



mhc

coimisiún meabhair - shláinte
mental health commission

Guidance for staff providing mental health services to persons with intellectual disabilities

Promoting Quality,
Safety, and Human
Rights in Mental Health



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The MHC particularly wishes to thank Inclusion Ireland, the Department of Health and HSE representatives with relevant experience in the delivery of co-occurring mental health diagnoses and intellectual disability services for their constructive feedback, which played an important role in shaping this guidance.

Preamble



About the Mental Health Commission

The Mental Health Commission (MHC) is an independent statutory body. At present, it is responsible for regulating inpatient mental health services in Ireland. Its main role is to promote, encourage and foster the establishment and maintenance of high standards and good practices in providing mental health services, and to protect the interests of people admitted and detained (held) under the Mental Health Acts 2001–2018 ('the Mental Health Acts').¹ Its mission is to safeguard the rights of service users and residents, encourage continuous quality improvement and report independently on the quality and safety of mental health services in Ireland.

The Assisted Decision-Making (Capacity) Act 2015² (the 2015 Act) establishes the Decision Support Service (DSS). The 2015 Act provides a new framework for adults who may need support, now or in the future, to make decisions about their personal welfare, property or financial affairs.

The statutory functions conferred on the Director of the DSS include functions to promote public awareness of and confidence in the 2015 Act, to register and supervise the performance of decision support arrangements, to investigate complaints arising in relation to decision support arrangements and to publish codes of practice. The Director and the Director's staff are staff of the Mental Health Commission.

Development process

Following a tender process, the MHC commissioned Trinity College Dublin, led by Professor Fintan Sheerin, to undertake an in-depth evidence review of national and international literature, best practice and policy to inform the guidance for staff providing mental health services to persons with intellectual disabilities. The MHC also undertook an extensive public consultation process to inform the development of the guidance. The consultation process included:

- A survey, which received 240 responses from service users, family members, friends, carers and staff in services and organisations
- Interviews and focus groups with service users, their family members and staff working in mental health services and advocacy organisations
- Feedback on the draft guidance from key stakeholders, including Inclusion Ireland, the Department of Health and HSE representatives with relevant experience in the delivery of co-occurring mental health diagnoses and intellectual disability services

Purpose of this guidance

The purpose of this guidance is to support staff in delivering care and treatment to individuals with co-occurring mental ill-health and intellectual disabilities (MHID) across all mental health service settings, including inpatient units, community residences and community based services. It

promotes a person-centred approach that upholds and protects human rights, ensuring that care is inclusive, responsive and respectful of individual needs. The document provides clear, practical recommendations for everyday practice, grounded in evidence and best practice. By enhancing accessibility, collaboration and effectiveness across services, this guidance aims to strengthen the quality of care and improve outcomes for service users, while also supporting families and professionals involved in their care.

Scope of this guidance

This guidance provides practical strategies that service providers and practitioners can implement to improve outcomes for persons with MHID. It replaces the previous MHC document titled *Code of Practice: guidance for persons working in mental health services with people with intellectual disabilities*, which was published in 2009. This guidance is based on the most recent evidence review, current best practice and consultation with experts by experience and professionals.

While the primary focus of this guidance is on individuals with MHID, it recognises the broader spectrum of cognitive and neurological diversity, which are sometimes referred to as 'hidden disabilities'. They can co-occur with intellectual disability, and many of the principles outlined here apply to neurodivergent individuals with or without other conditions.

1. [Mental Health Acts 2001–2018](#).

2. [Assisted Decision-Making \(Capacity\) Act 2015](#)



Note: In this guidance, the term ‘representative’ is defined as an individual who has either been appointed by the relevant person (if it is a designated healthcare representative) or by the court (if it is a decision-making representative) to make specified decisions on their behalf should they lose capacity to make them at a future time.

The representative will usually be a family member, a friend or another trusted person identified by the Relevant Person, unless there is nobody willing or able to act on their behalf. In such instances, the decision-making representative may be appointed from the DSS Panel of independent representatives by the court.

Disclaimer:

This document does not provide clinical guidance on the care and treatment of individuals with MHID.

Introduction



Background and context

Intellectual disability (ID) is characterised by significant limitations in both intellectual functioning and adaptive behaviour, originating in childhood (1). According to CSO figures from Census 2022, 109,288 people reported experiencing an ID to any extent, representing approximately 2% of the population and 10% of all individuals who reported at least one long lasting condition or difficulty (2). There is a growing demand for residential care, with 8,036 people with an ID currently living in residential settings and lifespans continuing to rise (2).

People with ID can experience the same mental ill health as the general population, but evidence indicates a higher prevalence of mental illness in this group. Many individuals with ID are expected to fit into systems that were not designed with their needs in mind, and this lack of accommodation or adaptation can itself contribute to distress and the development of mental health difficulties. Timely and accurate assessment can be challenging, as mental health difficulties may present differently, particularly among those with moderate-to-profound intellectual disabilities. Symptoms are often misattributed to the disability itself, and some individuals may struggle to interpret or communicate their experiences, making diagnosis more complex (1).

A national study on ageing in adults with ID in Ireland found that 44.4% of participants had a diagnosed mental illness (3). Similar studies in the United States and Scotland also report high rates of mental health difficulties among people with ID (4, 5). These findings highlight the urgent need for accessible, inclusive and rights-based mental

health services. However, evidence shows that many services remain under resourced to meet the specific needs of individuals with ID, leading to delays in diagnosis and treatment. Mental health symptoms may be misattributed to the disability, a phenomenon known as diagnostic overshadowing (6). For example, classic symptoms of depression may present differently in individuals with severe or profound ID, making them harder to recognise and more likely to be misdiagnosed (7). Input from family members or carers can support diagnosis, though staff must remain cautious of confirmation bias (8).

Why this guidance is needed

The *Code of Practice: guidance for persons working in mental health services with people with intellectual disabilities*, published in 2009, offered direction for staff supporting individuals with both mental health needs and intellectual disabilities. However, this guidance is now outdated. Since its publication, significant developments have taken place, including:

- The introduction of the Assisted Decision-Making (Capacity) Act 2015
- The appointment of a national clinical lead for MHID in the Health Service Executive (HSE)
- The introduction of the HSE's Mental Health Services for Adults with Intellectual Disabilities National Model of Service (Adult-ID) and the specialist Child and Adolescent Mental Health Services in Intellectual Disability (CAMHS-ID) National Model of Service

In addition, there is now a stronger emphasis on human rights-based approaches within mental health services.

Key objectives

This guidance is designed to help staff working in mental health services to:

- Apply the nine guiding principles outlined later in this guidance to ensure care is rights-based, inclusive and responsive to individual needs
- Uphold human rights and autonomy in line with national and international legislation and guidance, including the MHC's Guidance for Irish Mental Health Services on the Adoption and Implementation of a Human Rights-Based Approach to Care and Treatment which can be found at the following link: https://www.mhcirl.ie/sites/default/files/2025-10/MHC_Human%20Rights%20Guidance_FINAL%20FINAL.pdf
- Provide person-centred care that recognises and responds to each individual's mental health needs
- Support individuals with MHID to participate actively in their care, ensuring their voice is heard and respected
- Use clear, tailored communication strategies to build understanding and trust, and apply best-practice evidence to guide decisions and service improvements
- Improve access to appropriate services by identifying and removing barriers wherever possible
- Work collaboratively across disciplines and services to deliver joined-up care
- Recognise safeguarding responsibilities, including identifying risks, preventing or reducing harm and using the least-restrictive approaches wherever possible
- Strengthen service quality through effective governance, leadership and continuous performance development

Current policies and research

Policies on mental health services for people with intellectual disabilities

Over the past decade, there has been growing recognition of the need to improve mental health services for people with ID. Policies now emphasise rights-based, person-centred care, ensuring individuals are actively involved in decisions about their treatment and receive support tailored to their specific needs.

In Ireland, the national mental health strategy *Sharing the Vision – A Mental Health Policy for Everyone* highlights ID as a priority area. It recognises the higher prevalence of mental ill-health among people with ID, calls for integrated service responses across Adult Mental Health Services (AMHS) and Child and Adolescent Mental Health Services (CAMHS), and emphasises rights-based, person-centred care. The policy also recommends workforce training, accessible communication and collaboration between mental health and disability services to improve outcomes. By embedding ID into *Sharing the Vision*, the policy ensures that mental health services are not designed solely for the general population but explicitly consider the unique needs of people with ID. This represents a shift towards inclusive, rights-based and person-centred care (9). The Strategy's 2025–2027 Implementation Plan includes a dedicated focus on MHID:

- Recommendation 50 recommends that the development of a national network of MHID teams and acute treatment beds for people of all ages with an intellectual disability be prioritised.
- Recommendation 51 recommends that speech and language therapists (SLTs) be core members of the Adult-ID and CAMHS-ID teams.
- Recommendation 57 recommends a tiered model of integrated service provision for individuals with MHID.

These recommendations build on and are in line with the Health Service Executive's Model of Service for Adults with Mental Health and Intellectual Disabilities (2020) and the HSE Model of Service for CAMHS Intellectual Disability (2022) but are dependent on funding and approval (10).

The HSE has developed service models to improve care for both adults and children with MHID. The Model of Service for Adults with Mental Health and Intellectual Disabilities sets out how services should support adults who have both intellectual disabilities and mental health needs. It emphasises person-centred care that respects rights and choices, delivered by specialist multidisciplinary teams including psychiatrists, nurses, psychologists,

social workers and therapists. The model highlights the importance of joined-up pathways between disability services, mainstream mental health services and community supports, ensuring that individuals do not fall between systems. Accessible communication is a core feature, with staff encouraged to use Easy to Read materials, sign supported communication, and other tailored approaches to enable meaningful participation. To deliver this effectively, staff need training in inclusive practice, trauma-informed care and specialist MHID approaches, building confidence and competence across the workforce. For service users and families, the model promises better access to appropriate supports, more involvement in decisions, and care that uphold dignity and human rights. Strong leadership, clear governance and ongoing evaluation are also central to maintaining quality and consistency nationally (11).

The CAMHS ID Model of Service sets out how children and adolescents with ID should have the same access to mental health care as their peers, delivered through specialist multidisciplinary teams. These teams include psychiatrists, psychologists, nurses, social workers, occupational therapists, and speech and language therapists, working together to provide assessment, treatment and ongoing support. The model highlights that mental health difficulties can present differently in children with ID, and stresses the importance of avoiding 'diagnostic overshadowing', where symptoms are wrongly attributed to the disability rather than recognised as mental illness. Services are designed to be person-centred, rights-based and recovery focused, with clear referral pathways, staged care journeys and planned transitions from child to adult MHID services. Collaboration across disability services, primary care, paediatrics, education and inpatient units is central to ensuring joined up care. Families are recognised as key partners, with accessible communication and tailored supports provided to help them participate fully. Governance structures, workforce training and continuous evaluation are built into the model to maintain quality and consistency nationally. Overall, the CAMHS ID framework aims to close gaps in provision, reduce barriers to access and deliver equitable, effective mental health care for children and adolescents with intellectual disabilities (12).

Internationally, similar policy developments reflect these priorities. In the UK, Building the Right Support aims to reduce long-term hospital stays and promote community-based care with timely access to appropriate support for individuals with a learning disability and autistic people (13, 14). In Canada, service pathways have been established to deliver mental health care tailored to individuals with ID (15).

Regulations and quality standards for mental health services

The MHC plays a key role in ensuring high standards in mental health services, including those for people with intellectual disabilities. The Mental Health Acts and the Mental Health Act 2001 (Approved Centres) Regulations 2006 ('Approved Centre Regulations')³ set out legal requirements for inpatient services, covering governance, safety and quality of care.

The MHC also has strict rules on restrictive practices, including:

- The Code of Practice on the Use of Physical Restraint⁴
- The Rules Governing the Use of Seclusion⁵
- The Rules Governing the Use of Mechanical Restraints⁶

These Rules and Code of Practice require the least-restrictive options to be used over the shortest duration of time, and that the restriction must be proportionate to the risk of harm in line with the human rights principles underpinning the Rules.

The Mental Health Commission's *National Quality Framework: Driving Excellence in Mental Health Services* builds on these regulations by outlining best practices for mental health services, whether inpatient or community-based (16). It promotes a person-centred, recovery-focused approach, ensuring that services are designed to:

- Support individual needs
- Uphold human rights
- Be inclusive and accessible
- Involve individuals in decisions about their care.

The regulatory framework and quality standards align closely with this guidance for mental health staff, which emphasises early intervention, evidence-based practice, staff training and integrated care.

The importance of this approach is reinforced in the National Quality Framework. Criterion 3.2.4 states: 'Mental health services should provide access to acute treatment beds for people of all ages when clinically indicated with a dual diagnosis of ID and mental health illness' (16). Meeting this criterion

may involve coordination with intellectual disability services, using audit data to monitor delayed admissions, and establishing robust systems to ensure appropriate access and care.

Similarly, Criterion 4.1.6 highlights: 'A multidisciplinary approach to mental health care should be provided for individuals with a dual diagnosis across the continuum of care' (16). This includes building strong links with primary care, disability services and community mental health teams; delivering care through specialist, well trained professionals; and ensuring services are coordinated and community based wherever appropriate.

Together, these standards and this guidance support the development of a modern, effective and rights-based mental health service – one that ensures people with ID receive safe, high quality, evidence-based and person-centred support across all levels of care.

Research

Analysis of the consultation survey, interviews and focus groups conducted by the MHC highlights a range of positive developments across services, including the appointment of a national clinical lead for MHID.

Staff were consistently praised for their empathy, dedication and willingness to adapt care to individual needs. Many staff sought specialist training and use inclusive communication tools. Some services prepare individuals by providing accessible pre-appointment documents to reduce anxiety and improve engagement. Multidisciplinary teams, where present, are recognised for their holistic, person-centred approach. Service users are increasingly involved in audits, feedback initiatives and advocacy roles within services. Training programmes for staff are evolving to include lived experience and practical methods like role-play. Community integration efforts and ID awareness campaigns reflect a growing commitment to inclusion and respect.

However, the MHC's consultation process and evidence review (1) also identified challenges in delivering services to people with ID, as outlined below:

3. [Mental Health Act 2001 \(Approved Centres\) Regulations 2006, S.I. No. 551/2006](#)

4. [The Code of Practice on the Use of Physical Restraint](#)

5. [Rules Governing the Use of Seclusion](#)

6. [Rules Governing the Use of Mechanical Restraints](#)

Key challenges

1. Limited access and eligibility barriers

- Mental health policies have not always fully addressed the specific needs of people with ID, which can contribute to gaps in service provision.
- While referral pathways are now outlined in the HSE's Model of Service (MOS), availability of services can still vary depending on location.
- Individuals with mild ID may not access ID services and instead attend general CAMHS or AMHS, which can create challenges in ensuring their needs are consistently recognised.
- Waiting times for assessment and treatment can be lengthy, which may increase stress for individuals and families.

2. Diagnostic overshadowing

- Mental health symptoms can sometimes be attributed to a person's ID, which may delay accurate diagnosis.
- Differentiating between mental illness and ID requires specialist training, which is not always available in general mental health services.
- Behaviours of concern may occasionally be misinterpreted, highlighting the importance of careful assessment and appropriate training for staff.

3. Communication barriers

- Service users do not always have access to accessible materials.
- Limited availability of speech and language therapists (SLTs) can reduce opportunities for tailored communication support and engagement.

4. Use of medication

- Psychotropic medication may be prescribed during crisis presentations, underscoring the importance of clear diagnosis and ongoing monitoring.
- Polypharmacy can occur, particularly among older adults with ID, and while alternative therapies are valued, they are not always available or resourced.
- Access to therapeutic respite services is limited, reducing opportunities for holistic approaches to care.

5. Staff training and turnover

- Not all staff have specialist training in MHID, and dual-qualification remains limited.
- Staff turnover can affect continuity of care and make it harder to build long-term trust with service users.
- Some psychiatry trainees have reported feeling underprepared to support individuals with ID, pointing to the need for strengthened training pathways.

6. Crisis and residential support

- Acute mental health services are not always adapted to meet the needs of people with ID, which can result in placements that are not ideal.
- Residential admissions may occur when early community-based interventions are not available.
- Families providing full time care may experience significant strain, particularly ageing carers, and benefit from additional supports.

Recommendations for services

To improve outcomes for people with MHID, services should:

- Provide specialist training for staff across both mental health and disability sectors
- Adapt diagnostic tools to reduce misdiagnosis and improve accuracy
- Conduct regular medication reviews to ensure prescriptions are appropriate and monitored
- Offer psychological therapies tailored to communication and cognitive needs
- Use digital tools such as telehealth where appropriate to improve access, particularly in rural areas
- Strengthen integration between mental health and disability services to deliver integrated, person-centred care
- Involve service users in shaping care through feedback, advocacy and co-designed training initiatives

These recommendations are grounded in evidence from the report *Evidence to Inform the Revision of Guidance for Staff Providing Mental Health Services to Persons with Intellectual Disabilities* (1) as well as the MHC's interviews and focus groups. They inform the following principles for providing care and treatment to people with MHID, and reflect a rights-based, inclusive approach to mental health care and treatment. The below principles are considered good practice and are especially important for individuals with MHID, who may face additional barriers to care and treatment.

Guiding Principles



1. Rights-based

Mental health services must embed a rights-based approach in all aspects of care for people with MHID, ensuring dignity, autonomy and equality are upheld consistently. This principle is informed by the Mental Health Commission's [Guidance for Irish Mental Health Services on the Adoption and Implementation of a Human Rights-Based Approach to Care and Treatment](#).

1.1. Respect for autonomy

- Staff should presume decision-making capacity by default, recognising that capacity is issue-specific and time-specific.
- Staff should recognise that communication difficulties do not diminish a person's capacity to make decisions.
- Services should always consider the person's will and preferences when planning care and treatment.
- Staff should explain options clearly, check understanding and encourage active participation in decisions, in line with relevant policies and legislation.

1.2. Inclusion and accessibility

- Services should deliver reasonable accommodations under relevant legislation.
- Staff should ensure individuals are supported to know and understand their rights to reasonable accommodations, advocacy and complaints procedures.
- Accessibility audits and feedback from service users should be used to drive continuous improvement.
- Services should actively reach out to people who face barriers to access, ensuring inclusion across rural, residential and community settings where possible.

1.3. Guarantee of dignity

- Care plans should reflect the person's legal rights, including autonomy, dignity, privacy and consent.
- Risk assessments and safeguarding measures should support autonomy and minimise restriction, using positive risk-taking approaches and clear rationales for any actions which limit freedoms.
- Services should embed dignity, safety and inclusion in care planning, avoiding labels and ensuring plans reflect the individual's values and identity.
- Restrictive practices should only be used as a last resort, and must be lawful, proportionate, time-limited and clearly documented.

1.4. Holistic and person-centred care

- Services should develop care plans collaboratively with individuals, their decision supporters and professionals, ensuring their voice is central.
- Staff should support recovery through strengths-based approaches, goal setting and accessible formats for care planning.
- Services should provide a range of therapeutic options beyond medication, including talk therapies, creative therapies and sensory supports where possible.
- Staff should adapt therapies to suit communication and processing needs, using visual aids and supported decision-making tools.

1.5. Transparency and accountability

- Staff and services should transparently share information on the safety and quality of the service that they provide, including regulatory reports and audit reports.
- Service providers should promote a culture of learning and continual improvement whereby staff are encouraged to reflect on incidents and aspects of good practice to support overall service improvement.
- Service providers should have robust systems in place to reduce, eliminate and publish restrictive practice data in line with MHC Rules and Codes of Practice. Leadership teams should use data, feedback and lived experience to drive continuous improvement.
- Inter-agency collaboration should uphold the person's choices, rights and cultural identity, embedding these values in care plans and service policies.

1.6. Stigma reduction

- Staff should be trained in disability rights, anti-ableism and rights-based frameworks to foster respect, dignity and equality.
- Training should challenge stigma and unconscious bias, and promote humility, positive risk-taking, choice and self-determination.
- Services should embed a culture of inclusion and respect through ongoing education, reflective practice and inclusive policies.
- Staff should recognise that behaviour may be a form of communication and respond with empathy, curiosity and a commitment to understanding underlying needs.

2. Person-centred care

Mental health services should take a holistic, person-centred approach to care and support of those who present with MHID. Staff should prioritise each person's individual preferences, communication needs and overall well-being, offering flexible, tailored support that respects autonomy and lived experience.

2.1. Recognising mental health needs

- Staff should ensure that mental health is assessed using structured assessment tools, assessing across settings and consulting with multidisciplinary teams and carers to avoid diagnostic overshadowing where possible.
- Staff should carry out holistic assessments that include the person's communication style, preferences, support needs and strengths, using input from the person, their decision supporter and other professionals where appropriate.
- Services should support recovery by involving individuals in setting their own goals as appropriate, using strengths-based approaches, and offering choices in care planning through accessible formats and supported decision-making.

2.2. Reducing over-reliance on medication

- Services should be resourced to offer a variety of therapeutic options, talk therapies, sensory-based supports and creative therapies (such as art or music therapy) tailored to each person's individual preferences and needs, and evidence-based treatment of the person's mental ill-health.
- Staff should discuss these options during care planning to ensure individuals are aware of alternative options to medication available on the team if clinically indicated.
- Staff should conduct regular medication reviews in collaboration with the prescribing clinician, a pharmacist, the individual and their decision supporters to ensure that prescriptions remain appropriate.
- Staff should document observed effects and raise concerns about side effects or over-reliance on medication.
- Services should provide access to therapeutic respite, such as short breaks in calming environments or structured day programmes, to help individuals manage distress and reduce the need for medication as a first-line response.
- Staff should adapt therapies to suit individual communication and processing needs by using visual aids (e.g. picture schedules, emotion charts), involving decision supporters in sessions and allowing extra time for discussions and decision-making.

2.3. Supporting choice, independence and decision-making

- Staff should support individuals to exercise everyday choice-making and decision-making as a foundation for developing self-advocacy skills.
- Services should provide access to advocacy supports, including self-advocacy, peer advocacy, independent advocates or referral to national services such as the National Advocacy Service, explaining roles clearly and involving advocates in care planning or complaints processes where requested.
- Staff should ensure appropriate decision support arrangements are in place, such as supported decision-making tools, accessible information, visual aids, simplified explanations, extra time or the involvement of decision supporters, so individuals can understand options and express preferences confidently.
- Staff should presume decision-making capacity by default, recognising that capacity is issue-specific and time-specific, and that communication difficulties or decisions that appear unwise do not indicate a lack of capacity.
- Services should always consider the person's will and preferences when planning care and treatment, ensuring continuity of care through consistent key workers, thorough documentation of communication preferences and support needs, and careful transition planning when staff changes are unavoidable.

2.4. Providing reasonable accommodations

- Services should provide reasonable accommodations such as extended appointment times when needed, particularly for individuals who require more time to process information, communicate effectively or feel comfortable.
- Service leadership should recognise reasonable accommodation needs and ensure the service is appropriately resourced to support them, including staffing, training, physical space and materials.
- Staff should identify and flag reasonable accommodation needs in advance, adjusting scheduling and structures accordingly to ensure equitable access.

- Staff should prepare individuals for appointments by offering accessible formats as a reasonable adjustment, such as visual schedules, Easy to Read leaflets or short videos, and by checking in with decision supporters or support staff about anticipated communication needs.
- Services should create sensory-friendly environments as part of reasonable accommodation, offering quiet waiting areas, reducing harsh lighting and noise and providing calming resources (e.g. weighted blankets, fidget tools or soft seating).
- Staff should proactively offer adjustments to address sensory triggers, recognising these as reasonable accommodations necessary to uphold inclusion and accessibility.

3. Communication

People with ID communicate in a wide range of ways – using speech, eye contact, body language, vocalisations, pictures, sign language systems, communication devices and behaviour. This means that people supporting those with ID need to recognise the right of people to communicate using any means or modes of communication they choose, and the right to be understood.

3.1. Communicating directly and respectfully

- Staff should communicate directly with individuals, not just their family members, carers or decision supporters.
- Staff should use respectful, age/developmentally appropriate language.
- Staff should recognise that behaviours of concern may be a form of communication and respond appropriately.
- Services should ensure that staff respond appropriately to behaviours of concern and promote dignity, choice and inclusion.
- Staff and services should refer to HIQA's [National Guidance on Good Communication in Health and Social Care: Using Plain Language](#).

3.2. Adapting communication methods

- Staff should be trained in the use of a range of communication supports.
- Staff should ensure communication is tailored to each person's needs.
- Services should develop and use communication passports to ensure that all people interacting with individuals who have communication support needs can understand and respond appropriately.
- Services should provide Easy to Read materials and ensure all written information is available in accessible formats, such as large print, audio or symbol-supported versions.
- Staff should allow extra time during interactions, especially in appointments or care planning discussions, to help individuals process information and respond without pressure.
- Services should recognise the communication needs of service users with MHID and resource the service accordingly.

3.3. Involving communication specialists

- Services should include speech and language therapists (SALTs/SLTs) in care teams to co-develop personalised communication plans that identify strategies to communicate with individuals with MHID, where possible.
- Staff should collaborate with SALTs/SLTs to understand each person's preferred methods and integrate these into daily interactions and documentation, where possible.
- Services should ensure communication plans are clearly documented, regularly reviewed and shared across all relevant staff to maintain consistency and continuity.

3.4. Preparing for appointments and interactions

- Staff should provide clear, accessible information ahead of appointments.
- Services should offer visual schedules, social stories or other preparatory tools to reduce anxiety and support engagement, especially for individuals who benefit from routine and predictability.
- Staff should check understanding regularly during interactions and offer opportunities for individuals to ask questions or seek clarification in their preferred way.

3.5. Promoting choice through communication

- Staff should support individuals to express preferences and make choices, by offering clear options, using visual prompts and encouraging active participation in care decisions.
- Services should offer self-advocacy and communication training, such as workshops, peer-led sessions or role-play scenarios, to build individuals' confidence and independence.
- Staff should recognise that behaviour may be a form of communication, especially when verbal expression is limited, and respond with empathy, curiosity and a commitment to understanding underlying needs.

4. Care plans

Care plans should be clear, accessible and tailored to each individual. They should reflect the person's goals, preferences, communication needs and support requirements, and be co-developed with the individual and their parents/carers/supporters as appropriate and wherever possible.

4.1. Making person-centred care plans

- Services should develop individual care plans in collaboration with the person based on their preferences, needs and goals, ensuring their voice is central to decisions about treatment and support by using supported decision-making tools and accessible formats.
- Staff should ensure care plans reflect the person's strengths, goals and what matters most to them, by using strengths-based assessments and goal-setting conversations.
- Services should regularly review care plans with the individual and their family member, carer or decision supporter to ensure they remain relevant and responsive to changing circumstances, especially after major life events or transitions.

4.2. Ensuring accessibility

- Services should provide care plans in accessible formats and adapt them to suit each person's communication needs and preferences.
- Staff should explain care plans clearly and check understanding.
- Services should ensure individuals receive a copy of their care plan, and staff should explain the purpose of the care plan to the individual.

4.3. Promoting shared ownership

- Staff should treat care plans as a shared tool, developed collaboratively with the individual, their decision supporters and relevant professionals through co-planning sessions or multidisciplinary meetings.
- Services should encourage individuals to set their own goals where appropriate, using structured goal-setting templates or coaching-style conversations to identify what support they need to achieve them.
- Staff should respect the person's right to make choices, even if those choices differ from clinical recommendations, by documenting preferences and exploring safe ways to honour them.

4.4. Supporting continuity and coordination

- Staff should include clear information in care plans about who is responsible for each part of the person's support, using named contacts and role descriptions.
- Services should use care plans to coordinate input across teams, including mental health, disability, primary care and community services, by sharing plans securely and updating them jointly.
- Staff should ensure care plans are updated during transitions, such as moving between services or settings, by scheduling handover meetings and involving the individual in transition planning.

5. Accessibility of services and environments

Accessibility is about more than ramps and signage; it's about ensuring people with MHID can fully engage with mental health services in ways that are respectful, inclusive and empowering.

5.1. Access to services

- Services should be easy to find, understand and use, regardless of the person's communication, mobility or support needs.
- Services should offer flexible appointment times, remote options and support with transport where needed, such as arranging accessible taxis or providing travel guidance.
- Services should actively reach out to people who may face barriers to access, including those in rural areas, residential settings or with limited support networks, by using outreach teams, community partnerships or mobile services.
- Services should explore telehealth options so that service users have alternative methods to engage with services if appropriate.

5.2. Physical environment

- Service environments should be calm, welcoming and sensory-aware, avoiding overstimulation or distress by using soft lighting, neutral colours and quiet zones.
- Staff should ensure buildings are wheelchair accessible, with clear signage and facilities that meet diverse needs, such as gender-neutral toilets and adjustable seating.
- Services should involve people with lived experience in designing and reviewing physical spaces through consultation groups, walk-through audits or feedback surveys.
- Services should listen to and address any accessibility concerns raised by people with MHID, their decision supporters or professionals to ensure an inclusive environment.

5.3. Cultural and social inclusion

- Services should respect and reflect the cultural, linguistic and social identities of the people they support by incorporating diverse imagery, multilingual materials and culturally relevant practices.
- Staff should be trained in inclusive practice and aware of how discrimination or stigma can affect access, using real-life scenarios and reflective exercises in training.
- Services should work with families, advocates and community groups to build trust and improve engagement through co-designed outreach, community events or feedback forums.

5.4. Rights-based design

- Services should recognise accessibility as a key legal and ethical consideration, and it should be thoughtfully integrated into service policies, audits and staff training.
- Services should ensure people know their rights, including the right to reasonable accommodations, advocacy, and complaint procedures, by displaying this information clearly and discussing it during care planning.
- Staff should use accessibility audits and feedback from service users to drive continuous improvement, reviewing findings regularly and acting on identified gaps.

6. Education and training

Education and training should empower staff to deliver safe, inclusive and rights-based care. It should build confidence, challenge assumptions and equip teams to support people with ID in mental health settings.

6.1. Building core competencies

- Services should ensure all staff receive training in MHID, communication support, trauma-informed care and human rights, using interactive modules and real-life case studies.
- Staff should understand how diagnostic overshadowing, stigma and restrictive practices affect people with MHID, through reflective exercises and scenario-based learning.
- Training should include practical strategies for adapting assessments, care planning, interventions and environments to meet diverse needs, such as using visual tools, flexible spaces and personalised approaches.

6.2. Promoting human rights and inclusion

- Staff should be trained in the rights of people with disabilities, including autonomy, dignity, privacy and consent, using rights-based frameworks and practical examples.
- Services should embed a culture of respect, dignity and inclusion through ongoing education, reflective practice and inclusive policies.
- Training should challenge ableism and unconscious bias, and promote humility, positive risk-taking, choice and self-determination, using discussion groups, peer-led sessions, values-based exercises and continuous self-reflection.

6.3. Supporting communication and relationships

- Staff should learn how to communicate effectively with people who use non-verbal or alternative communication methods, through hands-on practice and support from SALTs/SLTs.
- Services should offer training in active listening, relational approaches and co-production, using role-play, feedback tools and collaborative planning exercises.
- Staff should be supported to build trusting relationships and respond to distress with empathy and understanding, through supervision, mentoring and trauma-informed guidance.

6.4. Ensuring continuous learning

- Services should provide regular refresher training, supervision and opportunities for reflective practice, using scheduled learning plans and peer support groups.
- Staff should be encouraged to learn from feedback, incidents and lived-experience voices, by reviewing case examples and participating in debriefs or learning reviews.
- Training should be tailored to different roles, with clear expectations for competence and accountability, using role-specific pathways and performance indicators.

6.5. Involving people with lived experience

- Services should co-design and co-deliver training with people who have lived experience of ID and mental health services, through paid roles, advisory panels or storytelling sessions.
- Staff should hear directly from individuals and families about what good support looks like, using video interviews, guest speakers or facilitated conversations.
- Training should include real-life scenarios, storytelling and opportunities for dialogue, encouraging reflection and deeper understanding of lived experience.

7. Inter-agency collaboration

People with MHID often rely on multiple services to support their mental health, physical health, social care and daily living. Effective collaboration between agencies is essential to ensure continuity, dignity and holistic care.

7.1. Building shared understanding

- Services should work together to develop a shared understanding of the person's needs, strengths and goals by using joint assessments, shared planning tools and regular case discussions where appropriate.
- Staff should communicate clearly across agencies, using consistent language and avoiding jargon, supported by agreed terminology guides or communication protocols.
- Services should recognise and respect each other's roles, expertise and legal responsibilities by mapping responsibilities and clarifying boundaries in collaborative agreements.

7.2. Coordinating support

- Services should agree on who is responsible for each aspect of the person's care and treatment and how they will work together, using written care coordination plans and contact lists.
- Staff should use joint care plans, shared protocols and regular meetings to coordinate support, ensuring updates are documented and accessible to all relevant professionals.
- Services should ensure transitions, such as hospital discharge or moving between settings, are planned and supported collaboratively, with clear timelines, named contacts and pre-transition meetings.
- Services should collaborate to identify gaps, reduce barriers and improve access across the system by conducting joint needs assessments and service mapping.
- Staff should use feedback, audits and joint reviews to improve how agencies work together, involving people with lived experience in evaluation processes.
- Services should advocate collectively for better resources, inclusive policies and joined-up service design by submitting joint proposals, participating in strategic forums and influencing policy development.

7.3. Involving the person and their circle

- Staff should ensure the person is central to all decisions, and that their decision supporters are included where appropriate and with the person's consent, using inclusive planning tools and supported decision-making approaches.
- Services should avoid duplication and ensure the person doesn't have to repeat their story multiple times by sharing summaries, using consistent documentation and coordinating communication.
- Agencies should work together to uphold the person's choices, rights and cultural identity by embedding these values in care plans, team discussions and service policies.

7.4. Sharing information

- Services should share relevant information in a timely, lawful and respectful way, guided by data-sharing agreements, consent protocols and decision support arrangements.
- Staff should explain to the person what information is being shared and why, and seek consent wherever possible, using accessible formats and supported conversations.
- Agencies should use secure systems and clear agreements to protect confidentiality and data rights, with regular audits and staff training on data protection.

8. Safeguarding and restrictive practices

Safeguarding is about protecting people's rights, safety and dignity, especially those who may be at greater risk due to disability, mental health needs or systemic barriers. Mental health services for people with MHID must take a proactive, rights-based approach to safeguarding, with clear procedures, accountability and a commitment to least-restrictive care.

8.1. Embedding a safeguarding culture

- Services should promote a culture where safety, respect and inclusion are everyone's responsibility. This includes embedding safeguarding as a core value across all teams, ensuring compliance with the Children First Guidelines and the National Policy for Safeguarding Vulnerable Adults, and designating a clear safeguarding lead within the service to provide oversight, accountability and support for staff in recognising and responding to safeguarding concerns.
- Staff should be trained to recognise signs of abuse, neglect, exploitation and poor practice, and know how to respond appropriately. Training should emphasise trauma-informed approaches and clear reporting pathways.
- Staff and services should provide the service user with knowledge and information to empower them to protect themselves.
- Services should have clear safeguarding policies that align with national legislation, policy and standards. This includes the joint HIQA and MHC National Standards for Adult Safeguarding, the Department of Health's National Policy Framework for Adult Safeguarding, the HSE's Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures.
- Staff and services should be aware of mandatory reporting requirements where any concerns are identified.

8.2. The use of regulated restrictive practices

- Services should prioritise an overall restraint-free environment where possible.
- Services should refer to the MHC's Rules and Code of Practice governing the use of seclusion, mechanical restraint and physical restraint.
- Staff should only use these restrictive practices as a last resort, when absolutely necessary to prevent serious harm.
- Restrictive practices should be lawful, proportionate, time-limited and clearly documented.
- Services should prioritise prevention through the provision of positive behaviour support, trauma-informed care, communication support and environmental adjustments.
- Staff should explain any restrictions to the person in a way they can understand and seek their views and consent wherever possible.
- Services should monitor the use of restrictive practices and report regulated practices of seclusion, physical restraint and mechanical restraint transparently, in line with MHC requirements.
- Staff should reflect on events to identify what could have been done differently and, where possible, eliminate regulated restricted practices.
- Leadership teams should use data, feedback and lived experience to drive continuous improvement.

9. Governance

Governance refers to the systems, structures, behaviours and processes that ensure MHID services are delivered safely, ethically and in line with national standards. It provides the foundation for accountability, leadership and continuous improvement, and must reflect a rights-based, person-centred approach across all levels of care.

9.1. Establishing clear leadership and accountability

- Governance structures should support joint oversight across the health, disability, social care, education and advocacy sectors by establishing cross-sector governance groups and shared reporting mechanisms.
- Leadership teams should be accountable for implementing MHID models of service and guidance and promoting consistency across settings through regular reviews, performance monitoring and transparent reporting.
- Governance frameworks should reflect the principles of the UNCRPD, Assisted Decision-Making (Capacity) Act 2015, and any other relevant legislation or policies by embedding these standards into policies and training.
- Services should have arrangements in place to monitor and oversee the quality of care which residents receive.
- There should be a clear commitment to meeting the diverse needs of individuals, including those with ID, by embedding inclusive practices into service design, delivery and evaluation.

9.2. Promoting quality, safety and learning

- Services should have systems in place for regular audit, incident review and continuous quality improvement, using standardised tools and involving service users in review processes.
- Data, feedback and lived experience should be used to inform decision-making and drive service development, with findings shared openly and acted upon.
- Governance should support reflective practice, supervision and staff development aligned with MHID competencies, through structured learning plans and regular supervision.
- Leadership teams should monitor outcomes and respond proactively to risks, gaps and emerging needs, using dashboards, risk registers and improvement plans.

9.3. Aligning with the National Quality Framework

- Governance practices should reflect the principles of the MHC's National Quality Framework, including:
 - Person-centredness
 - Empowerment
 - Access and responsiveness
 - Collaboration
 - Safety and accountability
- Governance should be embedded across all levels of care, from community teams to inpatient settings, and adapted to local contexts through tailored implementation plans and local leadership.

9.4. Supporting inclusive and sustainable structures

- Governance groups should include multidisciplinary representation and lived experience, with clear roles, inclusive recruitment and meaningful participation.
- Structures should be resourced and empowered to oversee implementation, promote consistency and support innovation, through dedicated funding, leadership support and strategic planning.
- Services should ensure that governance is not a one-off exercise but a sustained commitment to rights, quality and integration, by embedding governance into everyday practice and reviewing its impact regularly.

Glossary of Key Terms



Approved Centre

A mental health facility registered with the MHC, where inpatient care is provided under the Mental Health Act 2001 -2018. Only approved centres can legally admit and treat individuals under involuntary care provisions.

Assisted Decision-Making (Capacity) Act 2015

Legislation that supports decision-making for individuals who may have difficulties making certain choices, ensuring their will and preferences are respected, while providing necessary supports.

CAMHS-ID (Child and Adolescent Mental Health Service – Intellectual Disability)

A specialist service designed to provide mental health support for children and adolescents with intellectual disabilities, ensuring age-appropriate interventions and transition planning to adult services.

Diagnostic Overshadowing

A phenomenon where mental health symptoms in individuals with intellectual disabilities are overlooked, because professionals attribute them to the intellectual disability rather than recognising a separate mental health condition.

Dual Diagnosis

Refers to individuals with both an intellectual disability and a mental health condition. This combination can complicate diagnosis and treatment, requiring specialised care.

Health Service Executive (HSE)

Ireland's public health service provider, responsible for delivering health care services, including mental health supports for people with intellectual disabilities.

Integrated Care

A health care approach that ensures collaboration between mental health and disability services, promoting seamless transitions and avoiding service gaps.

Intellectual Disability (ID)

A significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood and has a lasting effect on development.

Mental Health Commission (MHC)

The independent regulatory body responsible for overseeing mental health services in Ireland. It sets legal standards and guidelines for inpatient and community-based mental health services.

Mental Health Intellectual Disability (MHID)

A term used to describe individuals who have co-occurring mental ill health and an intellectual disability.

National Quality Framework (NQF)

A policy framework issued by the Mental Health Commission, setting out best practices to ensure high-quality, person-centred and recovery-focused mental health services.

Polypharmacy

The use of multiple medications by a single individual, typically defined as five or more daily.

Psychological Therapies for Intellectual Disabilities

Therapies such as Cognitive Behavioural Therapy (CBT), Eye Movement Desensitisation and Reprocessing (EMDR), and Narrative Exposure Therapy (NET), which can be adapted to meet the cognitive and communication needs of individuals with intellectual disabilities.

Psychotropic Medication

Drugs used to manage mental health conditions. In individuals with intellectual disabilities, these medications are sometimes prescribed unnecessarily, emphasising the need for regular medication reviews.



Reasonable accommodations

Modifications made to mental health services and treatments to ensure they are accessible and effective for individuals with intellectual disabilities. These can include simplified communication, visual supports and adapted therapies.

Restrictive Practices

Interventions such as physical restraint, mechanical restraint or seclusion, used in mental health settings to manage behaviour when there is an immediate risk of serious harm to self or others. These must only be used when absolutely necessary and under strict guidelines set by the MHC Rules and Codes of Practice.

Telehealth and Digital Mental Health Services

The use of technology (video consultations, online therapy, digital resources) to improve mental health access, particularly for individuals in rural areas or with mobility challenges.

Tiered Approach to Care

A structured model of service delivery where mental health support is provided at different levels, including community-based, hospital-based and forensic services, ensuring individuals receive care appropriate to their needs.

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