Are we nearly there?
Caring for a child with intellectual or developmental disabilities: a road map from a developmental psychiatrist

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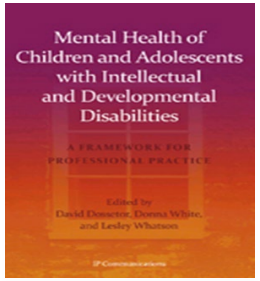
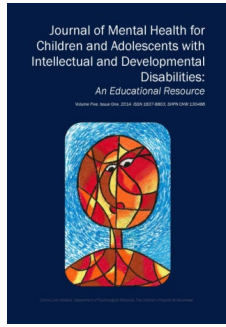
Parents are our most important partners in promoting **MH in IDD** in raising awareness and getting all the agencies to respond.

How much has NDIS contributed?

Context of 15 years of promoting evidence-based clinical expertise on Mental health of IDD



- MH of C&A with IDD, Dossetor, White & Whatson, IPCommunications, 2011. (Textbook).
- **Stepping Stones Triple P** in SSP schools (Ray et al, 2019)
- SSTP community intervention (MySay project, Einfeld et al, 2018)
- **Westmead Feelings Program**: emotional learning for Autism. I for mild ID, II for HFA, and soon Adolescent adaptation for mild ID, (publ: ACER 2017, 2018) plus on-line training



- SCHN School-Link: **Journal for MH of C&A with IDD**, 11 yrs, 27 editions, free to access
- '**Meet Jessica**', train the trainer awareness raising video animation
- **Webinars for Schools**: 'what you need to know and what you can do for the MH of C&A with IDD'
- 'Understanding and responding to behaviour in the classroom'; 'Supporting students with self-regulation'.
- **SCHN MHID Hub Kids Webinar launch: 'What is different about assessing and treating MH for C&A with IDD' with subsequent monthly topics**.

CHW SCHOOL Link

Supporting the mental health of children and adolescents with an intellectual disability

- All available on www.schoollink.chw.edu.au

‘He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all’.

William Osler, 1849-1919, Canadian doctor

- Can parenting be learned?
- Our knowledge base for parenting and child psychiatry has changed beyond recognition in the last 40 years.
- We should face uncertainty with an established road of shared knowledge.
- Prevention and promotion of MH is the most cost-effective health intervention (Dossetor, 2013)

Plan for Presentation

1. The scale of the challenge of the mental health of C&A with IDD
2. A framework for aiming for a quality of life
3. Acceptance, primary prevention and MH promotion through parent training
4. Promoting development and independence especially in context of Autism
5. MH and the bio-**developmental**-psycho-social-cultural framework & specialist IDD MH skills
6. Collaboration between disability, health and education
7. Burden of care: the handicap for the family
8. Conclusions

1. The scale of the challenge

‘A study of the dependency needs of adolescents with developmental retardation’ (1990)

4 hours 92 families demonstrated parental love and commitment

80% of families with a Down syndrome child was rewarding

Except where affected by Autism

30% in my study

40% of C&A with IDD have severe and persisting emotional and behavioural disturbance (Einfeld et al, 2006)

70% of C&A with Autism, often with more than one disorder,

Emotional and behavioural disturbance has more impact on family than the disability (Hatton et al, 2007)

MH intervention can significantly reduce that disability (Dossetor 2015)

Burden of Care, 7 hours a day, 7 days a week,

Increased economic burden

Parental burn out, stress, anxiety, depression (20-50%) and relationship challenge

15% end up in out of home care (OOHC); 30% of those in OOHC have IDD

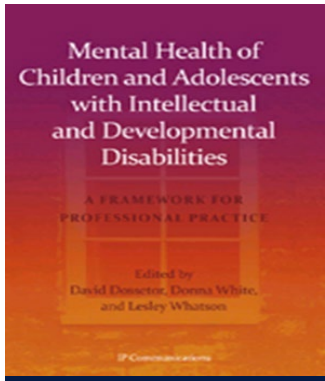
1b. The Scale of the challenge: Why to families with child with IDD breakdown?

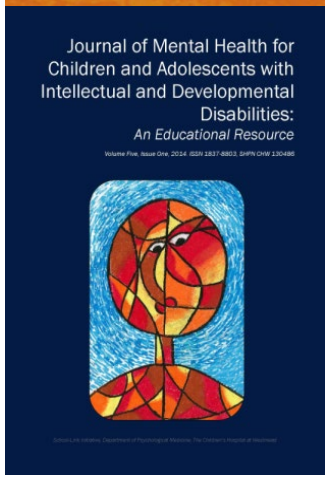
1. Problems of acceptance in infancy
2. Burden of care in childhood.
3. Behaviour disturbance in adolescents
4. Family burnout and relationship breakdown in adulthood. (Nankervis, 2012)

- Rising rates of OOHC
  Challenge of rising inequity and the widening gap for disability (Wilkinson & Pickett, 2009)(Emerson et al, 2013)
- Reasons for frequent attenders to emergency department (Helfer, 2019)
  moderate to severe ID,
  financial stress
  compromised carer capacity
  OOHC

2. A framework of hope in IDMH

- Equity of Access is now an ethical, moral and legal right.
- 2000 Developmental Psychiatry Clinic grew from the expertise and collaboration between disability and health and education.
- Independent review by Centre for Disability Studies reported that this provided classed intervention (O'Brien et al, 2014)
- 2005 Interdisciplinary curriculum and Textbook. MH of C&A with IDD, (2011)
- 2009 SCHN School-Link: education, PPEI, pathways to care and
- the Journal for the MH of C&A with IDD: on what is evidence-informed, novel and helpful





Evidence based Curriculum for the MH of C&A with IDD

1. Aiming for a quality of life
2. Focus on families and carers
3. Interventions that promote development
4. Interventions to promote MH
5. Integration of service systems

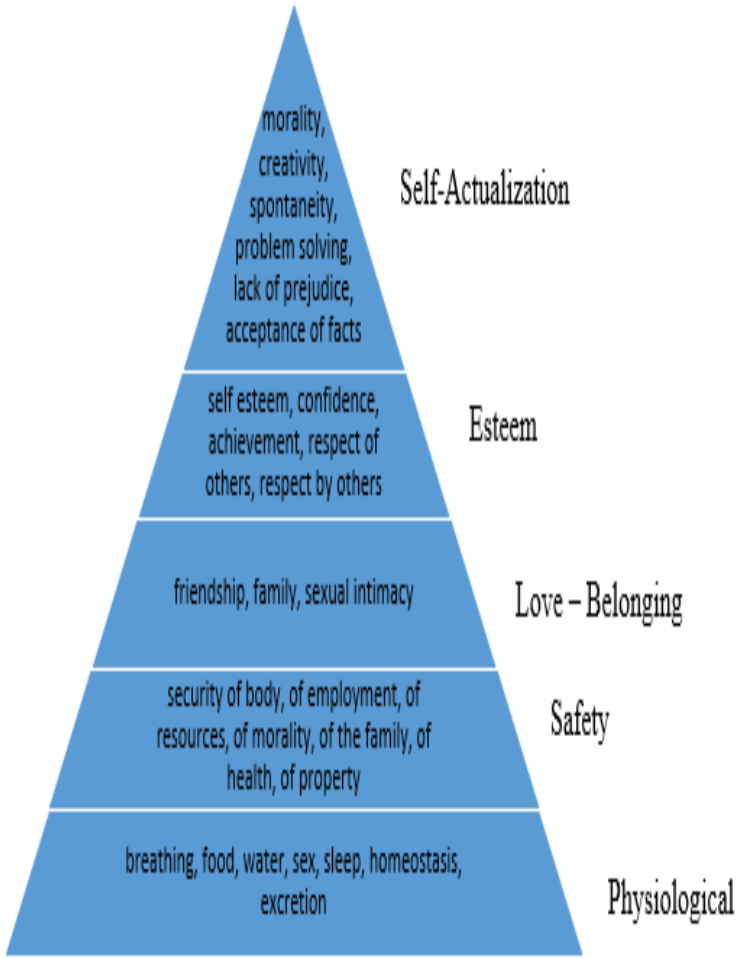
Parents are often amazing community heroes

2b. Maslow's Hierarchy of human motivation and wellbeing

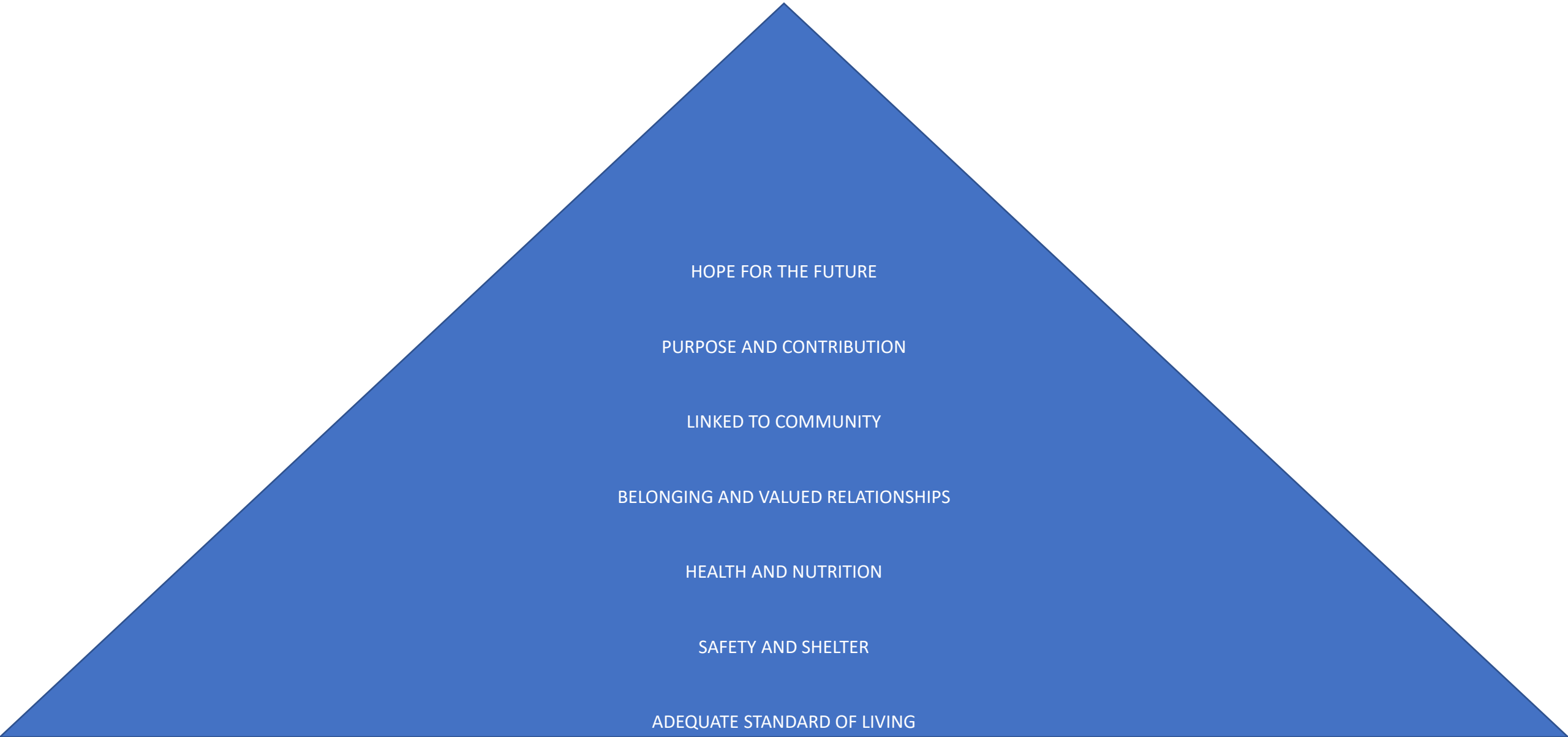
Self-Fulfillment

Psychological Needs

Physical Needs



2c. Quality of life (Cummins, 2012)



2d. Development of the Mind and Mental Competencies

Subjective experience but developmental concepts are critical to understanding children

Helps identify reasons for not coping and showing maladaptive behaviour

- Identification of self and non-self
- Motor regulation and coordination, sensory modulation
- Selective attention and attention switching
- Communication skills and theory of mind
- Mood regulation and empathy
- Self-concept and self-esteem
- Reality testing, perspective taking and other executive function skills

Best evidenced by the capacity of a young person to make new good quality peer attachments

Most important skills:

Development of attention and concentration, a pre-requisite for learning

Development of theory of mind: capacity to appreciate that other have separate thoughts and feelings to your own: central to Autism

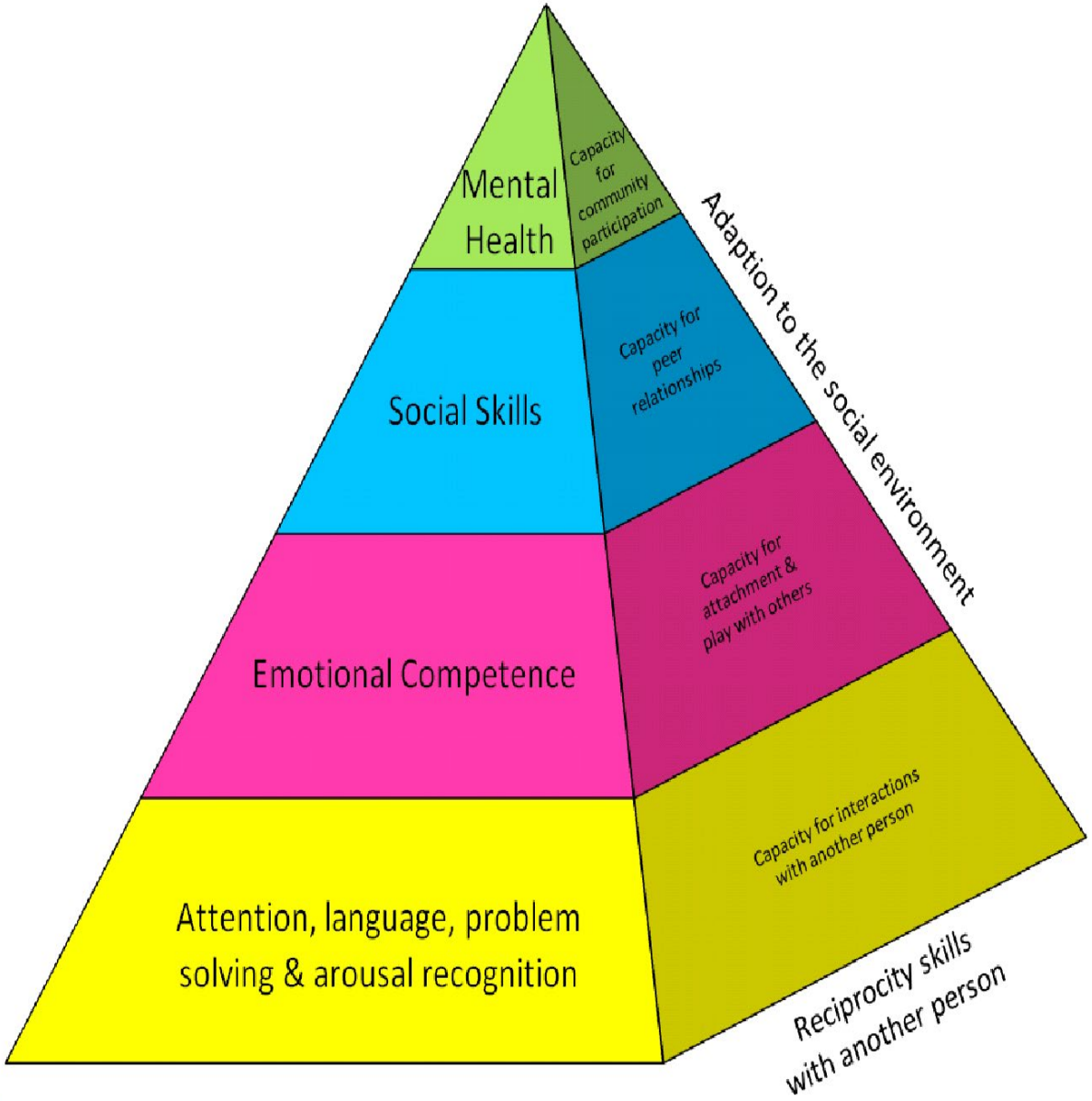
2e. Child Psychological Development

Adolescence
is preparation for adult role of contributing to community

Primary school age
Social Skills:
Best measure of well-being

Emotional competence skills (2-5)
The **Westmead Feelings Program develops these skills**

Behavioural regulation & management (0-4yrs)



3. “Parenting a child with IDD: the chosen & those that chose”

- Child is a source of happiness and joy, marveling at events and sequential small achievements
- Parents report an increased sense of purpose, with priority to love, affection, caring
- Expanded personal and social networks and community involved in caring
- Learning who your real friends are
- Increased spirituality & faith in humanity
- Greater family unity, although can be a make or break experience
- Increased tolerance and understanding for all differences
- A source of personal growth
- Influencing others who don’t understand disability

Mainstream families may miss out living life in the fast lane.

(Dossetor 2001, based on Stainton & Besser, 1998)

3b. Acceptance and MH prevention from parent training

- Acceptance by professionals from birth can influence future experiences with family and friends (Ch6 Silove, 2011)
- Disabilities often do not become evident for many months

- Parent training is the most cost-effective intervention to prevent MH of both emotional and disruptive behaviour
- Improves parental mental health and relationships
- Failure leads to a cycle of coercion and deterioration

- Stepping Stones derived from behaviour management and ABA, teaching developmental understanding and principals of normalization. Creating a safe and positive learning environment, using assertive discipline, adapting to a child with disability realistic expectations being part of the community and taking care of yourself as a parent. Strategies involve developing a positive relationship, encouraging good behaviour and new skills, and managing mis-behaviour (Sanders & Ralph, 2002)
- Critical is the reduction of coercive behaviour to the child, while enabling skill building in the child's self-regulation. .
- Self-regulation is a key skill to protect from future mental disorder for internalising disorders of anxiety and depression and externalising disorders of ADHD and ODD.
- Parent Training is not funded by NDIS, as it is seen as a preventative rather than early intervention program
- Is cost effective from increased time available for work

3c.“But my child is different”: eg Smith Magenis Syndrome

- Greater understanding of the genetic behavioural syndrome has earlier identification and intervention
- SMS parent support group provides enlightened support to new parents of SMS
- 10 yrs on parents have shown how despite biologically driven behaviour, supra-ordinate patience and behavioural persistence improves behaviour
- Judy Brewer Fisher argues that parents also need to advocate for their children with IDD to wider society for acceptance and service provision.
- Mutual parent support from a parent with the lived experience is valuable.
- Although biological disadvantage is a greater determinant of behaviour than family circumstances, yet supra ordinate parenting still makes a difference
- 2 year olds are the most violent beings and the role of parent is to teach self-regulation and socialisation, which in turn enables attachment and promotes the integration of self.

4. Promoting development and independence, esp in the context of Autism (Handicaps, Behaviour Skills Schedule, Wing 1981)

The main domains of development that progress with mental age are:

1. Motor and Sensory development & integration, including coordination, sitting still and calmness a pre-requisite for concentration.
2. Independence skills eg dressing, eating, hygiene & toileting skills. These are the best measure of general IQ before developing the '3Rs'.
3. Communication & Language: receptive, expressive, verbal, non-verbal (including object and picture communication).
4. Emotional, Social and play skills, the most complex skill; difficult to measure but we have well recognised descriptions of the sequence of skills.
5. Quality of imagination: stereotypic rigidity or imaginary preoccupation at the expense of social interaction versus ability to build reciprocal ideas
6. Educational and Community integration skills: keeping safe, accessing services, managing money. Schools are the primary setting in which these skills are tested and developed.

Promoting skill development even in small steps is key to independence and self-efficacy

4b. Factors that contribute to an easy or difficult child

Other factors also contribute to whether a child is easy or difficult to raise:

- **Health problems** including Neurological & sensory deficits
- **Intellectual ability**, incl learning problems & neuropsychiatric deficits
- **Temperament** with genetic & environmental contributors
- **Environmental Milieu**: Emotional warmth, stimulation, predictability and consistency
- **Earlier experiences**, positive, or traumatic
- **Attachment** style and strength

All contribute to the development & neuro-connectivity & to vulnerability and resilience.

Teaching emotional recognition skills, emotional perspective taking and emotional problem solving is key to developing attachments and social relationships.

“You can’t have social skills without emotional skills” and Westmead Feelings program targets this specifically.

4. Interventions to promote skill development

Interventions to promote skill development has a growing literature and in our textbook the topics include:

- Sensory integration and motor development.
- Promoting communicative competence and Alternative and assisted communication.
- Building life skills.
- Developing emotion-based social skills in Autism and ID.
- Promoting healthy sexual awareness and relationships, and
- Transition.

5. Mental health and the bio-developmental-psycho-social-cultural framework.

In Autism 50% have ADHD, 50% have impairing anxiety

Recognition requires awareness

The B**D**PSC framework enables professional communication with a recognition of multi-causal mechanisms of behaviour

Ideology about challenging behaviour is not part of empirical and evidence-based practice.

Children with IDD need access to psychotropic treatment and assertive discipline and safety interventions

‘”Any child under 10 years cannot be considered to have capacity for criminal intent in Australia law!"

With parents we share responsible management of disturbed children and need multidisciplinary collaborative skills.

(Dossetor D. **Violence in children and adolescents with an intellectual disability and the importance of safety**. 2016 (1): 4-12. Associated with Matthew’s Story.)

5. Interventions to promote mental health: key elements from curriculum and textbook.

1. **Promoting Safety and resolution** (Ch 21),
   - **often need multidisciplinary intervention**
   - **consider systemic issues of service provision**
   - **consider**
     - **behaviour management**
     - **co-morbid psychiatric disorder**
     - **safety management can be highly effective**
2. **Modification of CBT and counselling** (Ch 22). Modification of trauma focused CBT is also important (Jackson and Waters, 2015).
3. **Regulation of arousal** (Ch 23)
   - **considers, development, trauma, attachment, anxiety, carer response and complex repair processes**
4. **Psychopharmacology** (Dossetor, 2014, 2019)
   - **Audit found average of 3.5 diagnoses**
   - **needing average of 2.5 medication**
   - **Medications work differently in this population**

'A doctor worth his salt has to be prepared to prescribe'

Novel therapies that can be helpful, versus those without peer review, or those that can be harmful

Treatment Effectiveness in Intellectual & Developmental Disabilities

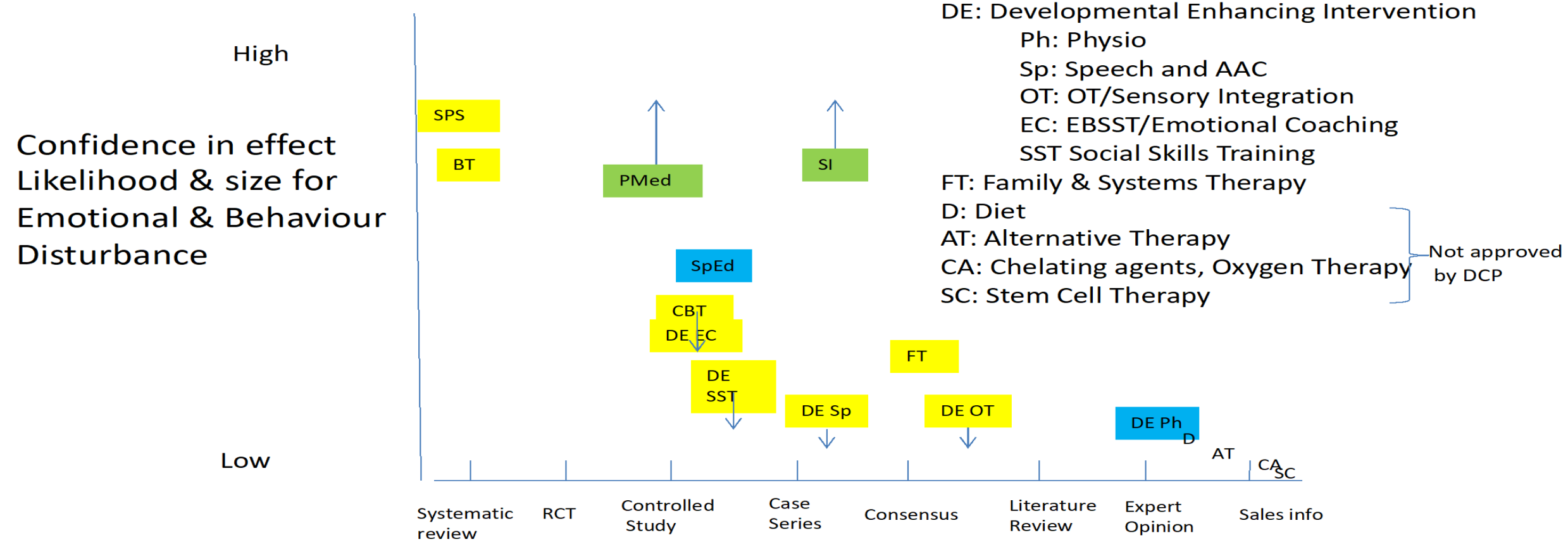
Rapid effect: days to weeks

Intermediate Effect: weeks to months

Slow long term effects: months to years

Direction of effect in more severe disturbance →

(The opposite generally applies for milder problems)



SI: Safety Intervention, incl room modification, CPI
SPS: Specialised Parenting Skills
BT: Behaviour Therapy; incl carer/staff training
PMed: Psychotropic Medication
SE: Special Education: skills to match needs
CBT: Cognitive Beh Therapy
DE: Developmental Enhancing Intervention
- Ph: Physio
- Sp: Speech and AAC
- OT: OT/Sensory Integration
- EC: EBSST/Emotional Coaching
- SST Social Skills Training

FT: Family & Systems Therapy
D: Diet
AT: Alternative Therapy
CA: Chelating agents, Oxygen Therapy
SC: Stem Cell Therapy

Not approved by DCP

Definitions of Mental Illness & Health in ID

Guide to Services framework in Australia

Term	Service	Disturbance	Severity	Examples
Mental Disorder/ Illness (3rd NMH Plan) 3%	Diagnosable Illness from DSMV Priority for Mental Health Services	Managed in community +/- short IP admission +/- MH Act	Significant impairment and high risk of harm to self or others	-Major Depression -Bipolar Disorder ·Schizophrenia ·Acute Mental Disorder
Mental Health problem (3rd NMHPlan) 20-40%	Diagnosed from DSMV but seen as a developmental disorder Rx by Paediatrics & disability service, +/- specialist ID MH. (not a serious MI)	EBD is as severe as impairment from ID. The combination makes for complexity and severity	Severe impairment, risks to care esp in acute exacerbation **Needs high expertise MD subspecialty collaboration of disability & health**	-ADHD/ODD/CD -ASD --Depressive symptoms -Anxiety Disorders, OCD, -Lability of mood, -Panic disorder, -Dissociation -Trauma based problems
Challenging Behaviour 40-60%	Culturally Abnormal Behaviours Disability Services, ABA approach	the physical safety of the person /others	High impairment, intensity, frequency or duration big impact on QOL	-aggression/self harm -behaviour disturbance -stereotypy -habits, Pica
Mental Health & Wellbeing (3rd NMH Plan) 100%	emotional & social wellbeing. PPEI across family, school, community & interagency	Promote resilience to cope with the normal life stressors	Chronic moderate severe EDBD probs. Aim to achieve potential & QOL	attention, restless, behaviour, reciprocity, self esteem, autonomy, skills, part'n, employm't

6. Collaboration between disability, health and education.

The policy guideline used to be that ‘there is no wrong door’. MOU now redundant.

NDIS is more funded more than twice as much as all of mental health, but has no mechanism for collaborating and cost shifts to the emergency departments of health if disability service provider is failing.

Parents are required to become experts in their own child’s problems and the services needed.

You need a trusted GP for intercurrent problems, a paediatrician to coordinate all other service inputs.

Complex cases can need:

paediatric, and psychiatric skills to assess Health, mental health, multidimensional formulation and medication.

Multidisciplinary allied health skills including Clinical Psychology, OT, Speech Therapy, Special Education, Pharmacy, Case management;

Skill building approaches as described above;

Specialised therapies eg Emotional-based learning skills, play therapy or modified or trauma focused CBT;

Family and System assessment and management Skills which may be different to mainstream families;

Cultural knowledge is often needed, as cultural difference can affect health literacy and access.

Awareness of child protection and human rights issues and the interface with DCJ and care systems of those in OOHC.

6b. Collaboration between disability, health and education.

No one agency has all these skill sets so there is a need for a high level of interagency collaboration.

Integration of Service Systems probably remains a major and complex challenge with a growing literature on what can go wrong

What can enable constructive collaboration?

Resource intensive approaches such as the Intensive Services Response has demonstrated that well funded persistence can help build interagency solutions

There is the expertise in the NDIS/NDIA to realise we need this again, and reason would suggest that at some stage in the development of NDIS funded services this will need to be developed again.

Tiered Pyramid of Services for C&A with ID & MH problems:

The specialist MH in ID Service for C&A when there is none.

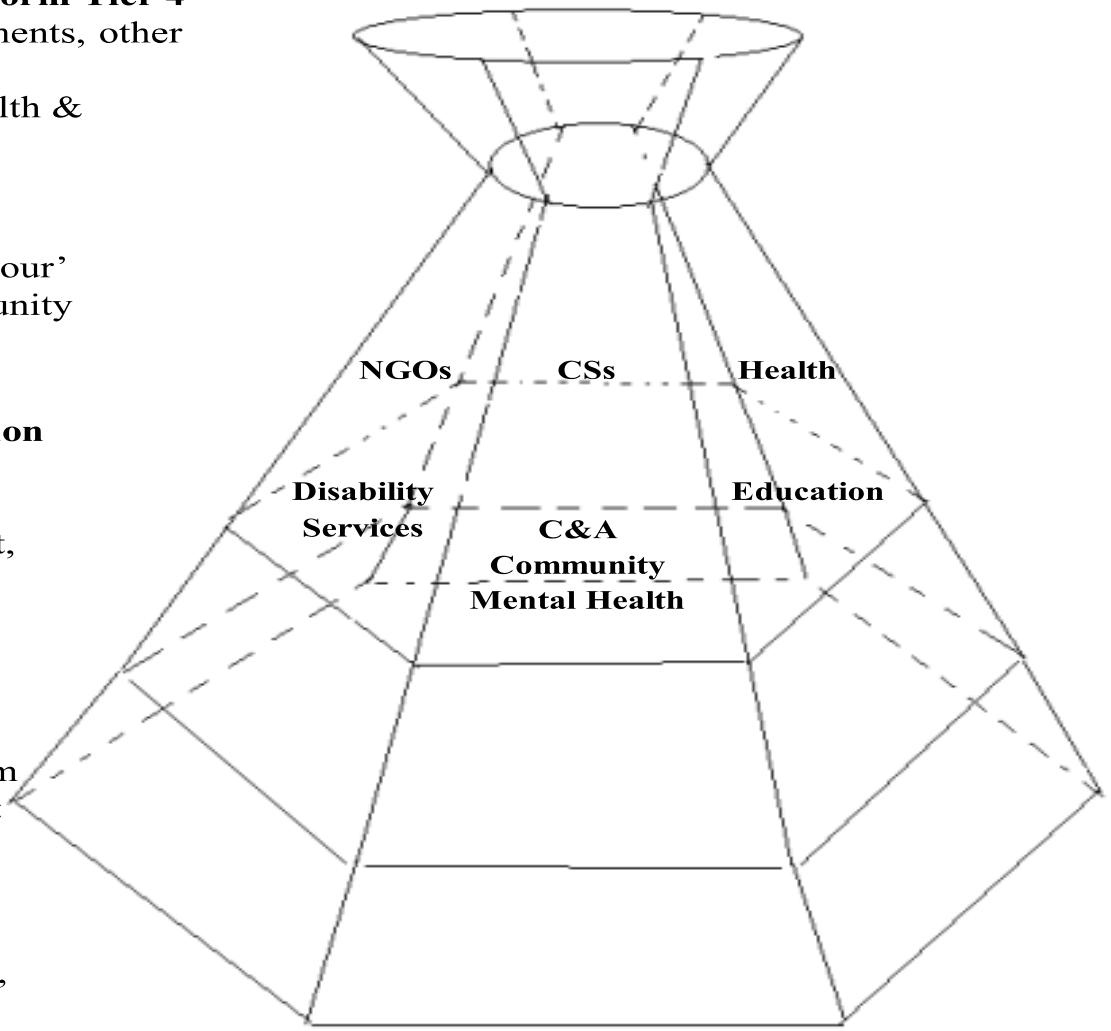
Tier 5: **Acute short/medium term interventions that inform Tier 4**
Includes: Emergency departments, MH in-patients assessments, other residential behaviour services; and
Specialist/Tertiary MH in ID clinicians from mental health & disability services.

The Tier 4 Circle: The Final Common Pathway
Complex case management decision making; 'best endeavour' obligations including decisions about out of family community placements.

Tier 3: Multidisciplinary and Multi-agency Collaboration
Disability Service: ADHC behaviour clinician, speech pathologist, OT, other specialist psychology service;
Health: GP, paediatrician or neurologist; MH Psychologist, SW, family therapist, psychiatrist; and
Education: teacher, aide, school counsellor, principal, behaviour support specialist.

Tier 2: **Community Disability Services providing case management and specialist parent training.** Mainly from ADHC but can be MH or other agency or non-government organisations.

Tier 1: **Generic Health Provision** for families
Includes: GPs, community nurses, child community teams, Families NSW, Triple P



*3D Model provides for **all other human services** to be part of the pyramid*

7. Families and The Burden of Care

- The biggest handicap with a child with IDD is the additional Burden of Care for the family: 7 hours a day 7 days a week
- the empowerment that arises from the Stepping Stones parent training, can have a strong effect, partly through improving behaviour but partly from engaging family and friends to be part of the child's life
- It helps with the parental helplessness and self-sacrifice that I see often leads to dangerous violence when the adolescent with IDD becomes bigger and stronger than the parent.
- NDIS doesn't directly focus on supporting carers.
- NDIS provides indirect respite in term of support for 'community access and other independence enhancing activities'.
- This can break the intensity of behavioural dysfunction eg between a fraught mother and a self-injurious child.
- Or the domineering teenager who never leaves his room or his social media for what can be years of stagnation.
- NDIS and the need to accept provide for residential VOOHC, emergency respite and shared care arrangements
- There is no doubt that there are massive costs for families and society of a failure to intervene early.
- Disability has first responsibility for 'challenging behaviour', and most violence is not due to mental illness.
- The interaction between NDIS and DCJ is a problem area which will need greater development for systems for complex cases and access to the complex support needs pathway.
- There is a lack of cooperative systems between health/mental health and NDIS/NDIA which is critical to provide the best of multiagency/multidisciplinary care for complex cases.

7b. Helping families survive

Requires attention to parental wellbeing

Assessment of family functioning includes:

- Quality of emotional communication and practical problem solving,
- Families depend on structure, rules and accountability with rewards and consequences for all.
- They provide love and welfare emotions, as well as practical resources.
- Relationships are healthier with appropriate closeness, not too enmeshed and not too remote.
- And managing emergency emotions: Emergency emotions include anger, anxiety, depression or rigidity (eg from OCD), are highly infections and can have harmful effects and, even if another member of the family experiences a different emergency emotion.

- Social isolation is a a poor prognostic factor of mental health.

(McMaster Model of Family Assessment, Miller, 2000)

8. Conclusions

A parent of child with IDD needs to become a developmentally attuned behavioural expert for both their child and for their benefit.

Need extra support for health and mental health

Needs collaboration between GPs, Paediatricians, CAMHS and specialist disability and mental health services

School need to provide adequate support for building emotional skills and peer engagement and mental health and resilience.

Families need support from family friends, caring communities as well as NDIS for ‘personal support and community access’

NDIS has added funding for developmental skills, but the quality of positive behaviour support remains critical

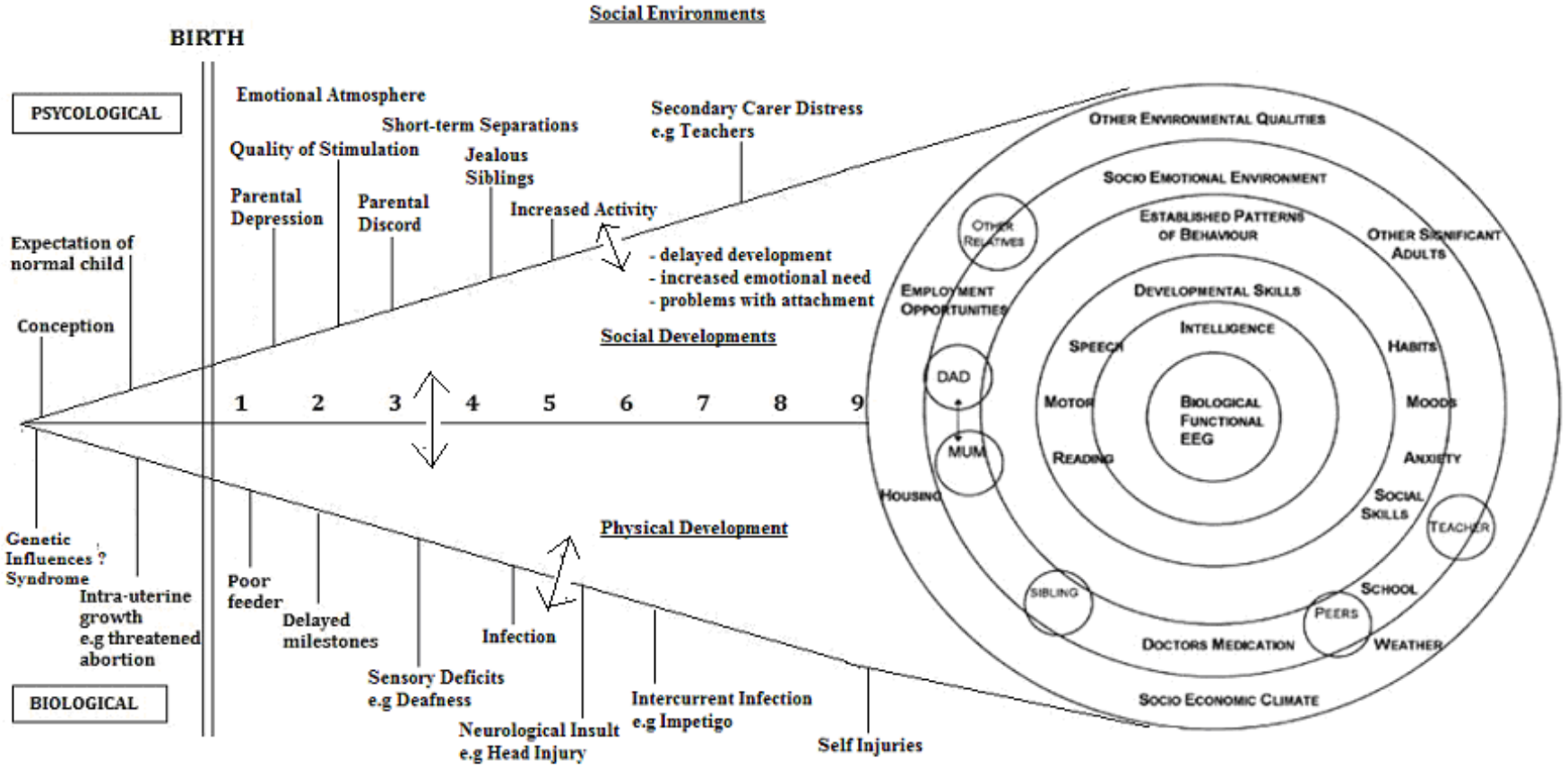
NDIA battles between economics and expertise in disability skills for complex emotional and behavioural support.

Skilled intervention for emotional and behavioural disturbance can make a huge difference.

All parents can aim for a quality of life for their child with IDD even if they are blown off course: with the brain, heart and courage of unlikely friends they meet along the road.

The bio developmental psycho social cultural multi-aetiological framework for child disorder.

After Brofenbrenner, 1979



J for MH of C&A with IDD: an educational resource

Partnership between Health/MH, Education and Disability

10th year, 25th edition; readership of >2000; still the only one

Continues the themes from the textbook:

Sample of Other Topics include:

- A developmental psychiatry assessment & process
- Other emerging frameworks
    - e.g. Practice Improvement Framework, IDMH Core Competencies
- *Behavioural Phenotypes, Fetal Alcohol Spectrum Disorder*
- Rights and Responsibilities to access health services
- *Health economics of preventative MH intervention in ID*
- Models of support eg. shared care
- Promoting resilience
- Parent training e.g. Stepping Stones Triple P
- Sibling Australia resources
- A Special Olympian: the benefits of exercise
- Positive Behaviour Support for Learning (PBL/PBS)
- Managing violence and the importance of safety
- *Grief/ loss intervention*
- *Creative therapies* e.g., Play Therapy, Music Therapy
- Communication and visual strategies
- Sensory modulation and self regulation
- Animal Therapy
- *Trauma and attachment informed practice framework*
- Getting students ready for life after school
- *Personalised learning & support in schools*
- Diagnosis, Medication and Outcome
- Personal guidelines on prescribing
- Strugglers and Copers: Psychosis in VCFS
- ASD implications of DSM-5
- Catatonia; Psychosis in ID
- Autism in girls
- Refugee mental health and intellectual disability
- Updates on Pharmacological Interventions
    - *The medicine cabinet series number 18*
- State and National forums on better health and MH
- Implications NDIS on services for complex emotional behavioural disturbance
- Insight into a mental health review tribunal
- Restrictive practices: Policy and practice
- Complex case reviews systems
- Practice leadership e.g. “A day in the life of...”
- Conference reports

Review by Centre for Disability Studies 2014

What enables Professional and interagency Collaboration: A review of the constructs by DPC

1. A belief we can help
2. A 'good enough' quality of life
3. Reciprocity
4. A common language
5. Mutual professional trust & respect
6. Tolerance & patience
7. Creativity
8. Valuing different skills
9. Family centred practice
10. Life span & future orientated
11. A capacity to prioritise
12. Respect within own agency
13. Evidence-based approaches
14. Practice based expertise
15. An assumption of beneficence
16. Systemic approaches
17. Personal professional engagement
18. Service prioritisation
19. Support from senior management
20. Practically orientated

What prevents a replication of Professional and Interagency Collaboration

1. Challenged by the severity
2. A lack of conceptualisation
3. Not willing to try
4. Lack of interagency open communication
5. A professionally egocentric view
6. Lack of MDT peer support
7. Despair
8. Professional isolation and stigmatisation
9. Decline of services
10. Business models rather than clinical need
11. Lack of pathways to care & service responsiveness
12. Lack of a system of prioritisation
13. Lack governance structure
14. Lack of recognition of the special population needs
15. Beginning with construction of rules and terms of engagement
16. Individual partners contributing as individuals
17. Lack of specialty professional skills and services

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- **Violence in children and adolescents with an intellectual disability and the importance of safety.** Dossetor D. Journal of Mental Health for Children and Adolescents with Intellectual and Developmental Disability. 2016. 7(1): 4-13.
- **Diagnosis, Psychotropic Medication and Outcome in an audit of 150 children and adolescent neuropsychiatric patients.** Dossetor D. Journal of Mental Health for Children and Adolescents with Intellectual and Developmental Disability. 2014; 5(1): 4-9.
- **The Developmental Psychiatry Clinic.** Dossetor D. Journal of Mental Health for Children and Adolescents with Intellectual and Developmental Disability. 2015. 6(2): 4-13.
- **Catatonia: an under-recognised, acutely treatable condition in young people with intellectual disability/ASD**. Dossetor D. Journal of Mental Health for Children and Adolescents with Intellectual and Developmental Disability. 8(1): 4-10.
- **Ewan's story: Psychosis in Intellectual Disability and Autism** by Ewan's parents and David Dossetor
- Dossetor D. **Mental Health Problems: Disorders of Social Development caused by Maladaptation's of Theory of Mind? A Developmental Psychiatry View.** CHW School-Link Newsletter 3(1). 2012.
- **www.schoollink.chw.edu.au: resources include all past editions of Journal of Mental Health for Children and Adolescents with Intellectual and Developmental Disability.**
- **Evaluation report on the Developmental Psychiatry Clinic: A Partnership between The Children's Hospital at Westmead and Statewide Behaviour Intervention Service (ADHC)** by CDC 2014.
- Promotion, Prevention and Early Intervention resources.
- **Webinars:**
    1. Curiosity, collaboration and action: Understanding & Responding to Behaviour in the Classroom;
    2. Cool, Calm, Collected & Connected in the Classroom: Supporting Students with Self-Regulation;
    3. The Mental Health of Young People with Intellectual Disability: What you need to know and what you can do.
    4. Hub Webinar Launch: What is different about diagnosing and treating the mental health of C&A with IDMH
    5. Self Injurious Behaviour: a case series
    - Other titles are to follow.

Additional Resoures/Podcasts

Partnership Projects with The Department of Developmental Disability Neuropsychiatry (3DN) UNSW (https://3dn.unsw.edu.au).

E-learning for IDMH for MH professionals, disability professionals and carers

Intellectual Disability Mental Health Core Competency Framework: A Manual for Mental Health Professionals and Toolkit. Committee Member and presentation. https://youtu.be/h15Y3yWfrxc

Accessible Mental Health Services for People with an Intellectual Disability: A Guide for Providers. https://3dn.unsw.edu.au/sites/default/files/ddn/page/Accessible%20Mental%20Health%20Services%20for%20People%20with%20an%20ID%20-%20A%20Guide%20for%20Providers_current.pdf

July 2016. **CardioMetabolic Syndrome in Adolescents with Intellectual Disability.** Presenter https://youtu.be/rqS20Sy7Uy8

Responsible Prescribing of Psychotropic Medication Podcast 2017. incl: **Prescribing in children and adolescents with intellectual disability.** https://3dn.unsw.edu.au/content/responsible-psychotropic-prescribing-people-intellectual-disability-podcasts

Episode 1: Recognising symptoms of mental illness in children and adolescents with an intellectual disability ;

Episode 2: Deciding if, when and what to prescribe

Episode 3: Instituting, monitoring and discontinuing psychotropic treatment

Handout: Guidelines for an assessment summary

SCHN MHID Hub: Service leaflet with range of services, including consultation and capacity building

Plus referral form and criteria. On SCHN website or on www.schoollink.chw.edu.au;