NATIONAL FEDERATION OF VOLUNTARY BODIES
Providing Services to People with Intellectual Disability

Report of the Working Group of the National Federation of Voluntary Bodies on Early Intervention Services

National Federation of Voluntary Bodies
Providing Services to People with Intellectual Disabilities

December 2006

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1. FORWARD

The National Federation Education Sub-Committee in light of changing structures within the Health Service Executive, the roll out of the Education for Persons with Special Educational Needs (EPSEN) Act 2004 and the Disability Act 2005 initiated the establishment of a Working Group to examine Early Intervention Services for People with Intellectual Disabilities.

The terms of reference were:

1. *Review of the current range of models of Early Intervention Services within the National Federation of Voluntary Bodies' membership.*

2. *Review of international best practice literature and research on all aspects of Early Intervention Services for Children and Families, including screening / referral / assessment / intervention processes / team and agency structures.*

3. *The Working Group are to prepare an interim report by October 2006. The Working Group is to prepare a position paper on the future direction of Early Services within National Federation Member organisations.*

However, the Education Sub-Committee became aware of the HSE draft discussion document in circulation within the HSE entitled "Proposal for the Re-Alignment of Developmental Services for Children with Special Needs" and asked the Working Group to focus their attention on this document as part of its work.

The Working Group chaired by Stephen Kealy, Director of Psychology, (Sisters of Charity of Jesus & Mary, Moore Abbey) included a range of staff generally working in the area of Early Intervention who are members of the National Federation of Voluntary Bodies.

As Chairperson of the Education Sub-Committee I welcome this report and its recommendations and would like to thank the Working Group for the efficient and effective way in which the report was completed.

Maura Nash
Chairperson of Education Sub Committee of the National Federation

2. Summary of Recommendations:

2.1 Mainstreaming:

2.1.1 Any model of clinical support services provided by the HSE should be informed from a life span perspective of the many and often complex needs of people with an intellectual disability.

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2.4.3 An intervention plan should be in place, for those children who need it, within one month of initial assessment.

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2.10.2 Local steering group should be in place to implement the roll out of the National Strategic Plan.

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2.11.1 The HSE should engage with all stakeholders to agree the priorities, actions, objectives for a National Strategic Plan.

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2.12.1 The HSE should engage with all stakeholders a number of agreed priorities which will convert vision to practice throughout the country.

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2.17.1 As part of the installation Process Research Assistant should be established in each Health Authority initially with the specific purpose of evaluating the effectiveness of the early services delivered through one point of entry.

3. INTRODUCTION.

3.1 HSE Document: "Proposal for the RE-alignment of Developmental Services for Children with Special Needs".

The Health Services discussion document "Proposal for the Re-alignment of Developmental Services for Children with Special Needs" sets out a broad vision for the development of clinical intervention services for children with special needs. The document identifies the changing and evolving context of the Health Services, particularly a number of operational components for service delivery.

The Health Services Executive commenced its corporate life in January 2005. A central objective of the new Health Service is a unified health service responsive to the needs of the individual on an equal basis.

The Health Services Executive has set out five key objectives –

I. to improve people's experience of services and their outcomes;

II. developing, changing, and integrating services in line with best practice.

III. to work to protect, promote, and improve the health and wellbeing of the population, based on identified need with the particular focus on measures to address social exclusion.

IV. to empower staff to deliver responsive and appropriate services, making effective team working a priority.

V. to develop the HSE as a dynamic, effective and learning organisation, in partnership with service users, patients, staff, not for profit / voluntary / community sector and other stakeholders.

The vision is rooted in the key principles set out in the Health Strategy – Quality & Fairness.

3.2 The National Disability Strategy – 2004:

The overall objective of the National Disability Strategy 2004 was to have in place an effective combination of legislation, built on an operational legislative basis for service delivery, linked to agreed policies, and institutional arrangements to support the equal participation of people with disabilities within our society. The Disability Strategy identified a number of cornerstones already in place, the Employment Equality Act 1998; the Equal Status Act 2000; the Equality Act 2004; and the Citizens Information Bill 2006 - formally the Comhairle (amendment) Bill 2004.

Since then the Disability Act 2005, the Education for Persons with Special Educational Needs Act 2004 is in place. The Education for Persons with Special Educational Needs Act 2004 identifies mainstreaming as an objective. The Disability Act 2005, however, imposes no obligation to compel mainstream health services to meet the needs of people with disability in the first instance.

3.3 The World Health Organisation – UN Standard Rules on the Equalisation of Opportunities for People with Disabilities:

In evaluating the UN Standard Rules on the Equalisation of Opportunities for People with Disabilities, the World Health Organisation has provided a number of examples of good practice in health care provision including:

- The provision of early detection diagnosis, assessment and treatment;
- Full involvement of people with disabilities and their families in the planning and monitoring of services and programmes;
- Provision of medical care for children and adults with disabilities in the general medical system.
- Awareness raising for health and medical personnel;
- Free provision of medical care for people with disabilities and their families.
- Trained medical and para-medical staff who are equipped to provide medical care to people with disabilities.
- A primary health care model.
- Provision of information and communication about services in Braille, tape, sign language, easy readers etc.

4. Response to HSE Document: "Proposal for the RE-alignment of Developmental Services for Children with Special Needs".

4.1 Mainstreaming:

The HSE draft discussion document, while identifying the requirements of developmental services for children with special needs, embeds the service in a generic community based model. The proposed clinical service, as set out, is one of the components for the provision of a continuing lifespan clinical generic model for people with disabilities. The other components are:

- ❑ teams for school going children 6 – 18
- ❑ Adults 19 years plus.

However, a very strong case must be made for retaining specialist pre-schools as a transitioning environment for some children. These specialist placements afford a safe environment and opportunities for some children to acclimatise to the noise and routines of pre-school and learn skills so necessary for inclusive pre-school attendance. Some children with complex and high medical needs and / or challenging behaviour will find it very difficult in mainstream schools without an initial transition period and careful planning.

Stronger supports need to be in place for children with disabilities in community pre-schools to enable inclusion to become a reality. No reference is made in the draft proposal to the work of the Centre for Early Childhood Development and Education (CECDE), which identifies the necessity of scaffolding pre-school education and interventions in clear government policy, particularly implementation actions assigned to the Dept. of Education & Science and the Health Services Executive.

This HSE document sets out a number of key proposals which for their implementation, will rely on a high level of co-operation between current providers and HSE decision makers and clinicians, if the health and social needs of people with disabilities are to be met over their lifespan. The HSE draft discussion document discusses briefly the development of pre school services. The National Federation acknowledge the key role special pre-school services currently play in providing an overall package of care education and emphasise the need to maintain and extend models of best practice. The members agree a range of pre schools support should be available to children and their families including specialist pre school, mainstream pre school with appropriate support and opportunities for shared placements.

International surveys and studies have indicated there are high levels of unmet needs among people with disabilities (Marshall et al, 2000; McConkey et al, 2003; Hogg et al, 2000; Jansen et al, 2004; Pre-school Services for Children with Special Needs, Hazel Trudgill & Linda McGrath CoAction, West Cork, Oct. 2006).

Primary Care Strategy:

The HSE's position paper recognises the pivotal position their primary care strategy will have in meeting the needs of people – children and adults – with disabilities. It is the view of the Federation members that primary care is currently not just set up to meet the needs of people with disabilities across the age spectrum. The direction, while welcomed, has not reached the momentum to deliver an integrated care package. Primary care relies too much "on demand" access and very often has insufficient time to address complex problems and G.P. education rarely covers this population (Kerr, M; unpublished article). Kerr goes on to say "a more fundamental change, such as the provision of health checks, recently introduced in Wales is the only way likely to make enduring and meaningful change". The Federation's view is that an over-reliance on the primary health care initiative as a driver, obscures the daily reality of inadequate integrated services on the ground.

The concern of the National Federation of Voluntary Bodies, while acknowledging the implicit inclusion vision set out in the HSE document, is that individual needs of people with disability over their life-span will not be adequately or always appropriately addressed in a generic one fit all model of service.

Recommendations:

- The model of clinical support services provided by the HSE should be informed from a life span perspective of the many and often complex needs of people with an intellectual disability.
- The choice of a special support pre-school evaluation process should continue to be available to families, as part of any intervention provision.

4.2 Barriers to Mainstream Community Based Health & Disability Services:

Different researchers have identified a number of factors as potential barriers to equity of access to health care service for people with an intellectual disability. These include factors that may arise because of the presence of learning disabilities, the previous experience of people with an intellectual disability, the abilities of professionals, the structures of services; and the negative attitudes towards people with an intellectual disability (Meehan et al, 1995; Kerr, 2004).

The HSE document as circulated expresses an inadequate understanding of the complexity of needs of people with intellectual disabilities and the system in which they live over their lifespan. To date lifespan needs have been met by Intellectual Disability Service Providers. In particular the comprehensive and extensive nature of early services was well set out in submissions for this response which does not appear to be reflected in the HSE document. This is of paramount concern to National Federation members.

Recommendations:

- All professionals involved in the delivery of Primary Health Care should be educated and trained in the health related needs of people with intellectual disabilities.

4.3 One point of entry:

The one point of entry will provide a welcomed framework for a co-ordinated approach to meeting the needs of the individual within the family, in an integrated and seamless manner. It is an ambitious and significant change posited on the re-alignment of all existing children's clinical services (0 – 5) currently positioned within HSE community care programmes and intellectual disability providers, both statutory and non-statutory.

For the age group 0 – 5, the one point of entry requires an effective, well resourced, evidence based, child surveillance programme. Child surveillance programmes, if implemented effectively, will assist in securing appropriate referrals to the one point of entry. Children with known birth disabilities will automatically access the Early Intervention Services through the one point of entry. Evidence based screening is seen as a solution focussed approach to targeting, appropriately, scarce resources.

Public Health Nurses (PHN) are mandated to visit all families with infants within the community (Dept. of Health & Children 1966).

Denyer et al in Best Health for Children identifies the Public Health Nurse as having a key role in the National Child Surveillance Programme with core visits at birth, 3 months, 7 to 9 months, 18 to 24 months and 3 years 6 months (Denyer S, et al).

The Public Health Nurse's primary role with children is to provide anticipatory guidance to families, thus promoting the health and development of their children (Hannifan S. et al 2002).

Recommendation:

- The one point of entry is crucial to access intervention services for children with intellectual disabilities.

4.4 Referral Sources:

The Primary Health Care Team, including the Public Health Nurse, Area Medical Officer, General Practitioner, and Practice Nurse, are often the first point of contact for parents with the public health services and are ideally placed to assist in the early identification and referral of any concerns regarding health and development of children. The Consultant Paediatrician also plays a key role to play in identifying children in need of early intervention services. A clear pathway of referral is essential to prevent duplicate services being offered and to ensure timely interventions are put in place. Reliable screening tools are needed by these various professionals to help early identification of children with developmental delay.

The aim of screening questionnaires is to identify children needing a more comprehensive evaluation. There are various developmental tools available, which are used for screening infants and young children. For example, the Denver Developmental Screening Test (DDST) has been used for more than three decades to identify children in need of more intensive diagnosis and assessment. The DDST is one of the most readily available screening tests used in the community to monitor a child's early development. There is considerable research data on its effectiveness as a screening instrument. However, a number of studies have questioned its sensitivity and suggests that the DDST fails to detect an unacceptably large number of children with developmental delay.

Recently, new parent friendly screening tools have been developed in response to parent concerns. Parents are actively involved in the care of their child and their concerns are proven to be highly predictive of true developmental delay. These questionnaires are standardised on a diverse population, completed by parents and provide accurate information about their child's development. These tests have the additional benefit of requiring less time from primary care providers for their completion (Schariff et al, 2006). These particular screening tests include:

- The Ages & Stages Questionnaire (ASQ).
- Parent evaluation of Developmental Status (PEDS)
- Child Development Inventories (CDI).
- Infant Checklist for Language and Communication.

The HSE document does not make a firm connection between the importance of consolidating child surveillance programmes in the context of accessing the one point of entry. It is imperative that surveillance procedures are consistent and reliably standardised so that they identify appropriate referrals. Failure to do so will lead to a high number of over-referrals with the consequent impact of overwhelming an already fragile system.

Recommendations:

- Evidence based parent friendly screening questionnaires should be used by primary health professionals e.g. general practitioners, paediatricians, public health nurses and others before a referral to the one point of entry.

- All referrals to the one point of entry should be seen within a month of initial screening.

- An intervention plan should be in place, for those children who need it, within one month of initial assessment.

- The HSE child surveillance programmes should be strengthened to take account of ethnicity, changing family configurations, lifestyles and working practices.

4.5 Assessment:

The document identifies a family system approach in making effective interventions based on a child's presenting needs. It also clearly, and reassuringly, identifies that a child may be actively engaged with the service prior to a full and completed assessment having taken place to allow for an extended period of ongoing assessment. It identifies additional clinical expertise will be available, for example, in making a diagnosis of autism. The working group on the management of health services for people with autism in their report to the Department of Health & Children's Strategic Review, recommends the establishment of separate Autistic Spectrum Disorder with specific clinics for children and adults. There is significant disparity between the positions outlined by the Strategic Review Committee of the Department of Health & Children and that outlined in the HSE discussion document.

Members of the National Federation believe that specialists, within the Early Intervention Team, will be required if the complex needs of some children, for example Autistic Spectrum Disorder are to be appropriately met. In the pyramid model some children with ASD will have extra needs which can only be met by the expertise and skills normally found on tertiary intervention teams.

The proposed model of assessment is broad and suggests flexibility. It identifies the contribution of play based assessment. The Education for Persons with Special Educational Needs (EPSEN Act), has at its core, the assessment of need as does the Disability Act 2005. The Special Educational Needs Organiser on the ground works within the constraints of resource allocation set down by the Council. (National Council for Special Education). Operationally, at a national level, an agreed template should be place for presenting specialist needs information to facilitate a child's transition to school.

Assessment for many children is evolving and needs change. The emphasis on an integrated team assessment is welcomed as it provides a holistic, multi-faceted understanding of a child and facilitates more focused interventions. Unfortunately, the document has not highlighted strongly enough the need for evidence based assessment.

Recommendation:

- Each transition in a child's, adolescent's or adult's life should be included in an agreed template of evidence based assessment of need.

4.6 Non recognition of Existing Services

A concern of the National Federation's working group is that the re-alignment proposal ignores the specialist knowledge and skill base already existing nationally within intellectual disability services, voluntary and statutory, and in doing so, may dilute the quality of assessment and interventions for children with intellectual disabilities and their family system.

Recommendation:

- The national strategy should build on existing models of service, their skill base and specialist knowledge.

4.7 Interventions:

The HSE model identifies a commitment to –

- The child
- The family.
- The individual child and family development plan.
- Inclusion

Recommendations:

- Interventions should not be assessment dependent.
- Evolving assessment of need should be the hallmark of continuing interventions and map on to family, and inclusive supports.

4.8 Individual Child & Family Development Plan:

The individual development plan, as envisaged, is multi-element, stating

- Parents are central to the planning and implementation process.
- That there will be Identified goals.
- Agreed priorities.
- Planned activities.
- Agreed responsibilities.

The underlying theme, although not strongly stated, is that an effective intervention is a partnership between the family and the HSE.

Recommendations:

- Parent partnership must be the basis of providing the intervention service.
- Each child and family should have an individual development plan that is updated over their life span.

4.9 Team & Clinical Supports around the child & family:

A key understanding expressed in the document is that of building a team around the child and family and all which that entails. In the context of children with intellectual disabilities, flexible interventions need to take place to maintain a child's trajectory of learning. Some children's trajectory of learning is compromised by complex medical and physical difficulties, others by their behaviour. Resources in the document are primarily clinical, with little attention given to, for example,

- Behavioural support.
- Support in pre-school settings.
- Family supports.
- Respite care.

A small number of children will require intensive educational supports, often provided by home tutors, or in a special pre-school. Other children will need multi-element positive behavioural support. Nationally Early Intellectual Disabilities Services provide many of these components. The generic model, as set out in the discussion document, suggests these services will be accessible to child disability spectrum with which staff may have no familiarity, or intellectual disability specific training.

Operationally, without addressing the philosophy, vision and policies of existing statutory and non-statutory services, the proposal is likely to compromise current provision in the short term. One of the consequences of this will be a negative impact on goodwill, motivation, confidence and more importantly the innovation and flexibility leadership continually provided over the years, particularly in the utilisation of scarce resources.

Recommendations:

- Interventions must take account of the complex needs, including social and emotional development of the child with intellectual disabilities.
- Children with intellectual disabilities have to be supported, as appropriate, in mainstream preschool settings.
- Account should be taken of existing models of services and practice.

4.10 Operational actions:

The document sketches, with a broad brush, some management operational directions but does not put any shape and form on what actions will be taken to make the proposal a reality, nor do the suggested directions in the proposal link to corporate strategic priorities, objectives and consequent actions. No attempt has been made to set out, in partnership, evaluative indicators.

The document sets out a vision for the future but unfortunately does not deliver –

A HSE corporate strategy road map with –
- Agreed national strategic priorities.
- Objectives for each priority.
- Agreed actions for each objective.
- Agreed performance indicators for each objective.

The National Federation members have an expectation of involvement in setting out in partnership a National Strategic Plan *but based on an understanding of how co-ordinated and integrated generic teams will continually support the life span model of service for people with intellectual disabilities.*

Statements in respect of vision and direction based on clear principles and values are welcomed as are those in respect of clear accountability.

Recommendations:

- A national steering group should be established to agree strategic priorities, objectives, actions, and evaluative indicators.
- Local implementation groups should be in place to install the roll out of the national strategic plan.

4.11 Strategic Plan:

There is, however, in effect, no emerging business plan, set out in the draft discussion document, to deliver a National Strategy. More anxiety provoking is the absence of any sense that the vision has been stress tested against –
- The competencies of available personnel.
- The management competencies to convert emerging strategic priorities and objectives through to operational actions.
- The willingness of existing providers to work with the proposed model.
- The existing pre-school and home teaching supports available from the Dept. of Education & Science.
- Criteria for caseload management.
- Pre-school availability, both special and inclusive.
- Robustness of child surveillance programmes to be an effective filter for the one point of entry.
- Working relationships between 0 – 5 teams and special educational needs organisers.

- The availability of senior clinicians in all disciplines on each intervention team.
- The capacity of clinicians to work within teams without engaging in active training and team building.
- The proposed Primary Health Care Strategy.

Recommendation:

- The HSE should engage with all stakeholders to agree the priorities, actions, objectives for a National Strategic Plan.

4.12 Converting Vision to Practice:

However, to become a reality at a local level, the priorities and their objectives must be set at a national level in a Strategic Plan. There is a very strong case for having a National Representative Steering Group to set the National Strategic Priorities and Objectives with a five year business plan, with agreed yearly target actions. Such a steering group could also critically examine the deployment of funding and set out criteria for realignment during the roll out of the strategy. At local health office level, representative implementation groups should also be in place to install actions from the National Strategic Document.

At this late stage, it would be worthwhile to set out the requirements of the realignment on the basis of five strategic priorities, with a number of objectives for each priority, and for each objective agreed actions.

Recommendation:

- The HSE should engage with all stakeholders to develop a number of agreed priorities which will convert vision to practice throughout the country.

4.13 Corporate governance:

Nowhere is corporate governance addressed in the discussion document. The discussion document naively suggests separate and legally incorporated bodies can seamlessly re-engineer internal agreements and understandings with employees without discussion. Corporate governance demands adherence to policies and procedures that affect how the individual organisation is organised, governed and controlled. Corporate governance also ensures that policies, procedures and practices reflect other strands of accountability.

Recommendation:

- Protocols, following discussion and agreement with all stakeholders, dealing with corporate governance should be in place to facilitate and embed the roll out of the national strategy.

4.14 Finance & Funding:

The document identifies resource re-alignment as a central building block for the vision 0 – 5. The need for additional resources is also signalled. However, there is no pathway identified for local health manager / agencies to secure additional funding. A strategic plan would clearly identify how priorities can be met within the constraints of financial allocation and policies.

Recommendation:

- Local steering group should have an agreed template to identify the funding needs of interventions, team maintenance and enhancement within agreed evidence based criteria.

4.15 Implementation strategy:

If the vision in this document is converted to a strategic plan then a detailed implementation plan can be drawn up in partnership with all key stakeholders. The implementation plan will identify the tasks which have to be carried under each action within an agreed time-frame.

Critical to the anticipated implementation time-frame, will be annual anticipated funding, supported by available and augmented human and technical resources. The National Disability Strategy reassuringly signals funding increases.

Recommendation:

- The HSE in consultation and collaboration set out in a Gantt chart the time lines for their implementation strategy identifying actions which need to be taken during the roll out process.

4.16 Performance Indicators:

The National Federation of Voluntary Bodies believes twice yearly monitoring should be in place as a pre-requisite for assessing the progress of the roll out of the National Strategic Plan, and in meeting the qualitative and quantitative performance indicators embedded in such a strategic plan.

National indicators could include:

- An even and equitable provision of Early Services throughout each HSE regional area.
- An agreed template for assessment.
- Parent Quality Groups in each HSE regional area.
- Number of new referrals processed.

The above indicators are illustrative. Objectives for each priority will have separate performance indicators.

Recommendation:

- The HSE should engage with all stakeholders to agree evaluative criteria for the roll out, implementation and effectiveness of their intervention strategy in the age group 0-5.

4.17 Research:

The National Federation of Voluntary Bodies agree that research is critical in ensuring that evidence based data is continuously applied to early intervention services to ensure quality delivery outcomes are in place.

The Health Research Board should engage in this process to ensure that data collated on the Intellectual Disability Database and the Physical and Sensory Database provide national information on delivery within new early intervention services, and that equity of service is improved.

However, outcomes also need to be measured on a standardised national basis. To this end, research positions should be established in each HSE region linked to the HSE Corporate Research Structure.

Contracts of employment currently set out the understanding that clinicians should actively engage in research. The implementation strategy should immediately identify actions which need to be taken to foster, and nurture research contractual obligations.

Recommendation:

- As part of the installation Process Research Assistant should be established in each Health Authority initially with the specific purpose of evaluating the effectiveness of the early services delivered through the one point of entry.

5. Summary:

The draft document identifies a way forward to achieve maximum utilisation of scarce resources but in the context of a generic model of service with an identified avenue of intervention support for children with intellectual disabilities.

It has an un-stated legislative focus of meeting the requirements of the national sector plans for children 0 to 5 by June 2007.

The weakness of the document is the non-engagement with current service providers and disability intervention services. In addition there is a significant non-recognition of well established, effective and co-ordinated intervention programmes currently in place. The overall weakness is the lack of stated national strategic priorities, agreed objectives and the necessary actions to convert policy to practice.

6. Conclusion:

As in all discussion documents, it is easy to identify points with which to disagree. The National Federation of Voluntary Bodies will actively engage in the installation of a new model of clinical and intervention services to address the needs of people with disabilities over their life span.

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Appendix 1

National Federation of Voluntary Bodies
Early Intervention Working Group Members

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Hazel Trudgill, CoAction, Cork.
Teresa O Loughlin, Daughters of Charity, Dublin
Breda Corcoran, Daughters of Charity, Limerick.
Maura Nash, COPE Foundation, Cork.
Mary Barrett, National Federation of Voluntary Bodies.

Appendix 2

National Federation of Voluntary Bodies Member Organisations

- Ard Aoibhinn Centre, Belvedere Road, Wexford
- Association of Parents & Friends, Carrickmacross County Ltd., Corcrin, Carrickmacross, Co. Monaghan
- Beam Services, Chestnut Court, Royal Oak Road, Bagenalstown, Co. Carlow
- Brothers of Charity Services, Banner House, Clare Road, Ennis, Co. Clare
- Brothers of Charity Services, Bawnmore, Limerick
- Brothers of Charity Services, Belmont Park, Waterford
- Brothers of Charity Services, Lanesbro Street, Roscommon
- Brothers of Charity Services, Lota, Glanmire, Co. Cork
- Brothers of Charity Services, Woodlands, Renmore, Galway
- Camphill Communities of Ireland, Ballytobin, Callan, Co. Kilkenny
- Cheeverstown House, Templeogue, Dublin 6W
- Children's Sunshine Home, Leopardstown Road, Foxrock, Dublin 18
- Clones Branch, Cairde Activation Centre, Canal Stores, Clones, Co. Monaghan
- CoAction West Cork, Slip, Bantry, County Cork
- COPE Foundation, Bonnington, Montenotte, Cork
- County Wexford Community Workshop, Beelefield, Enniscorthy, Co. Wexford
- County Wexford Community Workshop, Marshmeadows, New Ross, Co. Wexford
- DARA Residential Services, 89 Dara Court, Celbridge, County Kildare
- Daughters of Charity Service, St. Vincent's Centre, Navan Road, Dublin 7
- Delta Centre, Strawhall, Carlow
- Drumlin House, Cootehill, County Cavan
- Galway Association, Blackrock House, Salthill, Galway
- Holy Angels Day Care Centre, Strawhall Industrial Estate, Carlow
- KARE, Lower Eyre Street, Newbridge, County Kildare
- KASMHA, College Gardens, Callan Road, Kilkenny
- Kerry Parents & Friends Association, Old Monastery, Port Road, Killarney, Co. Kerry
- L'Arche Ireland Secretariat, Cluain Aoibhinn, Fairgreen Lane, Callan, Co. Kilkenny.
- Meath Association, St. Olivers, Commons Road, Navan, Co. Meath
- MIDWAY Services, Beechmount Industrial Estate, Navan, Co. Meath
- Moorehaven Centre, O'Brien Street, Tipperary
- North West Parents & Friends Association, Holy Family Day Centre, Ballytivnan, Sligo
- Order of Malta Enterprises, Industrial Estate, Donore Road, Drogheda
- Peacehaven, 138 Hillside, Greystones, Co. Wicklow
- Peamount Hospital, Newcastle, County Dublin
- Prosper Fingal, Vocational Training Centre, Piercetown, Skerries, Co. Dublin
- Rehabcare, Roslyn Park, Beach Road, Sandymount, Dublin 4
- Sisters of Charity of Jesus & Mary, Moore Abbey, Monasterevin, Co. Kildare
- Sisters of La Sagesse, Cregg House, Sligo
- Sisters of the Bon Sauveur, Carriglea, Dungarvan, Co. Waterford
- SOS Kilkenny Ltd., Seville Lodge, Callan Road, Kilkenny
- St. Aidan's Service, Millands, Gorey, Co. Wexford
- St. Anne's Service, Sean Ross Abbey, Roscrea, Co. Tipperary
- St. Catherine's Association, Newcastle, Co. Wicklow
- St. Christopher's Service, Leamore Park, Battery Road, Longford
- St. Cronan's Workshop Association, Grange, Roscrea, Co. Tipperary
- St. Hilda's Services, Grace Park Road, Athlone, Co. Westmeath
- St. John of God Hospitaller Services, Provincial Administration, Stillorgan, Co. Dublin
- St. Joseph's Foundation, Charleville, Co. Cork
- St. Margaret's Centre, Moorehampton Road, Donnybrook, Dublin 4
- St. Mary of the Angels, Beaufort, Co. Kerry
- St. Mary's Hospital and Residential School, Baldoyle, Dublin 13
- St. Michael's House, Ballymun Road, Ballymun, Dublin 9
- St. Patrick's Centre (Kilkenny), Kells Road, Kilkenny
- St. Vincent's Centre, St. Mary's Road, Cork
- Stewarts Hospital Services Ltd., Palmerstown, Dublin 20
- Sunbeam House Services, Cedar Estate, Killarney Road, Bray, Co. Wicklow
- Tipperary Association, Coolkip, Horse & Jockey, Thurles, Co. Tipperary
- Walkinstown Association, 1 Longmile Road, Dublin 12

- Waterford Association, Spring Garden Workshop, Cherrymount, Waterford
- Western Care Association, Pool Road, Castlebar, Co. Mayo
- Windmill Therapeutic Training Unit, Larkins Lane, South Main Street, Wexford