

**COMMENTS OF THE FACULTY OF PSYCHIATRY OF LEARNING DISABILITY  
TO THE REPORT OF THE EXPERT GROUP ON MENTAL HEALTH POLICY  
"A VISION FOR CHANGE"**

The following points outline our Faculty's specific response to chapter 14 of the report "Mental Health Services for People with Intellectual Disability". Overall our Faculty welcomes this document and specifically the framework for the development of mental health services with people with intellectual disabilities. "A Vision for Change" represents the first piece of Government policy on the delivery of a mental health service to people with intellectual disabilities.

The Faculty supports the community based thrust of the intellectual disability mental health service and the equitable and multidisciplinary nature of the service.

We have a number of specific comments, which will be outlined below.

**1. Community Mental Health teams for children with intellectual disability.**

Recommendation 14.8 indicates that one mental health of intellectual disability (M.H.I.D.) team for 300,000 population should be provided for children and adolescents with intellectual disabilities. We feel that this catchment population is too large for one team to provide a service given the diverse nature of the service needed and that a more detailed analysis of need be carried out to arrive at a more appropriate team population ratio.

In addition the Faculty is very concerned at the absence of any training programme for specialist training in the psychiatry of intellectual disability for children and adolescents. This training deficit needs to be urgently addressed before any development in the community mental health teams for children with intellectual disability is advanced.

**2. General issues associated with catchment services.**

Because of historic patterns of service delivery, many people with intellectual disability are now concentrated for their residential needs in certain urban centres e.g. many people with intellectual disability services from around the country now live in residential services in the Daughters of Charity service in Dublin. There are many other examples of this around the country. These issues need to be taken into consideration in the distribution of teams based in catchment service population.

In addition if the many high need individuals who are currently in out of State placements are returned to Ireland, their geographical distribution needs to be factored in when new teams are being developed.

In addition, with the closure of psychiatric hospitals and the transfer of people with intellectual disability out into the community, there may also be disproportionate distribution of people in certain catchments and these also need to be taken into consideration.

### 3. The composition of multidisciplinary teams.

Paragraph 14.7 of the document lists the human resources required in each M.H.I.D. team. Many people with intellectual disability often have communication difficulties and we feel that speech and language therapy should also be a core component of the M.H.I.D.team.

With regard to the M.H.I.D. team members for children and adolescents, clearly speech and language therapy **and** play therapy needs to be included as core therapies in order to provide a quality service.

#### **General Comments**

While the development of M.H.I.D teams is hugely welcomed, it is very important that existing intellectual disability services are not drained of resources in the setting up of these new services. In order for a M.H.I.D. team to work effectively with people with intellectual disability, the intellectual disability services in general need to be well resourced.

And finally, the need for modern Capacity legislation needs to be addressed as a matter of urgency to assist in the appropriate working of both the mental health of intellectual disability team and the general intellectual disability service teams.

Dr. Philip Dodd,  
Chair,  
Faculty of Psychiatry of Learning Disability,  
Irish College of Psychiatrists.  
July 2006.