Mental health and wellbeing of people with intellectual or developmental disability: challenges in the provision of integrated supports

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Funding Sources & Disclosures

Core
Family and Community Services NSW
Mental Health Branch, NSW Ministry of Health

Research and Projects
Family and Community Services NSW
NSW Ministry of Health & Related Organisations
Australian Government Department of Health & Ageing
NDIS Quality and Safeguards Commission
Australian Research Council
National Health and Medical Research Council
Autism CRC
About Us

Introduction

The Department of Developmental Disability Neuropsychiatry (3DN) was established by the Chair of Intellectual Disability Mental Health, Professor Julian Trollor, at UNSW Sydney in 2014. 3DN is a new, unique Department at UNSW that brings together experts in developmental disability, psychiatry, psychology and other health and human services disciplines to focus on the care and support of people with developmental disability and mental health conditions.

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3DN Department Head

Professor Julian Trollor
UNSW Chair of Intellectual Disability Mental Health
Vision

The highest attainable standard developmental disability.

Mission

To improve health policy, practice disability, with a focus on mental

Guiding principles

...
Health inequality and Epidemiology

Understanding risk factors

Contextual determinants of health inequality

Formulation and testing of interventions

Knowledge transfer

Projects to date

- Established ID population cohorts
- Analysis of ambulatory mental health data
- Analysis of mortality data
- Cohort study of elderly with ID
- Analysis of national GP dataset (BEACH)

- Analysis of cause of death data
- Review of cardiometabolic risk factors
- Mixed methods analysis of barriers to healthcare

- National audits of medical & nursing schools
- Statewide analysis of competence & training needs of mental health professionals
- National analysis of ID psychiatrist workforce
- National and State Policy analysis

- Developed/piloted healthy lifestyle intervention
- Delphi and scoping of tertiary ID mental health service
- Design and implementation of training curriculum in ID mental health
- Development and evaluation of cardiometabolic framework and toolkit
- Co-hosted 1st and 2nd National Round Table

Inclusive KT platform established, developed:
- National Guide ID and 2018 Communique
- Comprehensive e-learning portal for health, disability professionals and carers
- Core competencies framework and toolkit
- Responsible prescribing resources

Additional Projects:
- Determinants of mental illness in people with ID
- Risk factor analysis in ultra high risk groups
- Participation in preventative health programs
- Analysis of cause of death data
- Review of cardiometabolic risk factors
- Mixed methods analysis of barriers to healthcare
- Analysis of cause of death data
- Review of cardiometabolic risk factors
- Mixed methods analysis of barriers to healthcare
- Development and evaluation of cardiometabolic framework and toolkit
- Co-hosted 1st and 2nd National Round Table

Future Projects:
- Analysis of cause of death data
- Review of cardiometabolic risk factors
- Mixed methods analysis of barriers to healthcare
- Development and evaluation of cardiometabolic framework and toolkit
- Co-hosted 1st and 2nd National Round Table

- Predictors of mental health outcomes
- Interagency integration & continuity of care
- Costs and markers of service inefficiency
- Psychopharmacology and its relationship to outcomes
- Develop model of care and model costs
- Develop interagency services model
- Pilot a deprescribing intervention
- Host 3rd National Round Table on ID mental health to determine future priorities
- Collaborate with NDIA, Health department on policy revisions and services development initiatives
- Implement a state-wide service based on trial results
- Develop and launch a 'closing the physical health gap' strategy for people with ID and mental illness
Outline

Context

Overview of research

Workforce and capacity development in IDD psychiatry

Implications

For discussion
Context

Role of mental health professionals

Mental health care landscape

Intersection between health and disability supports
Opportunity

- Australian Government’s Joint Standing Committee on the NDIS recommended that “COAG Health Council (HC)… urgently undertake work to address…. interface issues between health and NDIS”

- COAG Disability Reform Council (DRC) Communiqué noted “the importance of greater clarity in roles and responsibilities between the NDIS and mainstream health systems”
People on the autism spectrum are the biggest group by primary disability type.
People with ID represent the 2nd biggest group.
About 65% of participants have a developmental disability.

People with ID represent the single biggest group for $ committed support
People on the autism spectrum are the second biggest
About 64% of total spend relates to people with developmental disabilities

Outline

Context

Overview of research

Workforce and capacity development in IDD psychiatry

Implications

For discussion
Research shows much higher rates of ill health and lower rates of disease detection

- On average, people with intellectual disability have 2.5 times the number of health conditions than people without intellectual disability.
- Some people with intellectual disability are at risk of specific health problems.
- Most health problems are not related to the specific cause of the disability, eg:
  - higher rates of potentially modifiable cardiometabolic risk factors: obesity, low physical activity, poor diet
  - higher rates of psychotropic prescription and polypharmacy
- Half of all medical conditions are undetected, including high blood pressure, metabolic syndrome.
ID impacts what happens in primary care

- Bettering the Evaluation and Care of Health (BEACH) program
- People with ID have:
  - Non uniform access to GPs (better access in States with initiatives, better in rural areas)
  - Over-representation of presentations for psychological reasons
  - Administrative rather than medical needs dominating their GP encounter
  - Much higher rates of psychotropic medication recommendations eg 10 fold for antipsychotics
  - Less attention to preventative health needs and preventative prescribing

ID Papers
Paper 1: doi.org/10.1111/jir.12301;
Paper 3: http://dx.doi.org/10.3399/bjgpopen18X101541

ASD Papers
Paper 1: http://dx.doi.org/10.1177/1362361317714588
Paper 2: http://dx.doi.org/10.1177/1362361317702560
What this means

- People with ID are not accessing primary care services in a way that meets their needs
- Mental health is a major issue
- Time pressures make nuanced considerations around complex issues more difficult
- Time pressures mean that interagency and interdisciplinary ways of working are under done
- Requests for paperwork related to restrictive practices are hard to fulfil
NHMRC partnerships for better health project

Analysis of Barriers and Enablers of Access to Mental Health Services

Representation of People with ID in Mental Health Policy

Big Data and (Mental) Health of People with ID
Multiple barriers to access

Barriers and Enablers to Accessing Mental Health Services: The experiences of people with intellectual disabilities

Erin Louise Whittle, Karen Raewyn Fisher, Simone Reppermund, Julian Trollor

Received: 21 July 2017 | Revised: 6 June 2018 | Accepted: 3 September 2018
DOI: 10.1111/jar.12533
Multiple barriers to access

Supply or availability of healthcare services
  • Lack of services, distance and location

Relevance and effectiveness
  • Problems meeting the need and lack of effectiveness

Barriers at personal and systems levels
  • Financial, organisational
  • Recognition of mental health disorder
  • Challenging behaviour

Health inequity and the social determinants of health
Representation of People with ID in Mental Health Policy

Debate

Representation of people with intellectual disability in Australian mental health policy

Simone Reppermund¹,², Leanne Dowse³, Angela Dew³ and Julian Trollor¹,²
Linkage Study & Cohorts

Linked multiple NSW service system data sets to establish large cohorts of interest

On basis of presence of diagnoses
- mental health diagnosis
- neurological disorder
- intellectual disability
- develop mental disorder

On basis of use of a service system
- Disability services
  - ED
  - Mental health
  - Non-mental health admissions
  - Ambulatory MH services
- Health services
Cohorts & Linkage

Linkage contains 35,257,037 records for 2,199,534 individuals

Admitted Patients (2001-2016)
Emergency Department (2005-2016)
Ambulatory Mental Health (2001-2015)
Disability Services (2005-2015)
Offenders data (1994-2016)
Corrective Services Disability (2001-2016)
Public Guardian NSW (1994-2016)
NSW Ombudsman (2002-2015)
Education Disability dataset (2011-2015)
RBDM & Death Unit Record (1994-2016) & (1985-2013)
% of NSW Health service users with ID, FY 14-15

- **5.7%** of people using any mental health services (6.2% regional, 5.4% metro)
- **6.3%** of people using inpatient mental health services (6.8% regional, 6.1% metro)
- **5.6%** of people using non-inpatient mental health services (6.2% regional, 5.5% metro)
- **3.8%** of people using ED services (4.3% regional, 3.6% metro)
- **3.6%** of people using inpatient non-mental health services (3.8% regional, 3.6% metro)
- **5.6%** of people using any mental health services (6.2% regional, 5.4% metro)

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ID impacts trajectory after first psychiatric admission

- People with ID represented 3% of group with index presentation.
- Accounting for all relevant variables, at 1 month, 2-5 months and 6-24 months after index admission ID was associated with
  - 3 times the risk of presenting to the emergency department
  - 55-75% higher likelihood of being readmitted

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Emergency department presentation and readmission after index psychiatric admission: a data linkage study

Xue Li,¹ Preeyaporn Srusuebkul,¹ Simone Reppermund,¹,² Julian Trollor¹,²

**ABSTRACT**

**Objective** To use linked administrative datasets to assess factors associated with emergency department (ED) presentation and psychiatric readmission in three distinctive time intervals after the index psychiatric admission.

**Design** A retrospective data-linkage study.

**Setting** Cohort study using four linked government administrative datasets.

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**Strengths and limitations of this study**

- This study identifies factors associated with emergency department (ED) presentations and psychiatric readmissions following index admission after controlling for potential confounding factors in a large population-based dataset.
- This study represents the only study internationally...
What this means

• People with ID should be a major concern to mental health services

• Existing evidence supports inefficient care

• Limited awareness of, and support for, working in an integrated way between disability and mental health supports

• Capacity building is needed to make services responsive
Mortality in People with ID

Mortality among a Cohort of Persons with an Intellectual Disability in New South Wales, Australia

Tony Reiter1 and Julian Trollor2
1School of Psychological Sciences, Australian College of Applied Psychology (ACAP), Sydney, NSW, Australia; 2Department of Developmental Disability Neuropsychiatry, UNSW, Sydney, NSW, Australia

DOI: 10.1111/jar.12190

http://bmjopen.bmj.com/content/7/2/e013489
Findings: Deaths in people with ID

- Median age at death in people with ID was 54 years; (81 years for general NSW population)

- Comparative mortality figures:
  - 4.0 for the 20-44-year age group
  - 2.3 in the 45-64-year group.

- Causes of death:
  - diseases of the respiratory system (20%); circulatory system (18%); malignant neoplasms (18%); diseases of the nervous system (13%); injury and poisoning (6%).

- Potentially avoidable deaths
  - 38% (17% for the NSW population)
  - Dominated by cardiovascular, infections, cancer, other and respiratory.
Mortality in Autism

What we did

• Examined death rates and cause of death in people on the autism spectrum from ages 5-64 in Australia's most populous state of NSW

How we did it

• Deidentified linkage of multiple health and human services administrative data sets

• 36,000 people with ASD from 5-64 years inclusive

• Compared death and cause of death in autistic individuals from 5-64 years of age with those in the general population in NSW

Mortality and Cause of Death of Australians on the Autism Spectrum

Ye In (Jane) Hwang, Preeyaporn Srasuebkul, Kitty-Rose Foley, Samuel Arnold, and Julian N. Trollor

Focused investigations regarding mortality rates, risk factors, and cause of death in autistic populations remain scarce. The present study used large linked datasets spanning 2001–2015 to report the rates and risk factors for mortality and cause of death in individuals on the autism spectrum ($n = 35,929$ age range 5–64) with and without concurrent intellectual disability (ID) in New South Wales, Australia. Mortality rates for those on the autism spectrum were 2.06 times that of the general population. Concurrent ID, epilepsy, mental health conditions, and chronic physical health conditions were associated with a higher risk of death for those on the spectrum, whereas demographic variables such as gender and socioeconomic status were not. A differing profile of top causes of death was found for autistic individuals relative to the general population, with “nervous system and sense disorders” and “injury and poisoning” being the top-ranked causes for those on the spectrum. The findings alert the need for health promotion and management of concurrent physical and mental health conditions for those on the autism spectrum. There is also a need for better identification, diagnosis, and documentation of older adults on the autism spectrum. Autism Res 2019, 9999: 1–10. © 2019 International Society for Autism Research, Wiley Periodicals, Inc.
Table 2. Adjusted Death Rates and Comparative Mortality Figures (CMFs) for Those With ASD (With and Without ID) and the NSW General Population

<table>
<thead>
<tr>
<th></th>
<th>N (person years)</th>
<th>Deaths, N (%)</th>
<th>Median age at death [IQR]</th>
<th>Crude rate (per 10,000)</th>
<th>Adjusted rate</th>
<th>CMF [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparison cohort</td>
<td>(77,967,924)</td>
<td>120,020,000</td>
<td>51.9 [45-58]</td>
<td>15.4</td>
<td>14.6</td>
<td>1</td>
</tr>
<tr>
<td>ASD overall</td>
<td>35,929 (313,840)</td>
<td>244 (0.7%)</td>
<td>35 [20-52]</td>
<td>7.7</td>
<td>30.0</td>
<td>2.06 [1.64-2.58]</td>
</tr>
<tr>
<td>ASD only</td>
<td>19,823 (158,646)</td>
<td>62 (0.3%)</td>
<td>27 [10-50]</td>
<td>3.9</td>
<td>23.5</td>
<td>1.61 [1.17-2.21]</td>
</tr>
<tr>
<td>ASD with ID</td>
<td>16,106 (155,194)</td>
<td>182 (1.1%)</td>
<td>35 [20-53]</td>
<td>1.2</td>
<td>32.3</td>
<td>2.26 [1.74-2.94]</td>
</tr>
</tbody>
</table>

Note. ID = intellectual disability; ASD = autism spectrum disorder; CI = confidence interval.

* The number of individuals in the comparison cohort and subsequently the percentage of deaths could not be ascertained from this

Figure 2. Age-specific death rates for those with autism spectrum disorder and those from the general population with 95% confidence intervals.
Table 3. Top Three Underlying Causes of Death in People With ASD Compared to the General Population in NSW

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>NSW general population</th>
<th>ASD all</th>
<th>ASD only&lt;sup&gt;a&lt;/sup&gt;</th>
<th>ASD with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rank</td>
<td>Rank</td>
<td>Rank</td>
<td>Rank</td>
</tr>
<tr>
<td>Nervous system and sense organ disorders</td>
<td>6 (2%)</td>
<td>2 (20%)</td>
<td>1 (23%)</td>
<td></td>
</tr>
<tr>
<td>Neoplasm (malignant)</td>
<td>1 (53%)</td>
<td>3 (19%)</td>
<td>2 (19%)</td>
<td>2 (19%)</td>
</tr>
<tr>
<td>Circulatory diseases</td>
<td>2 (22%)</td>
<td>3 (8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury and poisoning</td>
<td>3 (13%)</td>
<td>1 (23%)</td>
<td>1 (50%)</td>
<td>3 (16%)</td>
</tr>
</tbody>
</table>

<sup>a</sup> Ethical approvals for this study prevent the display of the percentage proportions for lower-ranked causes of death in the ASD groups.

Note. ID = intellectual disability; ASD = autism spectrum disorder.
Table 4. Factors Associated With Increased Risk of Death for Individuals With ASD

<table>
<thead>
<tr>
<th></th>
<th>Univariate</th>
<th></th>
<th></th>
<th>Multivariate</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HR</td>
<td>95% CI</td>
<td>P</td>
<td>HR</td>
<td>95% CI</td>
<td>P</td>
</tr>
<tr>
<td>Sex (female)</td>
<td>1.64</td>
<td>1.25-2.16</td>
<td>&lt;0.0001</td>
<td>1.06</td>
<td>0.80-1.40</td>
<td>0.681</td>
</tr>
<tr>
<td>Age category (5–14)</td>
<td>2.04</td>
<td>1.34-3.12</td>
<td>0.001</td>
<td>1.30</td>
<td>0.84-2.00</td>
<td>0.238</td>
</tr>
<tr>
<td>15–24</td>
<td>8.00</td>
<td>5.53-11.55</td>
<td>&lt;0.0001</td>
<td>3.50</td>
<td>2.32-5.28</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>25–44</td>
<td>30.51</td>
<td>21.51-43.29</td>
<td>&lt;0.0001</td>
<td>7.87</td>
<td>4.91-12.59</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Data source (health)</td>
<td>3.52</td>
<td>2.72-4.55</td>
<td>&lt;0.0001</td>
<td>1.30</td>
<td>0.95-1.78</td>
<td>0.096</td>
</tr>
<tr>
<td>ID</td>
<td>3.17</td>
<td>2.38-4.22</td>
<td>&lt;0.0001</td>
<td>1.90</td>
<td>1.38-2.63</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>8.75</td>
<td>6.72-11.40</td>
<td>&lt;0.0001</td>
<td>3.00</td>
<td>2.20-4.09</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Mental health</td>
<td>9.39</td>
<td>6.83-12.91</td>
<td>&lt;0.0001</td>
<td>3.53</td>
<td>2.43-5.11</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Charlson comorbidity index (0)</td>
<td>16.44</td>
<td>11.54-23.43</td>
<td>&lt;0.0001</td>
<td>3.20</td>
<td>2.09-4.88</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>1–3</td>
<td>25.92</td>
<td>9.61-69.91</td>
<td>&lt;0.0001</td>
<td>3.44</td>
<td>1.10-10.72</td>
<td>0.033</td>
</tr>
<tr>
<td>4–6</td>
<td>137.79</td>
<td>95.21-199.42</td>
<td>&lt;0.0001</td>
<td>26.02</td>
<td>15.88-42.63</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Remoteness (Major cities)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inner regional</td>
<td>1.07</td>
<td>0.80-1.44</td>
<td>0.637</td>
<td>1.19</td>
<td>0.879-1.62</td>
<td>0.258</td>
</tr>
<tr>
<td>Other</td>
<td>1.01</td>
<td>0.65-1.58</td>
<td>0.958</td>
<td>0.99</td>
<td>0.614-1.61</td>
<td>0.983</td>
</tr>
<tr>
<td>IRSD (1–2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3–4</td>
<td>1.12</td>
<td>0.75-1.69</td>
<td>0.575</td>
<td>1.14</td>
<td>0.75-1.72</td>
<td>0.547</td>
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<tr>
<td>5–6</td>
<td>1.12</td>
<td>0.75-1.66</td>
<td>0.578</td>
<td>1.13</td>
<td>0.76-1.69</td>
<td>0.544</td>
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<tr>
<td>7–8</td>
<td>1.26</td>
<td>0.85-1.86</td>
<td>0.244</td>
<td>0.98</td>
<td>0.66-1.47</td>
<td>0.936</td>
</tr>
<tr>
<td>9–10 least disadvantaged</td>
<td>0.97</td>
<td>0.63-1.49</td>
<td>0.895</td>
<td>0.98</td>
<td>0.63-1.51</td>
<td>0.916</td>
</tr>
</tbody>
</table>

Note. ID = intellectual disability; ASD = autism spectrum disorder; IRSD = index of relative social disadvantage; CI = confidence interval.
What this means

- People with ID and people with ASD die prematurely. Mortality for these groups is way in excess of the general population.

- Depending on the cause of death classification used, the patterns of causes of death indicate that respiratory, nervous system and circulatory system deaths are significant contributors. Injuries and poisonings in people with ASD without ID deserve special attention.

- The much higher rates of potentially avoidable deaths in people with ID suggest a major problem with healthcare and preventative health care for people with ID.

- Factors related to death differ in people with and without ID/ASD; a substantial risk is having a mental health condition.
Table 3. Clinical hours

Building workforce capacity in Australia and New Zealand: a profile of psychiatrists with an interest in intellectual and developmental disability mental health

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and Centre for Healthy Brain Ageing, School of Psychiatry, UNSW Sydney, Sydney, NSW, Australia

* p < .05.
Training capacity

Table 1. Respondent demographics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Category</th>
<th>n</th>
<th>%</th>
<th>(N=71)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Female</td>
<td>27</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>44</td>
<td>62</td>
<td></td>
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<tr>
<td>Age</td>
<td>30–39 years</td>
<td>4</td>
<td>6</td>
<td></td>
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<tr>
<td></td>
<td>40–49 years</td>
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<td>35</td>
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<td>50–59 years</td>
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<td></td>
<td>60–69 years</td>
<td>14</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>70–79 years</td>
<td>5</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Primary country of work</td>
<td>Australia</td>
<td>63</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New Zealand</td>
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<td></td>
<td>Australia and New Zealand</td>
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<td>IDOMH expertise</td>
<td>Expertise in IDOMH</td>
<td>38</td>
<td>54</td>
<td></td>
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<tr>
<td></td>
<td>Interest but not expertise in IDOMH</td>
<td>33</td>
<td>47</td>
<td></td>
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<tr>
<td>Country initial medical degree gained</td>
<td>Australia</td>
<td>40</td>
<td>56</td>
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<td></td>
<td>UK</td>
<td>9</td>
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<td></td>
<td>India</td>
<td>5</td>
<td>7</td>
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<td></td>
<td>New Zealand</td>
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<td></td>
<td>South Africa</td>
<td>3</td>
<td>4</td>
<td></td>
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<tr>
<td></td>
<td>Other</td>
<td>9</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Country postgraduate psychiatry qualification gained</td>
<td>Australia</td>
<td>46</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td></td>
<td>UK</td>
<td>10</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New Zealand</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>9</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

Figures 1. Service locations across Australia and New Zealand where potential rotations could be offered.

Note: Eight service locations are not mapped: for five services the number of potential rotation posts was unknown, and three services were state-wide (n=2 in Queensland and n=1 in New South Wales).
Further paper: Clinical Capacity of Australian and New Zealand Psychiatrists who work with People with Intellectual and Developmental Disabilities

Objective: To describe the characteristics and clinical capacity of Australian and New Zealand psychiatrists working in intellectual and developmental disability mental health (IDDMH).

Accepted for publication overnight
Equipping psychiatrists to meet the mental health needs of people with intellectual and development disability

- **Phase 1** - Review of current RANZCP training curricula and international curricula
- **Phase 2** - Analysis of RANZCP 2014 workforce survey data and Section of Psychiatry of IDD (SPIDD) membership
- **Phase 3** - Survey of Australian and New Zealand psychiatrists with expertise/interest in the area of IDD and short survey of RANZCP Faculty/Section Chairs and Trainee Representative Council members.
- **Phase 4** - Consultation with the RANZCP around future subspecialty training in the psychiatry of IDD
- **Phase 5** - Development of draft curriculum for advanced training in the psychiatry of IDD and enhanced IDD content in the Stage 2 syllabus
Equipping psychiatrists: recommendations

• Suggested modifications for Stage 2 Syllabus
• Suggested core competencies for an advanced psychiatry of Intellectual and Developmental Disability training curriculum
• For IDD to be formally recognised as an Area of Practice, with the formation of more rotations in this area.
• Forming a working group to determine:
  – Conducting further scoping work around the potential development of a CAT
  – the structure and content of the advanced training program, and to drive its development
NSW Specialised Health Services

- NSW Agency for Clinical Innovation: Intellectual Disability Network
- Currently 3 whole of ID health; expanding to 6
- Variable focus
- Hub and spoke model
- Each with mental health component
Mental health specific

IDD Training Fellowships: Health Education Training Institute

PHN capacity building in NSW

Some LHDs capacity building within MH service

Clinical coordinator roles x 10 new positions

Private practitioners

IDD Interest Group: NSW’s Section arm

Tertiary services
The Guide

Who is it for?
Mental health professionals and organisations that provide mental health services.

Aims
To assist health services in providing equitable access, a skilled workforce and appropriate treatment to people with an intellectual disability and a mental disorder.

Where to find it:
https://3dn.unsw.edu.au/the-guide
Hard copies of The Guide are available for purchase for $15 (including GST) per copy, which covers the cost of printing. To order and purchase hard copies of The Guide, contact Rachel Roth, rachel.roth@unsw.edu.au.

Contents

The Guide provides an overview of intellectual disability mental health and the importance of accessible services, including information on the mental health needs of people with intellectual disability and the barriers to accessing appropriate mental health services.

It highlights the principles that should guide service delivery, practical strategies for inclusive and accessible services and the implications for the service system. This includes suggestions of reasonable adjustments for mental health services to meet the mental health needs of people with intellectual disability.

The Guide also includes a comprehensive reference list of tools for inclusive practice.
Intellectual Disability Mental Health Core Competency Framework: A Manual for Mental Health Professionals

Who is it for?
Mental health professionals (including clinicians, managers and educators) from a range of professional backgrounds.

Aims
- To describe the core attributes required of the mental health workforce to deliver quality services to people with an intellectual disability.
- To inform readers of reasonable adjustments to clinical practice that should be made when working with people with an intellectual disability.

Where to find it:
https://3dn.unsw.edu.au/dmh-core-competency-framework

Contents
The Core Competency Framework provides background information on intellectual disability and mental health and describes the specific knowledge, skills and attitudes (arranged over 11 domains) that mental health professionals require to provide quality mental health services to people with an intellectual disability.

The resource also includes:
- A self-assessment tool for professionals to determine which core competencies they already meet, and which they will work towards
- A detailed list of resources that support professional development in intellectual disability mental health.
Intellectual Disability Mental Health Core Competency Framework: A Practical Toolkit for Mental Health Professionals

Who is it for?
Mental health professionals (including clinicians, managers and educators) from a range of professional backgrounds.

Aims
Designed as a companion document to the IDMH Core Competency Framework Manual, the Toolkit has been developed to provide applied guidance as to how mental health professionals in mainstream services can develop the core competencies outlined in the Framework Manual.

Where to find it:
https://3dn.unsw.edu.au/idmh-core-competency-framework

Contents
The main section of the Toolkit covers considerations for each stage of the treatment pathway – i) Intake, ii) Engagement, iii) Assessment, iv) Treatment, and v) Transition.

The Toolkit also contains:
- a section with information for service managers
- a summary of assessment tools that are suitable to use when assessing people with an intellectual disability (e.g. psychopathology, behaviour and emotion, and support needs)
- links to resources including training and education opportunities, guides, reports and discussion papers, relevant policy documents, and resources that can be provided to people with an intellectual disability, their family and support networks.
Positive Cardiometabolic Health for People with an Intellectual Disability

Who is it for?
Health and mental health professionals.

Aims
The early intervention framework aims to support health professionals to screen for cardiometabolic risk factors in people with an intellectual disability and provide targeted intervention strategies. The suite of resources also educates professionals, and empowers people with an intellectual disability and carers to ask their doctors to monitor cardiometabolic health.

Where to find it:
Early Intervention Framework, postcards and online resources:
https://3dn.unsw.edu.au/positive-cardiometabolic-health-
E-Learning modules:
http://www.rthealtheducation.edu.au/

Contents
The resources on Positive Cardiometabolic Health for People with an Intellectual Disability includes an early intervention framework.

Resources also include:
• Postcards for people with an intellectual disability and carers to take to the doctor. The front side provides information on cardiometabolic health for people with an intellectual disability or carers; the back side informs the doctor about the Early Intervention Framework.
• E-Learning modules for health professionals on Cardiometabolic Health in People with an Intellectual Disability. These modules will enhance professional knowledge and skills in the assessment and treatment of cardiometabolic ill health in people with an intellectual disability.
• Podcasts on prescribing psychotropic medications (next page).
Responsible Psychotropic Prescribing to People with an Intellectual Disability Podcasts

Who is it for?
Medical and mental health professionals.

Aims
To educate professionals on safe and effective prescribing practices for the treatment of mental health disorders in people with an intellectual disability.

Contents
Responsible psychotropic prescribing to adults with an intellectual disability:
Episode 1: Recognising symptoms of mental illness in adults with an intellectual disability
Episode 2: Deciding if, when and what to prescribe
Episode 3: Instituting, monitoring and discontinuing psychotropic treatment
Episode 4: Consumer perspectives

Responsible psychotropic prescribing to children and adolescents with an intellectual disability:
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
Episode 4: Carer perspectives

Where to find it:
https://3dn.unsw.edu.au/content/responsible-psychotropic-prescribing-people-intellectual-disability-podcasts
IDMH e-Learning

Contents

There are currently three portals within the e-Learning site: Professionals; Carers; and Consumers. At present the ‘Professionals’ and ‘Carers’ portals are active. Future funding will look to develop e-Learning for consumers.

The ‘Professionals’ portal is divided into two parts upon registration which directs the user to the appropriate modules based on whether the user works in disability or mental health.

Each suite of modules has been designed specifically for the particular audience and are based on peer reviewed literature and consultations with professionals (working in the corresponding areas) and with carers.
e-Learning for Mental Health Professionals

Who is it for?
Mental Health Professionals (GP’s, psychiatrists, psychologists, mental health nurses).

Aims
The modules aim to equip the mental health workforce in responding to the needs of people with intellectual disability and mental illness.

Where to find it:
http://www..rdfhealtheducation.edu.au/

Courses

About Intellectual Disability
Module 1 – Introduction to Intellectual Disability
Module 2 – Living with an Intellectual Disability
Module 3 – Intellectual Disability – Changing Perspectives

Fundamental Skills in IDMH
Module 4 – Communication: The Basics
Module 5 – Improving your Communication
Module 6 – Equality in Mental Health Care – A Guide for Clinicians
Module 7 – Consent, Decision-making & Privacy – A Guide for Clinicians

Clinical Foundations in IDMH
Module 8 – Mental Disorders in Intellectual Disability
Module 9 – Assessment of Mental Disorders in Intellectual Disability
Module 10 – Management of Mental Disorders in Intellectual Disability

Specialist Topics in IDMH
Module 11 – Challenging Behaviour I – Introduction
Module 12 – Challenging Behaviour II – Assessment
Module 13 – Challenging Behaviour III – Management
Module 14 – Emergency Mental Health Care 1: Understanding Intellectual Disability in the Emergency Department
Module 15 – Emergency Mental Health Care 2: Journey Through the Emergency Department
# e-Learning for Disability Professionals

## Who is it for?
Disability Professionals (e.g. support workers, advocates, supervisors/managers).

## Aims
The modules aim to further equip the disability workforce in responding to the needs of people with intellectual disability and mental illness.

## Where to find it:
http://www.idhealtheducation.edu.au/

## Courses

### IDMH Introduction
- Module 1 – Why is it Important to know about Mental Health?
- Module 2 – Introduction to Mental Health
- Module 3 – Mental Illness in Intellectual Disability

### IDMH Practical Skills
- Module 4 – A Person-Centred Approach
- Module 5 – Recognising Common Mental Illness
- Module 6 – How to Support a Person with a Possible Mental Illness and Intellectual Disability
- Module 7 – Supporting Behaviours of Concern

### IDMH Advanced Topics
- Module 8 – Enhancing Interagency Working with Health Professionals
- Module 9 – Treatments and Supports for Mental Illness
- Module 10 – How to Support a Person in a Mental Health Crisis
- Module 11 – Supporting Carers, Colleagues and Self Care

*Further modules are planned for release in 2018*
e-Learning for Carers

Who is it for?
Carers

Aims
The modules aim to equip carers in recognising and responding to the mental health needs of people with intellectual disability.

Where to find it:
http://www.whealtheducation.edu.au/

Courses

Foundation
Module 1 – About Intellectual Disability
Module 2 – About Mental Health

Mental Health and Illness
Module 3 – Mental Health and Intellectual Disability
Module 4 – Detecting changes in Mental Health and Wellbeing

Specific Mental Illnesses
Module 5 – Signs and Symptoms of Mood Disorders
Module 6 – Signs and Symptoms of Anxiety Disorders
Module 7 – Signs and Symptoms of Schizophrenia and Other Psychotic Disorders
Module 8 – Signs and Symptoms of Dementia

Wellbeing Record
Corresponding to the e-Learning, a downloadable ‘wellbeing record’ has been developed. This document will support carers to keep a record of the person’s wellbeing.

The wellbeing is available at:
https://dn.unsw.edu.au/wellbeing-record
COMMUNIQUÉ
Recommendations from the National Roundtable on the Mental Health of People with Intellectual Disability 2018
For discussion

- Behaviour, mental health and restrictive practices
- Addressing quality prescribing and monitoring of risks doesn’t happen in isolation
- Future vision- identifying the key infrastructure, systems, services and professionals
National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018

A restrictive practice is a regulated restrictive practice if it is or involves any of the following:

(a) seclusion, which is the sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted;

(b) chemical restraint, which is the use of medication or chemical substance for the primary purpose of influencing a person’s behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition;

(c) mechanical restraint, which is the use of a device to prevent, restrict, or subdue a person’s movement for the primary purpose of influencing a person’s behaviour but does not include the use of devices for therapeutic or non-behavioural purposes;

(d) physical restraint, which is the use or action of physical force to prevent, restrict or subdue movement of a person’s body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.

(e) environmental restraint, which restrict a person’s free access to all parts of their environment, including items or activities.

Note: For the definition of restrictive practice, see section 9 of the Act. Only regulated restrictive practices are covered by this instrument.
For discussion

- Behaviour, mental health and restrictive practices
- Addressing quality prescribing and monitoring of risks doesn’t happen in isolation
- Future vision- identifying the key infrastructure, systems, services and professionals