data that violates;

- Data Protection Law
- Data Protection Regulations
- Contractual Obligations
- Requirements of this Policy
- If the HSE no longer requires the Data

6.6 Data Anonymisation and Pseudonymisation

The HSE must anonymise and / or pseudonymise personal data when it is being used for purposes other than the direct provision of public health and health and social care services.

6.7 Information Security

All HSE staff must familiarise themselves with the up-to-date information security policies which are available on https://www.hse.ie/eng/services/publications/pp/ict/information-security-policy.pdf

Referral Response Template:

Thank you for your email.

This response is to confirm receipt of your email to the Young Adults Disability Team. The team meets on a fortnightly basis to discuss new referrals where your referral will be discussed. Following the meeting, a member of the team will be in

contact with you. Please note that this email address is not monitored on a daily basis.

Description of CHO7 Team Young Adult Team Personnel

Role	WTE
Project Manager	1
Senior Social Worker	0.5
Staff Grade Occupational Therapist	1
Staff Grade Speech and Language Therapist	1
Staff Grade Physiotherapist	1
Behaviour Support / Assistant Psychologist	1
Administrator	0.6

*Psychology role vacant. Essential requirements identified by that team for the establishment of the Young Adult Team: Database module development to support GDPR-compliant recording of client data.

Overview of challenges and supports experienced in first year of the team's operation:

Challenges	Enablers
Rehabilitative Training referrals (broad range of support needs, age range, multiple professionals / episodes of care required).	Team co-ordinator role is a full time post currently filled by OT Manager. TC holds responsibility for the day-to-day operating of the team and is accountable for upholding quality standards and the provision of safe care.
Lack of Adult Primary Care / MHID / Adult Disability services to refer to following involvement with the team.	Operational database that all team members can access which facilitates recording of KPI's and reduces the need for paper-based files.
Inability to close cases, reducing accessibility of the service to School Leavers.	The use of eReferrals has led to swifter referral processes.

Safeguarding issues requiring longer-term team involvement.	Clear referral criteria and agreement at steering group promoted clarity and collaboration.
Administration support needs to support the team particularly in relation to KPI recording.	Development of webinars to introduce the team and communicate about professional's roles.
Lack of own accessible clinical space initially leading to inefficiencies / increased travel costs.	Service provider involvement in referrals led to more information and details regarding supports currently in place.
Need for agreement regarding definition of *complex needs* leading to inappropriate referrals.	Accessible accommodation with appropriate supports: kitchen space, hoist / plinth.

HSE Mid West Community Healthcare

Model of Service for the Young Adult Disability Team CHO 3

HSE MID WEST
COMMUNITY HEALTHCARE
Mental Health | Older Persons | Disabilities
Primary Care | Health & Wellbeing