

# Collaborating for Change: School Clinics to Improve Well-Being of Children with Intellectual and Developmental Disabilities



Hebah Saleh & Natalie Hunter

School-Link Team

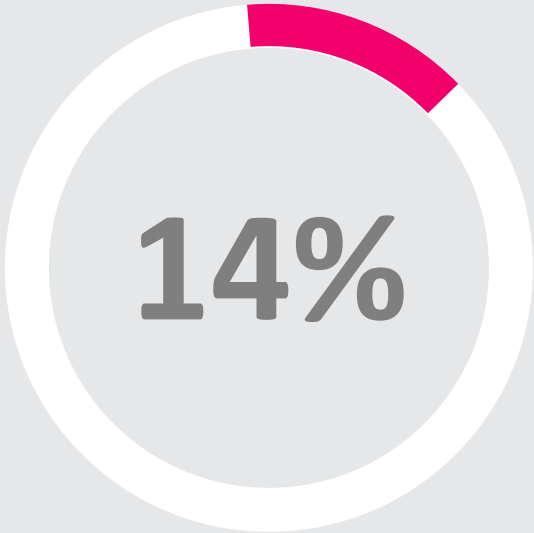


Department of Psychological Medicine- Sydney Children's Hospital Network

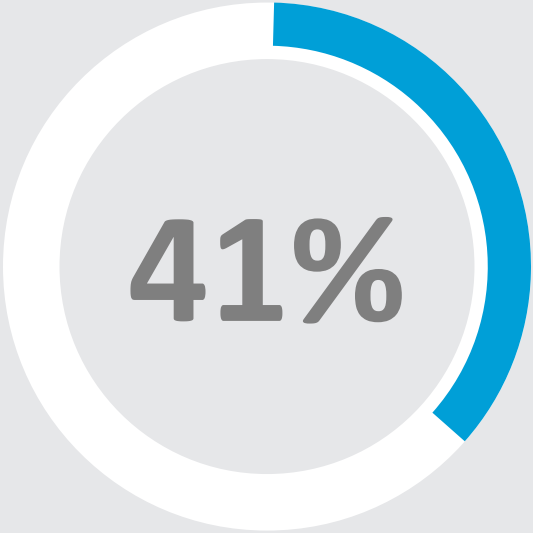
*Our images in this presentation are artworks made by young people from Operation Art for the Sydney Children's Hospital Network*



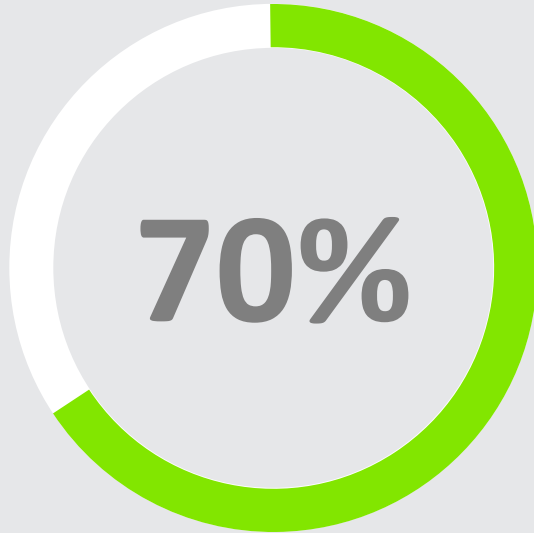
# PREVALENCE of MENTAL ILLNESS



**All school aged children**  
experience a mental health  
disorder  
(Lawrence et al 2015)



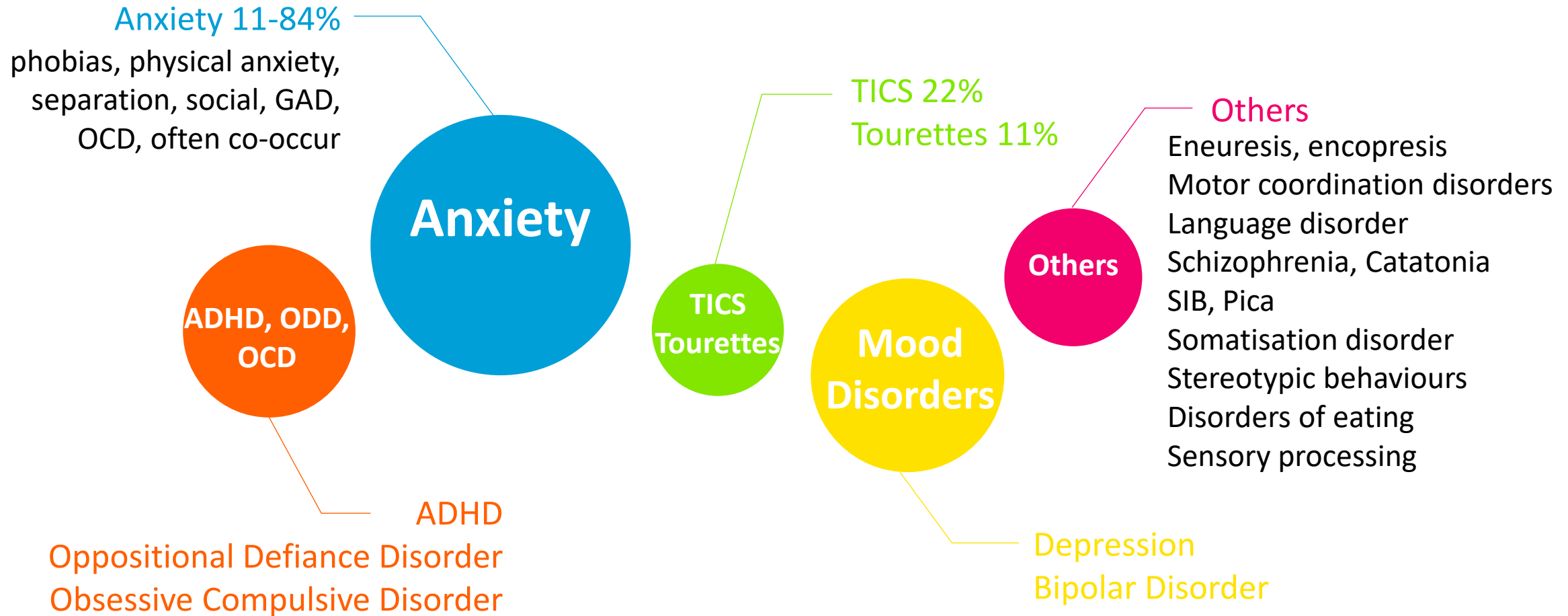
**Children with intellectual  
disability**  
experience severe emotional or  
behavioural problems  
(Einfield & Tonge 1996, 2006)



**Children aged 10-14yrs  
with ASD**  
have psychiatric disorder  
(Simonoff et al, 2008)

# CHILDREN WITH ASD

have increased rates of:



# AUDIT: COMMON DIAGNOSES



70%

ASD

63%

ADHD

47%

ODD

45%

ANXIETY

19%

DEPRESSION

16%

LABILITY OF MOOD

13%

Self Injurious  
Behaviour

10%

Developmental  
Coordination  
Disorder

6%

Sensory  
Sensitivity

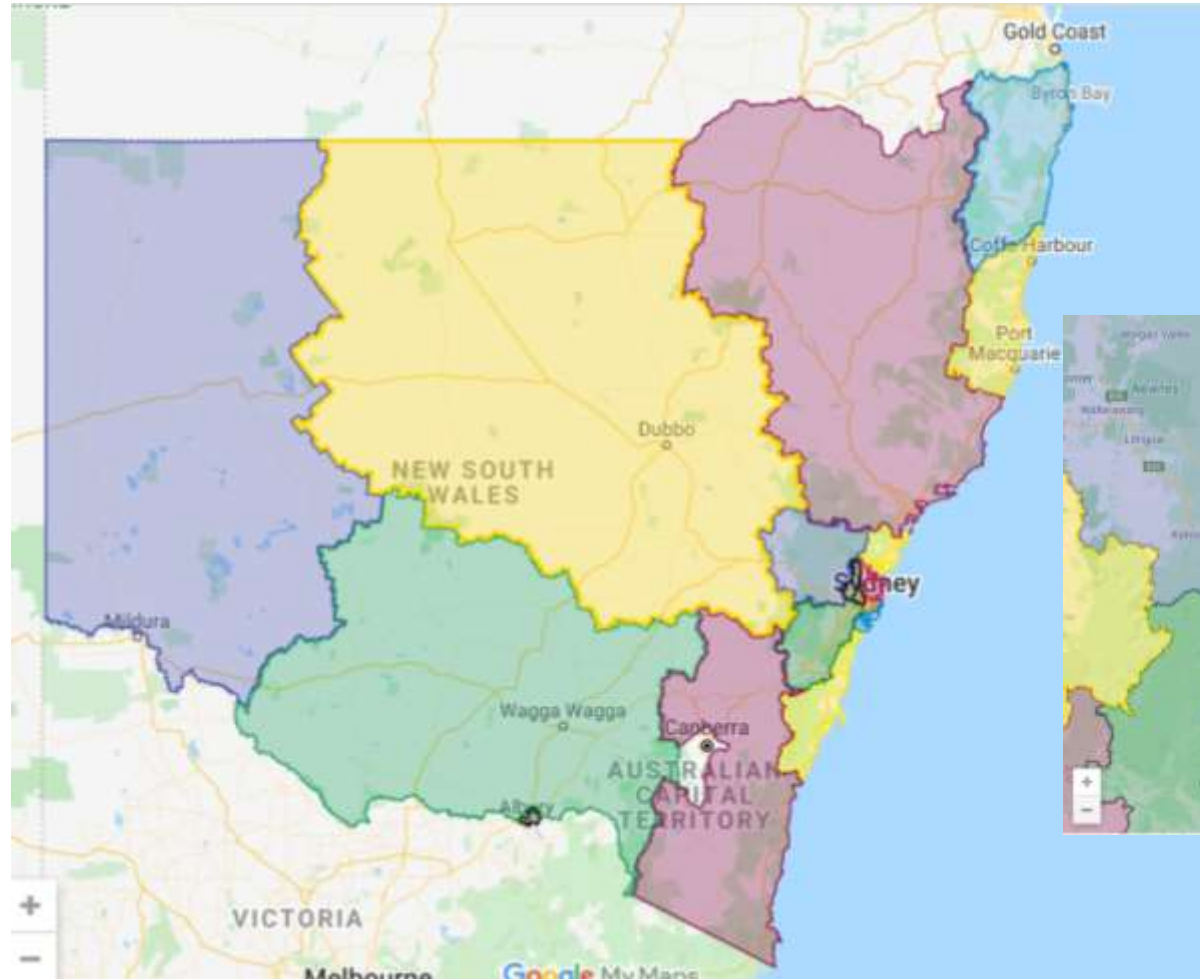
5%

Sleep  
Disorder

# NSW SCHOOL-LINK



Central Coast  
Far West  
Hunter New England  
Illawarra Shoalhaven  
Mid North Coast  
Murrumbidgee  
Nepean Blue Mountains  
Northern NSW  
Northern Sydney  
South Eastern Sydney  
South Western Sydney  
Southern NSW  
Sydney  
Western NSW  
Western Sydney



SCHN  
Justice Health

<https://www.health.nsw.gov.au/lhd/Pages/lhd-maps.aspx>



# SCHN SCHOOL-LINK



Focuses on improving mental health outcomes for children & adolescents with an intellectual disability & developmental disorders



Click here to go to the website: [www.schoolink.chw.edu.au](http://www.schoolink.chw.edu.au)

# SCHOOL CLINICS



- School Clinics are a multidisciplinary collaboration between School-Link, PECAT and two SSPs in Western Sydney
- Outreach clinics provided on-site





# PURPOSE



- Developed to meet the needs of children, their families and schools by providing holistic advice and recommendations
- In addition, provides teaching opportunities for paediatric registrars and psychiatry trainees
- School Clinics provide multi-disciplinary short-term review of young people who present with complex psychological and behavioural needs which is impacting on their ability to participate in school, home and community settings

# SCHOOL CLINIC PARTICIPANTS



## School

- Classroom teacher
- School principal or exec member
- School Counsellor
- Allied health

## Family

- Parents/carer
- Other family members
- Support person

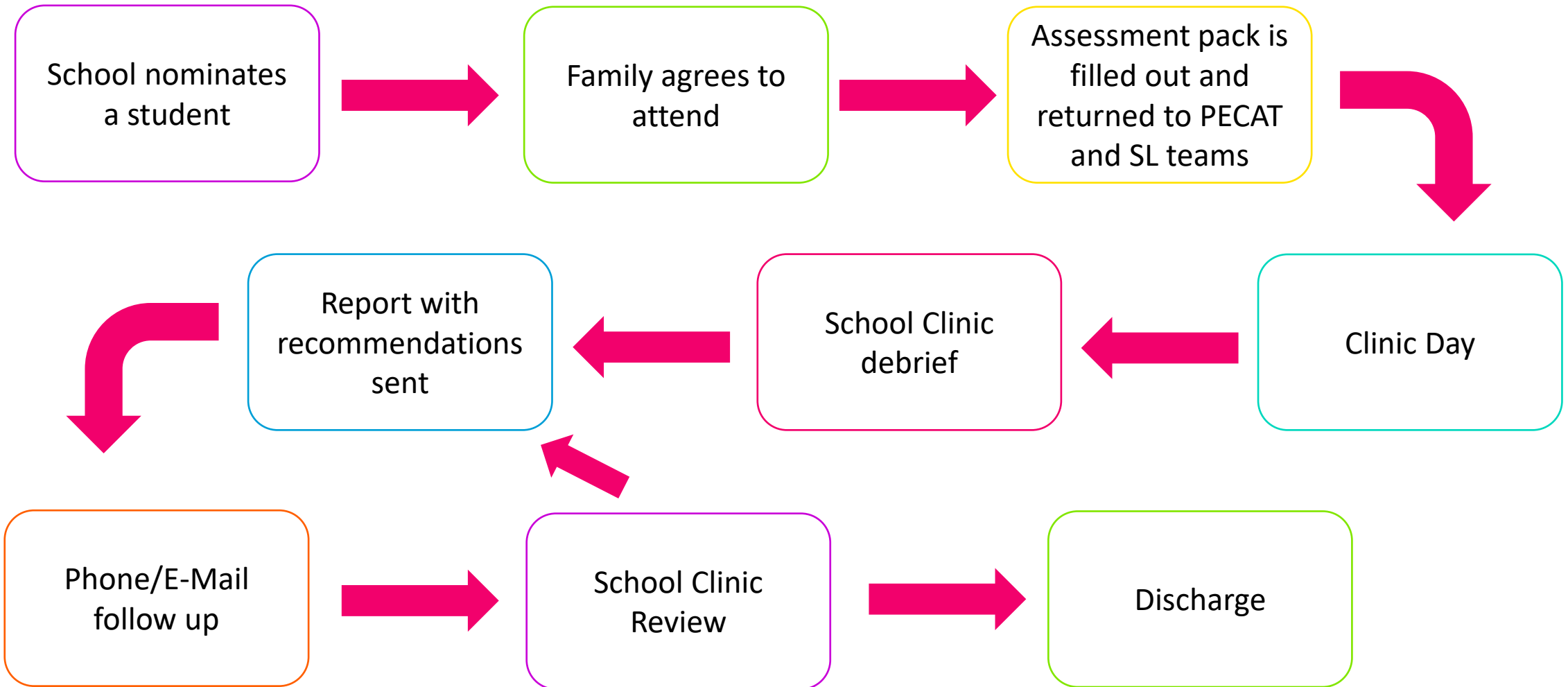
## Other

- DCJ Caseworker
- NDIS team

## NSW Health

- Paediatrician
- Paediatric registrar/psychiatry trainee
- School-Link team
- Clinical Psychologist
- Occupational Therapist
- NDIS Mental Health Worker

# SCHOOL CLINIC: PROCESS



# SCHOOL CLINIC ASSESSMENT PACK

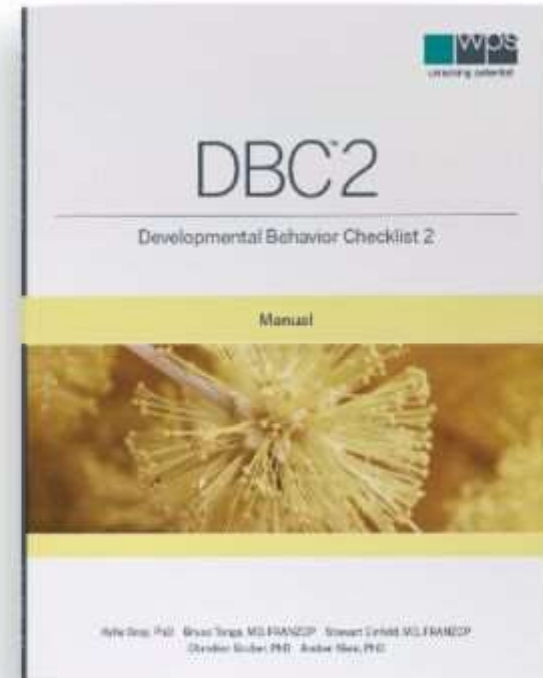


## Parents

- Parent letter
- Consent form
- Clinic questionnaire
- Developmental Behaviour Checklist (DBC-P)
- Depression, Anxiety and Stress Survey (DASS)

## Teachers

- Clinic questionnaire
- Developmental Behaviour Checklist (DBC-T)



# School Clinics Data

Term 2, 2015 – Term 2 2023



# THE SAMPLE



## School A

- A K-12 school in Western Sydney, >100 students enrolled
- Moderate, severe or profound ID
- Established 2015

## School B

- A K-12 school in Western Sydney, >100 students enrolled
- Moderate, severe or profound ID
- Established Term 2, 2022

56 Families

36%  
Complex  
Medical  
Needs

62%  
Adolescents

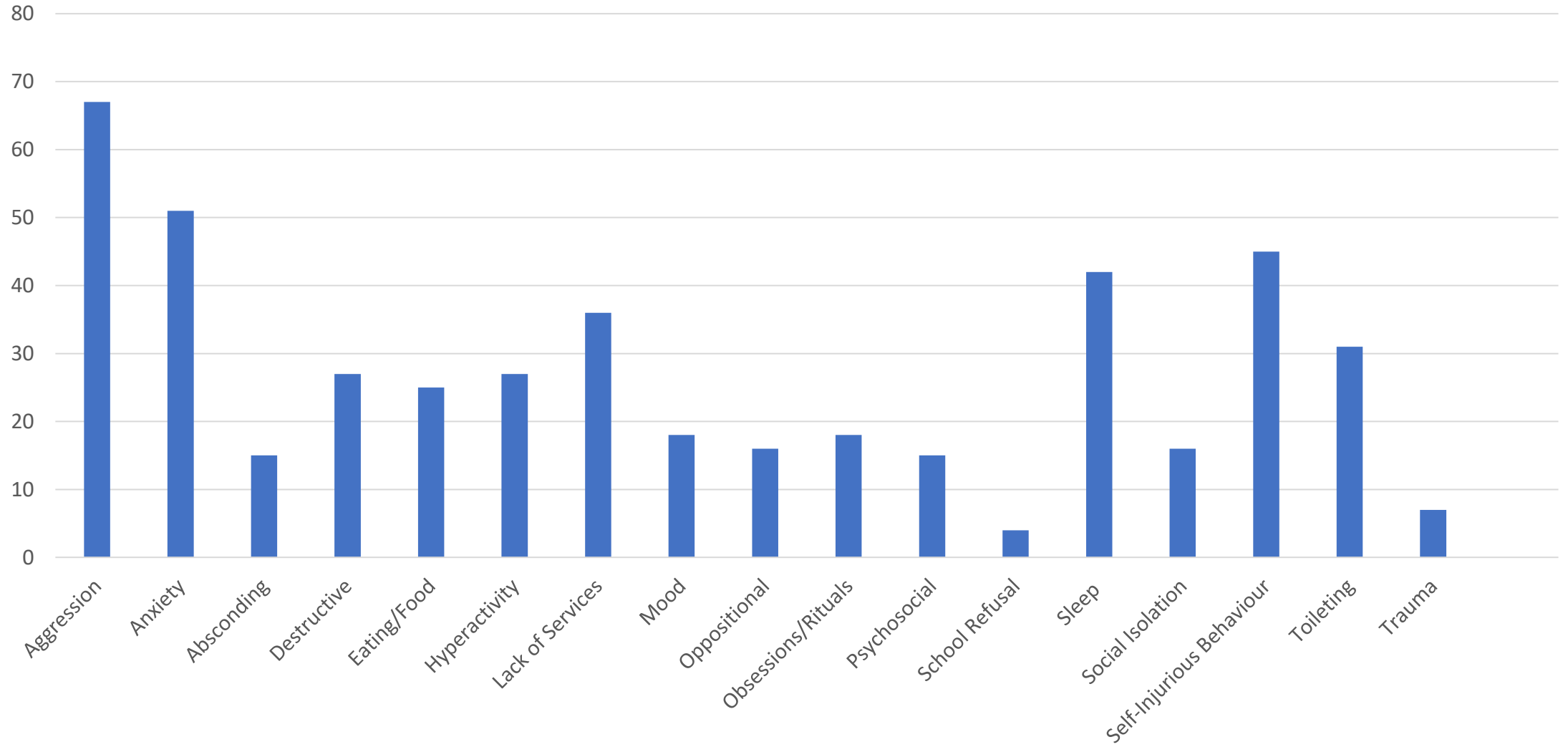
80%  
Males

78%  
Mod-Sev  
Intellectual  
Disability

140  
Consultations

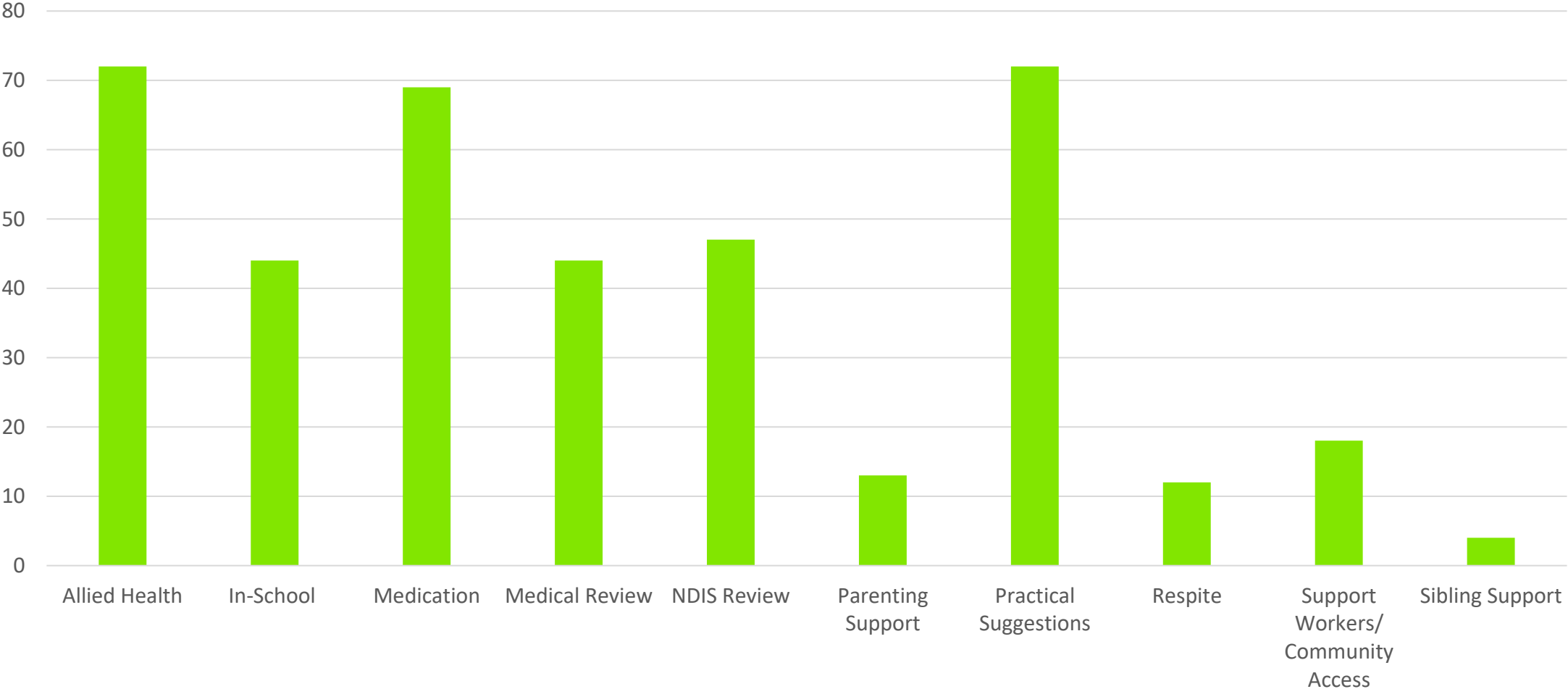
88%  
Autistic

# PRESENTING ISSUES





# RECOMMENDATIONS



# SCHOOL CLINICS: BENEFITS



- Easily accessible and in familiar environment
- Families are able to access expertise and support from a range of disciplines in one place
- No cost to families and no risk of being lost to follow up



# SCHOOL CLINICS: BENEFITS



- Recommendations take into account educational needs and school environment
- Able to gain richer, in-depth information from teachers and other school staff
- Can observe the young person in their own environment, rather than a clinical setting



# SCHOOL CLINICS: CHALLENGES



- Limitations of our service model
- Staffing
- Time limits
- Completion of needed documentation
- Recommendations not being followed

# SCHOOL CLINICS: HOW TO IMPLEMENT?



- Finding a paediatrician!!
- Having a clear service model
- When and where?
- Set boundaries on what clinic can/cannot provide
- Feedback processes
- <https://schoolkit.org.au/>

# CASE STUDY



# CASE STUDY



## REFERRAL

8 year old boy, severe ASD & intellectual disability, self-injury & aggression.

## FAMILY CONCERNS

Parental burnout and murder suicidal ideation; 19 years old sister's mental health, 10 year old brother risk of harm.

## RISK of HARM

To self, parents, teachers, siblings  
Deterioration from no services for 18 months. No response to FACS notifications and no family respite.



## POSSIBLE CONTRIBUTORS

Breakdown of school placement; urinary tract infection; effect of Ritalin?

## BEHAVIOURS OF CONCERN

On examination: Grisly and miserable; crying spontaneously; intense anger ; sleep disturbance; loss of independence skills over 18 months: dressing, toileting, feeding.

# CASE STUDY: RECOMMENDATIONS



- Medications: Trial of Fluoxetine then Zoloft
- Behaviour support at home, sharing strategies with school
- Referral to NDIS services
- Communication: Social stories about mum's illness, iPad for app, visual schedules concerning carers
- OT: Trial walker and weighted blanket, trampoline or swing at home
- Multidisciplinary meetings
- Modifications in the home for showering
- Family: Parenting program, grief counselling, cooking support for Dad





# SCHOOL-LINK PROJECTS



Survey needs of Professionals working at SSP's and Support units:

- Webinar topics
- Journal articles
- Professional development opportunities
- Case formulation

Children's Hospital at Westmead  
School-Link Survey 2022



# BEHAVIOUR TIP SHEETS



Behaviour Tip Sheets are now live on [www.schoollink.chw.edu.au](http://www.schoollink.chw.edu.au). Topics include:

- Why is my child Anxious
- How can I help my child navigate adolescence?
- Why does my child hurt themselves?
- Sensory processing difficulties
- Why does my child hurt others?

## TIP SHEET

### Why is My Child Anxious?

Helping Children with an Intellectual Disability and Autism Manage their Anxiety

**WHAT IS ANXIETY?**  
It is normal for a child to feel anxious sometimes. Anxious children and those with an intellectual disability tend to be more anxious.  
Anxiety is our body's natural response to stress. Anxiety can protect us from harm or stress (real or imagined) by preparing our body to respond to danger - fight, flight or freeze.  
Anxiety can trigger feelings such as fear, nervousness, anger and helplessness. When a child is anxious, they often worry about what might happen.  
Mostly, reassurance and support from family and school is enough to help a child cope with a new or stressful situation. However, when worry is excessive or lasts for a long time, it can be a problem. Excessive worry makes it difficult for a child to be involved in daily tasks, enjoy their usual activities and try new experiences. Anxiety can reduce a child's confidence in their ability to cope.  
Learning to manage new and stressful situations, and influence fear and worry, are important life skills.

**WHAT DOES ANXIETY LOOK LIKE?**  
Anxiety for most children is experienced as changes in the body, as well as changes in thinking and feelings.  
Physical signs of anxiety include:  
- *feeling nervous*  
- *breathing more quickly*  
- *feeling dizzy*  
- *a tight or sick stomach*  
- *headaches*  
- *sweating*  
- *going to the toilet a lot*  
- *having trouble getting to sleep and staying asleep*  
- *feeling tired or shaky*  
- *slow or tight muscles*  
- *feeling restless*  
Some children might experience one or two of these symptoms, while others will experience several. Some children will also find it difficult to identify and tell others about what they are feeling.  
Parents and teachers are also likely to notice that when a child is anxious, their mood and behaviour changes. These changes can include:  
- *insistence on routine and sameness*  
- *hypervigilance and checking*  
- *avoidance / withdrawal from social situations*  
- *irritability and being easily upset by small things*  
- *sensums in younger children*  
- *being angry, aggressive or disruptive*  
- *increased preoccupation with their special interest*  
- *increased repetitive or obsessive behaviours*  
- *avoidance of school, or school work*  
- *self-harm, such as scratching their skin or hitting their head*

**Physical Indications of Fight, Flight or Freeze**

**Why is My Child Anxious? TIP SHEET** | Developed by Sydney Children's Hospital Research, WISH School Link & SAU Consulting | 8

# BEHAVIOUR TIP SHEETS



**TIP SHEET**  
**Sensory Processing Difficulties**

Understanding How Children with Autism or an Intellectual Disability Experience Sensory Input

**WHAT IS SENSORY PROCESSING?**

We all experience the world through our senses - sight, sound, touch, smell, taste, body awareness, movement and proprioception (sensing our mental body size e.g. feeling hungry, sick, tired).

Sensory processing is the way we filter, process and organise the information we receive from within our bodies and from the environment around us.

How we interpret sensory information and respond to it is called sensory processing.

How we process sensory input is different for everyone. We all have our own sensory preferences - things we enjoy and seek, and things we dislike and try to avoid. Sensory preferences can influence the way we play, socialise, learn, and do everyday tasks and activities.

For example, some children don't like the feel of certain fabrics, labels and tags; some dislike being hugged, while others seek out physical contact. Some children have strong food preferences, enjoy fast and intense movement, or struggle to manage loud or specific noise.

Our senses are flooded with input all the time - traffic noise, bright lights, cooking smells, the movement of swings and playground equipment, brushing our teeth, washing our hair. We need to filter out what is irrelevant, and pay attention to what is important. If we don't, sensory input can be overwhelming.

**SENSORY PROCESSING DIFFICULTIES**

The ability to process sensory information begins in utero, and continues to develop and change throughout life. The fastest development of sensory systems happens in early childhood as the child's central nervous system matures.

Each sense develops at its own pace and by the time a child starts pre-school, they are able to identify different forms of sight, sound and touch, and regulate (control) their responses to them.

All children experience difficulties processing sensory information at some point. Most children, however, learn how to adjust and manage so that they can participate in everyday activities and cope in group situations. This adjustment happens alongside physical development, and the accumulation of experiences as they grow.

Children with sensory processing difficulties struggle to filter out repeated or irrelevant sensory information, and do not adjust their responses to sensory input over time. They continue to 'over' or 'under' respond to things in their physical and social environments, or within their bodies.

Children with sensory processing difficulties often have a sensory profile with one or more of the following characteristics:

**High-sensitivity** - these children are more sensitive to sensory stimuli than most children. They tend to become overwhelmed by sensory information and react intensely, often with strong negative emotion (crying, aggression). They can become quickly upset when exposed to some forms of input.

**Sensory Avoiding** - these children actively avoid certain input because it causes unpleasant sensations. They tend to enjoy routine and structure so that sensory input is predictable. Lower tolerance of some input may mean they prefer to spend time alone.

**Low-sensitivity** - these children are less sensitive to sensory input than most, and can appear passive and withdrawn. They require a lot of sensory input for their brains to register and filter information. They often appear unaware of, or slow to respond to, certain sensory information, including pain.

Sensory Processing Difficulties TIP SHEET | Developed by Julie Thomas (Occupational Therapist, BPP University) & Dr. Catherine...

Behaviour Tip Sheets are available in:

- Long version
- Short version
- Vietnamese
- Simplified Chinese
- Arabic

# BEHAVIOUR TIP SHEETS




**TIP SHEET**  
**How Can I Help my Child Navigate Adolescence?**

Helping Young People with Intellectual Disability and Autism Navigate the Social, Emotional and Physical Changes of Adolescence

**WHAT IS ADOLESCENCE?**  
 Adolescence is the transition time between childhood and adulthood. It begins around 10 - 13 years, and ends when the young person reaches 18 - 21 years. During this transition, big changes happen to the young person's body and to the way they relate to the world.


**Adolescence** refers to the social and emotional changes that happen at this time, while **puberty** refers to the physical and sexual development of a young person's body.

Children with an intellectual disability (ID) and autism usually experience the same physical changes through puberty and at the same age as other young people. These changes can bring excitement and curiosity as their body matures both physically and sexually. For children with an ID and autism these feelings are often experienced without the social, emotional and cognitive skills to understand them. This can create confusion and worry.



**WHAT DOES ADOLESCENCE LOOK LIKE?**  
 Adolescence for most young people is experienced as:

- Physical changes, such as:
  - Increased growth of bones, muscles, organs and body systems
  - Increased appetite
  - Altered body shape
  - A deeper voice
  - Sex maturation (penis and testis)
  - Increased sweat
  - Increased hair growth and distribution
  - Additional teeth (second and third molars)
  - Changed sleep patterns
  - Menstruation (periods)
  - Excitement and emotional ups and downs
- Changes in thinking and behaviour, as the brain grows and changes
- Strong emotions, irritability and unpredictable moods
- An increase in aggression
- An increased interest in peers, friendships and social opportunities
- A desire to be more independent, try new things, and set rules and boundaries



**Managing Adolescence TIP SHEET** | Developed by Solihull Children's Hospital Network, WIR School 144 & SK Consulting | 1

**TIP SHEET**  
**Why is My Child Hurting Others?**

Helping Children with an Intellectual Disability and Autism Manage their Aggression

**AGGRESSION IN CHILDREN AND YOUNG PEOPLE**  
 It's common for children and young people with Autism and an Intellectual Disability to act aggressively sometimes when they are feeling angry, frustrated or anxious. Aggressive behaviours can include:

- Verbal aggression, such as verbal threats, arguments, name-calling and swearing
- Physical aggression, such as pushing, hitting, kicking, biting, hair pulling, scratching

Children and young people can be aggressive towards themselves (self-injury), property, or others.

There are two key types of aggression:

- Reactive aggression** - sometimes a young person has one and turns someone or something without thinking. They act impulsively because they are frustrated or feel threatened. As these states, they are often distressed, angry or anxious.
- Proactive aggression** - is goal-directed and used to achieve something other than hurting another person. It is often used to communicate something. If it's useful in achieving a goal (e.g. avoiding an activity, or taking an item from another person), it is likely the aggression will continue.



**WHY DOES MY CHILD HURT OTHERS?**  
 Children and young people with Autism and an Intellectual Disability often lack the skills needed to manage big emotions and the behaviours related to them. Some of these emotions include:

- Frustration - when they have difficulties making themselves understood
- Pain/relief - when a task is too hard, or goes for too long wanting to escape the situation
- Frustration or anger - when wanting to force access to an item or an activity
- Confusion - when having trouble understanding others, or a social situation
- Jealousy or competition - with peers, siblings
- Anxiety or stress - e.g. about changes, feeling overwhelmed by sensory input (e.g. lights), being surprised by unexpected events or a sudden noise
- Curiosity - about what might happen if they hit out, sometimes the reactions of others are rewarding

**HOW CAN I HELP?**  
 You can help by remaining calm - stop, take a breath, and monitor the calm you want the child or young person to feel.

It's important that any response to aggression is matched to your understanding about why your child or young person is having this. If you understand why they use this behaviour to manage a situation or environment, you will be better able to:

- Prevent the behaviour
- Respond, rather than react, if the behaviour occurs
- Teach your child better ways to respond to emotions and manage behaviour

Find out as much as you can about the behaviour - what exactly does it look like? When does it happen? What is the child or young person doing when they become distressed or hit out? What triggers the behaviour? How do these around them respond?

**Managing Aggression TIP SHEET** | Developed by Solihull Children's Hospital Network, WIR School 144 & SK Consulting | 2

**TIP SHEET**  
**Why Does My Child Hurt Themselves?**

Helping Children with an Intellectual Disability and Autism manage their Self-Harmful Behaviour

**WHAT IS SELF-INJURY?**  
 Adolescence is the transition time between childhood and adulthood. The term self-injury is commonly used to describe behaviour that results in a person causing physical harm to themselves. The injury usually happens when the young person is trying to communicate a message or need.

Sometimes, self-injurious behaviour can seem as repetitive behaviour used by the child or young person to make themselves feel better (soothe, calm, or remain alert). These behaviours can be shaped and rewarded by the responses of others. The young person can learn that these behaviours are useful in having their needs met.

Diagnoses of intellectual disability and Autism makes it more likely that a child or young person will self-injure. The more severe the intellectual disability, the more likely it is that they will self-injure.

Most young people with intellectual disability and Autism find organising, planning, problem-solving, remembering, and controlling emotions hard. This can make meeting the urge to self-injure difficult, especially when they can't communicate their needs effectively. Problems coping with everyday challenges can also make it hard to stop once they have started.



**WHAT DOES SELF-INJURY LOOK LIKE?**  
 Some children and young people may use more than one way of hurting themselves. How often the behaviour occurs, and how intense or harmful it is, also varies from mild and infrequent, to severe and chronic.

Self-injurious behaviours include:

- Biting themselves, e.g. biting hands or forearms
- Scratching their own body with hands or feet, e.g. scratching their face, leaving their temples with a closed fist
- Scratching their own body with an object
- Hitting their own body against an object, e.g. banging their head on the floor or wall
- Scratching, skin picking or pinching
- Hair pulling
- Fur picking and gouging
- Tearing inedible objects

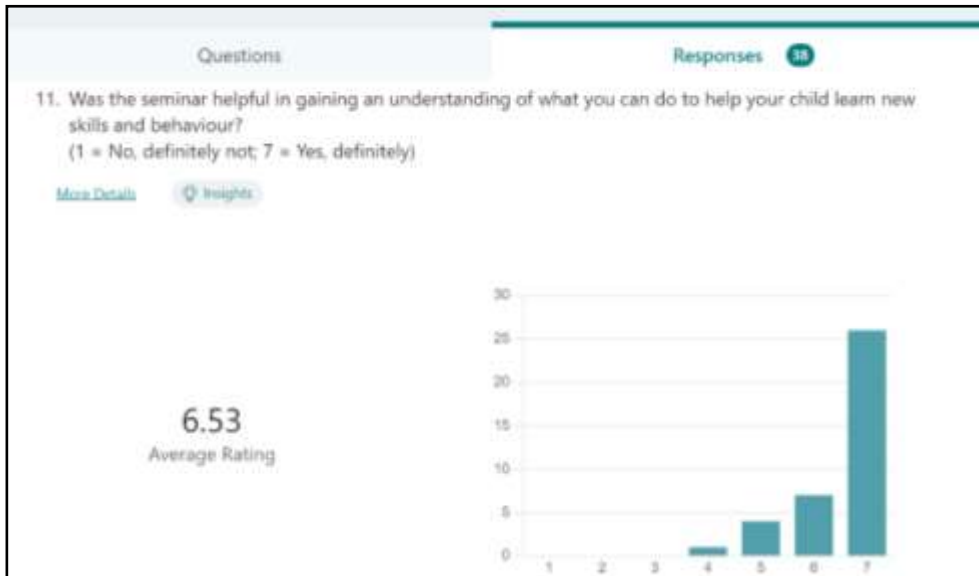
**WHY DOES MY CHILD HURT THEMSELVES?**  
 Considering why your child or young person might be hurting themselves will help you choose the best way to respond. Sometimes, different behaviours mean different things to different areas.

Some reasons for self-injury include:

- Physical health issues**, e.g. pain, ear infections, reaction to medication, constipation, poor sleep (being tired makes coping with challenges more difficult)
- Genetic/pre-disposition**. Some genetically determined syndromes can make a person especially vulnerable more likely to self-injure, e.g. Smith Maguire Syndrome, Cornelia de Lange Syndrome, Fragile X, Laeche-Nyhan Syndrome and New Syndrome

**Self-Harm TIP SHEET** | Developed by Solihull Children's Hospital Network, WIR School 144 & SK Consulting | 3

# STEPPING STONES TRIPLE P Scholarships



- 2023 SSTP Scholarship program
- SSTP Selected Seminar training and PASS sessions
- Information session is this Monday the 24<sup>th</sup> of July at 3:30pm via teams
- Email us your name to register your interest
- [SCHN-CHW-SchoolLink@health.nsw.gov.au](mailto:SCHN-CHW-SchoolLink@health.nsw.gov.au)

# CONSULTATION



SCHN School-Link provides support and advice on relevant mental health services for children and adolescents with intellectual and developmental disabilities. Please contact:

- [schn-chw-schoollink@health.nsw.gov.au](mailto:schn-chw-schoollink@health.nsw.gov.au)
- 9845 2005/ 0409 656 899





# WEBSITE



[www.schoolink.chw.edu.au](http://www.schoolink.chw.edu.au)

**CHW**  
**S C H O O L**  
**Link**  
CHW School-Link

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

**General**

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- Contact Us
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- Resources
- Journal of MHCADD

**Information: mental health and intellectual disability**

- Mental Health & Intellectual disability
- A-Z Glossary

**Developmental Disabilities, Challenging Behaviour and Mental Health Conference**  
WEDNESDAY 11TH 2014 AT 5.30PM

**SAVE THE DATE - FRIDAY 7 NOVEMBER 2014**

**Developmental Disabilities, Challenging Behaviour and Mental Health: Research to Practice and Policy**

The latest developments in disability and mental health research and practice will be presented by leading international and Australian researchers.

Presenters include:  
Prof James Harris, Johns Hopkins University USA  
Prof Martin Barkley, Harvard University USA  
Prof Michael Bevan, Institute of Psychiatry London UK  
Prof Paul Howlin, Institute of Psychiatry London UK, University of Sydney  
Prof Eric Emerson, University of Sydney, Lancaster University UK  
Prof Rhonda Lovell, University of New South Wales  
Adjunct David Coccato, University of Sydney  
Adjunct Julian Taylor, University of New South Wales

**Latest Journal**

Click [here](#) for a copy of our latest June 2014 journal.

**Schools Conference MH+ID**

Mental Health and Intellectual Disability Schools Conference 8th August



# JOURNAL



Sign up to our e-list at:

<http://www.schoollink.chw.edu.au/e-list/>

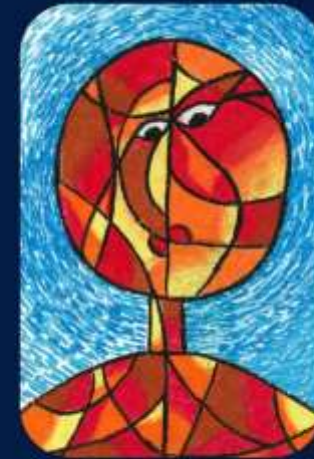
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# SCHOOL WEBINARS



- Introduction to Anxiety
- Reflective Practice
- Understanding & Responding to Behaviour
- Self Regulation
- Self-Injurious Behaviour

<http://www.schoollink.chw.edu.au/webinar-series/>



# WellSEQ



## Wellbeing in Special Education Questionnaire





# THANK YOU



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[@CHWSCHOOLINK](https://twitter.com/CHWSCHOOLINK)



[MEET JESSICA ANIMATION](#)



The Sydney children's Hospitals Network



NSW  
**School-Link**  
Health and Education Working Together

# REFERENCES and FURTHER READING



- Dossetor, D., White, D. and Whatson, L. (Editors). (2011). *Mental Health of Children and Adolescents with Intellectual and Developmental Disabilities: A Framework for Professional Practice*. IP Communications.