Dual Diagnosis
Mental Health and Intellectual Disability

School Clinics
Lif O’Connor
Clinical Nurse Consultant
Metro-Regional Intellectual Disability Network

A partnership model for integrated health care in metropolitan and regional areas
The Kogarah Model

Target Group:
• Children, adolescents and adults with developmental delay/disabilities and associated health and mental health conditions

Catchment Areas:
• Local Health District (Kogarah DAS)
  – St George/ Sutherland, South Eastern Sydney
• Metro-Regional (MRID.net)
  – Metropolitan and Regional NSW: with a focus on Illawarra Shoalhaven

Specialist Clinics:
• Comprehensive range of coordinated, comprehensive and continuous paediatric and adult multidisciplinary clinic services
Specialist Clinic Services

Paediatric Clinics
- Developmental Paediatrics
- Psychiatry
- Neurology
- School
- Sleep
- Genetics
- Rehabilitation
- Orthopaedics
- Endocrine
- Gastroenterology
- Nutrition
- Feeding
- Allergy
- Neuropsychology
- Transition

Adult Clinics
- Medical
- Neurology
- Psychiatry
- Rehabilitation
- Sleep
- Genetics

Allied Health & Nursing Support
- Social Work
- Psychology/Neuropsychology
- Occupational Therapy
- Physiotherapy
- Speech Therapy
- Nutrition
- Autism Educator
- Clinical Nurse Consultant

MRID.net
Metro-Regional ID Network
Broad Aims of MRID Team

- To develop a partnership model of service delivery using the existing services in South East Sydney LHD to establish an inter-regional specialist health Tier 4 service for people with ID and complex health needs in the Illawarra Shoalhaven LHD and beyond.

- To identify the opportunities and barriers relevant to the development of inter-regional services.

- To create a service model which may be implemented in other regional, rural or under-serviced areas within NSW.
Model of Care

MRID.net
Specialised Multidisciplinary Team

Specialist Health & MH Care Providers

Primary & Community Health

Review

Advice

Primary Agencies – Private, Public NGOs

Education

Consultation

Consultation

Carer Support

Carer

AHDC

DEC

Management

Assessment

Capacity Building

Service Identification and Engagement

GP

Other Agencies – Private, Public NGOs

Health Care Planning

Young Person

Family
Health Care Needs

• Students with Intellectual Disability (ID) have poorer health outcomes and greater difficulty accessing healthcare in comparison with the general population.

• They experience a high prevalence of significant medical problems and their health and mental health conditions are often unrecognised, misdiagnosed and poorly managed.

• The needs of a student with a borderline to mild ID are significantly different to a student with a severe to profound disability.

• Students with ID are a disadvantaged group with complex health, educational and socio-economic needs and require services from a number of professionals and agencies.
School Clinics

Aims:
• Explore the student’s health and psychosocial needs that impact on the student’s functioning in an integrated and holistic manner

Location:
• Special schools
• Support classes in mainstream schools
• ASPECT and NGO schools

Collaborative Case Plan:
• Develop with teachers, school counsellors, medical specialists, allied health and nursing professionals, student and parents/ carers

Transition Clinics:
• Students commencing school
• Students leaving school
Youth - DSM IV Axis I Diagnoses

- Autistic
- Depressive/ Bipolar
- Anxiety
- Impulse-Control/ Explosive
- ADHD/ Disruptive
- Schizophrenia/ Psychotic
- Antisocial
- Eating
- Dissociative
- Adjustment
- Others

MRID.net
Metro-Regional ID Network

NSW
Health
South Eastern Sydney Local Health District
Youth Transitions – Comorbidities

- Autism Spectrum Disorder
- Behaviour/ Mental Health
- Neurological/ Seizures
- Rehabilitation/ Orthopaedic
- Nutrition/ Feeding/ GIT
- Endocrine
- Vision/ Hearing
- General Medical
- Out-of-Home-Care (OOHC)
School Transition Clinic

16 – 18 years of age = years 11 and 12
Multi-disciplinary and multi-agency
Paediatric and Adult health

Holistic approach to health & wellbeing:
• Health – physical and mental
• Dental care
• Psychosocial needs
• Family/Carer health – physical, mental
• Preventative health measures
• Post School Options
• Equipment provision
• Respite Care and Out of Home care
• Finance
Participants

- Young person and their parents and/or carers
- Paediatric and Adult Physician
- Adolescent Psychiatrist
- School Therapy Team member
- Social Worker
- Head Teacher and Class Teacher
- ADHC Case Manager and ADHC RBIT Representative
- Transition Care Coordinator – ACI
- Translator
Transition Plan

Goals:

• Registered with GP

• Respite services in place

• Post School Option planned

• Engagement with adult medical professionals commenced

• Contact details for all professionals involved in care recorded

• Medical summaries /handover completed
Transition Plan cont...

Areas addressed:

- Immunisation
- Sexual Health education
- Risk taking behaviours
- Leisure plans
- Mobility needs & equipment
- Adult medical services
- Adult Allied Health services
- Dental services
- Chronic illness self-management
- Support groups – young person + parents/carers + siblings
- Social Work/case management needs
Interagency Collaboration

- Clinics are provided in collaboration with DEC, FACS | ADHC, NGOs, Mental Health and Community Health and conducted off-site in mainstream and schools for specific purposes.
- Interagency partnerships ensure smooth pathways between health and other services.
- Regular interagency meetings support clients with complex needs and their families in their transitions between health, disability and educational services.
- Targeted to the student and family’s need – paediatric, psychiatric, rehabilitation, gastroenterology and transition.
MRID My Toolkits

- Schoolkit ®:
- Interactive website
- Video and cartoon – Max’s story
- Resources – templates

- Sponsored by ACI
- Launched this year
- First of a series: co-design, hospitalisation and NGE collaboration
Thank the person next to you for not falling asleep...

...or wake them up for afternoon tea