CSI 83 SI10/91

ADIDD

Association of Doctors in Developmental Disability

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Ms Rachel Simpson
The Director
Standing Committee on Social Issues
Parliament House
Macquarie St
Sydney NSW 2000
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15th October 2010

Dear Ms Simpson,

Re: Inquiry into services provided or funded by the Department of Ageing, Disability and Home Care

I refer to your correspondence dated 1st October 2010 re the above. As requested, I have attached our response to the Questions on Notice.

ADIDD would like to acknowledge the expert and professional advice of its wider consultative group in informing the response to these Questions on Notice.

Thank you for the opportunity for our Association to comment on the above Inquiry. If you have any questions on the matter, I can be contacted at the above address,

Yours sincerely,

Dr Robert Leitner, Chairperson
ADIDD Executive Committee

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1. *The Committee has received evidence that families who have young children with significant communication and feeding difficulties are often reluctant to be transferred to ADHC services once their child has been diagnosed with a disability. It is thought that parents are frustrated by issues of ADHC's service quality, quantity, timeliness and transparency (submission 44, page 1).*
   a) *Could you suggest reasons why parents may be more comfortable using NSW Health services rather than those provided by ADHC?*

PARENTAL CHOICE TOWARDS NSW HEALTH SERVICES

There are a number of reasons why parents may prefer to access services from NSW Health, rather than ADHC:

- *Inadequate level of service provided by ADHC*:
  Often the ADHC service is consultative and no therapy is provided. Sessions may be limited and focussed only on a single issue.

- *Skill level of staff*:
  Parents often report a lack of confidence in the skills of the ADHC staff who may have limited experience in this area of expertise. NSW Health services tend to have skilled staff with strong professional support within a departmental structure. Parents often report that hospital therapists have a better knowledge of clinical issues and are more easily able to access medical input.

- *Staff turnover*:
  There is a high turnover of staff in ADHC. Therapists are often young graduates and they receive limited professional support. When a therapist from ADHC leaves, the client family may be left with no other therapist to take over their role. Health seems to have more permanency of staff and families are able to develop working relationships with therapists.

- *Familiarity with Health services:*
  Many children with a disability receive services from NSW Health prior to being referred to ADHC. For example, a child may be managed from birth by an integrated, multidisciplinary Health care team that includes medical services. They may be seen by the Health providers for a significant period of time.

- *Barriers to entry:*
  With ADHC, parents report that they have to go through an intake officer and it usually takes several attempts to talk to the intake officer. They often have to leave a message with the receptionist and keep on ringing and re-referring. Parents also report that if their child is eventually accepted, ADHC services are often for defined purposes only and time-limited. Families may be unsure of what access they will have to other services in the future.

- *Comprehensive client and family centred services:*
  NSW Health services aim to assess a problem, investigate, make a diagnosis and plan appropriate interventions including therapy. There is then an ongoing service/ commitment to address the child's health needs. It is not a "block of service of predetermined length" and then case closure. It is transparent in the sense that the diagnostic work up is in most cases done by the clinicians who will then be involved in planning, delivering and evaluating the service/ therapy given. If there is an ongoing need there is an accepted obligation to ensure continuity of service.

- *Lack of physiotherapy services:*
  Often ADHC funding does not include physiotherapy. This results in families opting to remain with Health services in order to be able to receive all therapies in the one location. Many ADHC and NGO teams may only have speech pathology and occupational therapy.

- *Waiting lists:*
  Generally there are shorter waiting lists with NSW Health compared with ADHC. In NSW Health, parents can usually find out how long it will take to receive a service, what type of service they will receive and an indication of waiting list lengths. In ADHC, the complicated intake system leaves the families with uncertainties about the eligibility of their child for services, what type of service they will receive and when they will receive a service.

The table below highlights the key reasons why parents prefer NSW Health rather than ADHC services.

Parental Choice towards NSW Health Services

ADHC	NSW Health
Inadequate level of service, often only consultative with limited interventions often focused on a single issue	Comprehensive diagnostic & assessment services and integrated care
High turnover of staff who are often young graduates and there is limited professional support	More permanency of staff; experienced therapists with strong professional support within a departmental structure
Intake system is not user friendly and presents many barriers to accessing services	More client and family focused; families may have close relationships with paediatric staff from the child's birth or an early age
Limited therapy interventions with lack a physiotherapy services	Comprehensive multidisciplinary and integrated services
Long waiting lists with uncertainties about eligibility for services as well as the type and duration of services	In general, more timely services with clearer referral pathways and consistency in the provision of services

OPTIONS FOR ADHC CLINICAL SERVICES:

Given the significant concerns re ADHC's service quality, quantity, timeliness and transparency, the options for the provision of clinical services for children with disabilities include:

Option 1: *Restructure of ADHC clinical service*

Option 2: *Transfer of ADHC clinical services to NSW Health*

Option 1: *Restructure of ADHC Clinical Services*

The restructure would need to create more accessible and client focused services.

- *Intake processes:*
  Overhaul of the intake model where clients are not discharged but can be reactivated. The client family should remain with the same case manager wherever possible. There should be seamless mechanisms for re-referral back to therapists etc. at time of need. The complexity of ADHC intake and related processes should be reduced.

- *Needs Assessments:*
  A needs assessment by ADHC should not really be necessary when the referring agent such a Diagnosis and Assessment Team has provided a comprehensive multidisciplinary assessment and report of both the child and families needs. Needs assessments are often reported by families as a waste of resources and of clinicians' time. They can add confusion at times as families assume that the needs they have reported will be acknowledged and met. Often, the needs assessment leads to a lengthy wait on a list which renders the data collected out of date. Needs assessments should be briefer and completed upon initial intake or re-referral.

- *Delivery of services:*
  ADHC services should to be delivered in a collaborative and interdisciplinary manner, rather than consultative. Services should be flexible and responsive to the immediate needs of client families. ADHC should provide more regular reviews of the children and more contact with families, either face to face or over the phone. ADHC should keep families up to date with referral procedure and waiting list times etc. There should be more consistency with the same caseworker/ therapist seeing the client through subsequent visits and future needs. At a case work level, ADHC need to accept the life-long nature of a disability. The importance of working as multidisciplinary teams, evaluation and documentation of assessments, interventions and follow-up should be stressed.

- *Key Performance Indicators:*
  Consistent performance targets and clinical indicators should be developed state wide to facilitate consistency of service provision across ADHC services. These measures should be transparent and available to the community, parents and other services.

Option 2: *Transfer of ADHC Clinical Services to NSW Health*

This option would provide a number of advantages including:

- Better access and referral pathways for client families
- Better patient journeys - streamlined, seamless, requiring less paperwork therefore less waiting around
- Better communication between professionals
- Improved opportunities for staff education/ training/ upskilling/ supervision
- Ready access for patients to a range of health professionals
- Comprehensive multidisciplinary and integrated services

NSW Health would need to be funded for this increased workload. New positions for therapists who provide health services should be allocated to the NSW Health Tier 4 multidisciplinary Disability Health Teams where there can receive adequate professional support and supervision.

2. *The submission from the NSW Ombudsman states that families report extensive waiting times to access aids and equipment, from assessment to application, application to approval and from approval to receipt of the equipment (submission 100a, page 6). The waiting period is reported to be up to two years, resulting in adverse effects on education, health and independence (evidence, PWD, 3 September, page 39).*
   a) What is your experience of people accessing equipment and aids?

ACCESSING EQUIPMENT AND AIDS

- *Consistent but stringent guidelines:*
  In general, EnableNSW provides more consistent and transparent services than individual PADP lodgement centres. This is due to the centrality of information collected which can be accessed by varying levels of staff (customer service level staff, advisors etc). However, the EnableNSW guidelines are very stringent and inflexible.

- *Wording of applications:*
  It is difficult for any therapist not familiar with the guidelines to prescribe equipment and get it approved. Therapists need to know the specific wording that EnableNSW is looking for.
  Example:
  - A "standing frame" will not be funded, but a "standing frame to use during art at pre-school" is more likely to be funded.

- *Excessive waiting times:*
  Unless the priority is "immediate", it will take at least 6 months or more for the client to receive the equipment even if it is considered a high priority.

- *Delays in administrative processes:*
  In general, the delay is not between the assessment and application – the delay is between the application and approval, and approval and delivery.

- *Extensive documentation required:*
  Clinicians are asked to supply increasing amount of evidence to support the application and this seems to be slowing down the process. The initial application is most tedious, with the need to photocopy Medicare and Health care cards and a separate Application Form with demographic data, some of which are repeated on the Prescription Form.

- *Unmet needs in Paediatrics:*
  There is a substantial unmet need for equipment. In paediatrics, the developmental changes and growth may require a number of changes and upgrades to equipment. Unfortunately, this is not always funded. A number of services access charities to purchase high cost equipment.

- *Equipment Loan Pools:*
  In NSW Health, Equipment Loan Pools are often used whilst a client is waiting for equipment to come from PADP/ EnableNSW. Some NGOs such as the Spastic Centre and Northcott Disability Services also have wheelchairs and equipment available for loan to eligible clients. ADHC often do not have their own Equipment Loan Pools.

3. *The Ombudsman identified that the administrative process of equipment and aid programs is lengthy due to the number of parties involved (submission 100a, page 6). What is your view on the reasons why there is unmet need in equipment programs such as Enable NSW?*

Reasons for Unmet Needs in Equipment Programs

- *Rigid funding guidelines:*
  The EnableNSW guidelines for funding are very specific around "function related goals" rather than treatment.
  Examples:
  - More severely disabled clients may have applications for orthotics declined on the basis that they are not capable of doing standing transfers. Therefore, these clients may not be able to benefit from standing programs unless the family can fund AFOs privately.
  - Less severely disabled clients who could still perform standing transfers may receive funding based on the orthotic helping maintain their "functional" goal of a standing transfer.

- *Limited approvals – only one mobility device:*
  EnableNSW have not been approving second/ alternative mobility devices for students who are classified as presenting with "mixed mobility". Students with various physical disabilities may have more independent mobility indoors using a walker or manual wheelchair and may also need a power wheelchair for distances in the community and at school. The students are expected to use their one mobility device to access all environments and settings which in some cases can put their carers at significant risk of injury (managing a power wheelchair on doorways with lips/ small steps) or pushing a young adolescent up and down hilly areas and for prolonged periods.

  Whilst the aim of the alternative mobility device is "functional" and to assist in independent function in different settings, second mobility devices are not being funded. This places significant demands on therapists to source alternate funding through charities and "make do" by loaning older (often donated or outgrown by others) mobility devices. These devices can be costly to repair and service and this burden often falls on the service lending the product or on the family. Issues like product safety, wear and tear and incorrect sizing can lead to injuries/ accidents, pain or exacerbate existing deformities.

- *Prescription of equipment in Paediatrics:*
  Given the lengthy waiting times for equipment, therapists may need to anticipate the children's equipments needs 6 to 12 months in advance. As children grow and develop, their equipment needs change.
  Examples:
  - A therapist may need to apply for AFO's almost straight away after the child gets a pair, so they will be funded in 12 months when the growing child needs the next pair.
  - A walking frame needs to be ordered some 6 months before the therapist thinks it might be needed because the order will take that long after it is approved. However, the child may have undergone a growth spurt and may be too tall for the equipment when it arrives.

Solutions:

- *Streamlining of the administrative processes:*
  Independent clinicians should sit in the application from start to finish of the process to determine where the bottlenecks are.

- *Separation of the funding and approval process:*
  The option of separating the funding body (EnableNSW) from the approving body (discretionary commmittee staffed separately from EnableNSW) would avoid a potential conflict of interest.

- *Review of the funding guidelines:*
  The rigidity of the funding guidelines should be reviewed. There should be flexibility to cater for the client needs such as the approval of both a manual wheelchair for use indoors and power wheelchair for use outdoors.

- *Equipment Loan Pools:*
  Equipment Loans pools may reduce the administrative and clinical load when prescribing equipment particularly in young children whose needs change quickly as they grow and develop. ADHC should develop a loan pool system with a focus on specialised paediatric equipment incorporating ADHC, Spastic Society and Northcott. ADHC therapists should receive appropriate training to assess and prescribe equipment and relevant home modifications.

- *Equipment Pool for Early Intervention Pilot:*
  This pilot project is aimed at reducing the administrative and clinical load when prescribing equipment for first time users of mobility or personal care equipment. It is aimed at 0-6 year olds whose needs become more apparent following a diagnosis, progression of disease, change in environments etc. Equipment such as wheelchairs and commodes are readily available for the children as they have been ordered in bulk by EnableNSW. A review of the project is outstanding.

- *Staff training:*
  Therapists working in disability services should receive appropriate training to assess and prescribe equipment and relevant home modifications.

- *Follow-up:*
  Therapists need to follow-up their recommendations after the equipment is supplied. Follow-up is required to ensure that the equipment is appropriate and is suitable for the client and that the client family is aware of the necessary referral details in case something goes wrong. This is part of the duty of care to the client. Often this is not the case in ADHC and ADHC funded services because of the rapid staff movement and long delays in the funding process. The follow-up post supply of equipment needs to be addressed.

4. *Your submission states that there are significant issues regarding services for people with mental health problems (page 3). The Committee has heard little evidence to date about gaps in mental health services.*
   a) *Do you know how NSW Health and ADHC divide the responsibilities of funding and providing mental health services?*
   b) *In your experience, what are some of the issues facing people who have co-morbidities of mental health issues and other disabilities, in accessing services?*
   c) *How can ADHC improve services to people with mental health problem?*

a) Responsibilities of funding and providing mental health services:

The specific mental health needs of people with intellectual disability are almost un-catered for by both ADHC and NSW Health. Whilst ADHC assumes responsibility for behavioural intervention (i.e. intervention which complements mental health services), neither Department assumes responsibility for provision of specific mental health services for this population. People with intellectual disability and mental disorders therefore experience major problems accessing appropriate mental health care.

b) Access to mental health services:

- *Lack of Funded Service within Acute Hospital and Community Health Setting:*
  Very few mental health services offer a specific and specialised service to people with intellectual disability. The assessment and management of mental disorders in this population is complex. The task therefore requires specific teams of dedicated individuals who are embedded within mental health services and who can provide timely review in the *community health setting, inpatient mental health setting, general hospital and accident and emergency departments.* The absence of such a skilled team is a likely contributor to the difficulty people with intellectual disability and their carers experience in accessing timely mental health care. It is also likely to result in a poor quality of service to individuals with intellectual disability. A simple illustration is that currently, if either a person with intellectual disability or a carer calls in an attempt to refer a potential problem to an acute mental health intake service, there is a real possibility that the person will be diverted to ADHC intake, where there is no mental health expertise. This is because suitable specialty services do not currently exist within mental health and mental health staff are under the misconception that this problem can be dealt with by ADHC. A result is delayed or absent access to an appropriately tailored and skilled mental health review.

- *Lack of specialised inpatient mental health beds for people with intellectual disability:*
  Leading models of care for people with intellectual disability recognise the need for provision of segregated mental health inpatient facilities for many individuals with intellectual disability. For example, in the United Kingdom, there is approximately one intellectual disability mental health bed per 100,000 population. In contrast, there are no specific beds in NSW. Carers and consumers have repeatedly expressed their frustration to us at the lack of ability of existing inpatient mental health services to adequately address the needs of the person with intellectual disability. *This problem should be addressed by NSW Health and ADHC, by consideration of short-term specialist mental health beds within a tertiary mental health setting.*

- *Lack of access to early intervention services:*
  Early intervention represents the current standard of care within a general mental health setting. Given the vulnerability of people with intellectual disability to mental disorders, we find it surprising that specific funding is not available for early intervention mental health care for people with intellectual disability. The benefits of early intervention and prevention to help people with developmental and intellectual disabilities establish successful and independent adult lives as well as the associated cost savings to the Government is well supported by evidence.

c) Improved access to mental health care:

The reader is directed to our response under Questions 5 and 6.

5. *Do you know what percentage of people with physical, intellectual or developmental disability also have mental health problems?*

PREVALENCE OF MENTAL DISORDERS IN PEOPLE WITH ID

- People with ID represent about 1.8% of the NSW population (i.e. 128,000 people) and compared to their peers, have a substantially higher prevalence of mental disorders (~40%) and "challenging behaviour" (52%), i.e. at least 2.5 times the average rate of mental disorders seen in the general community (Bouras & Drummond, 1992).

- *Unmet Needs of People with ID and Mental Health Disorders:*
  Apart from behavioural support, the specific mental health needs of this population are almost entirely unmet by both ADHC and NSW Health, with neither Department having assumed responsibility for service provision. People with ID and mental disorders therefore experience major problems accessing appropriate mental health care.

Solutions:

- We have outlined a comprehensive range of solutions in our response to question 6 below. This includes the formation of specific Intellectual Disability Mental Health Teams within Child and Adolescent Mental Health and Adult Mental Health Services, Specialist Disability Health Teams and the urgent establishment of a Clinical Network (as part of the Agency for Clinical Innovation).

6. *The Committee has heard evidence that some people wait up to two years for early intervention services such as physio or speech pathology (evidence, PWD, 3 September 2010, page 39). Your submission states that there is an "inadequate workforce in place to implement early intervention programs" (page 1).*
   a) *What do you mean by "inadequate workforce", are you referring to the number of staff, their level of training or other explanations?*
   b) *Do you believe that the inadequate workforce is the main reason why there are problems with families accessing early intervention program?*

EARLY INTERVENTION OF MENTAL HEALTH ISSUES IN PEOPLE WITH ID

This section of our submission focussed on the paucity of mental health resources and funding for individuals of all ages with intellectual disability. Early intervention for mental disorders has become a standard component of mental health care for the general community where it is seen as a critical strategy to reduce disability secondary to mental disorder. Given that people with intellectual disability represent an 'ultra high risk' group, early intervention is critical for people with intellectual disability. Our submission statement that there is "inadequate workforce in place to recognise the early signs of mental illness and to implement early intervention programs" (*page 1*) is due to a combination of factors:

- *Inadequate Funding and Staffing:*
  - Generic mental health services are not funded, equipped or trained to provide mental health services to people with intellectual disability.
  - Currently, there are only a few specialist Health Services and even fewer Mental Health Services across the state. There is only a limited number of funded positions.
- *Lack of Training and Expertise:*
  - There are limited opportunities for staff within mainstream mental health services to be exposed to or specifically trained in intellectual disability mental health.
  - There are few psychiatrists, nurses and allied health staff who are trained in ID and psychiatry, and there is a lack of opportunities for trainees in these disciplines to develop such expertise.

Solutions:

The following proposed solutions are relevant to questions 4, 5 and 6, as they articulate specific points designed to address the deficits in mental health services for people with intellectual disability.
In our view, there is an urgent need for additional funding to develop:

- *Intellectual Disability Mental Health Teams* within Child and Adolescent Mental Health and Adult Mental Health Services. These teams would address the needs of people with intellectual disability and mental disorders who attend the community mental health clinics, acute inpatient services, accident and emergency and general hospital. *These teams align with the proposed NSW Health Service Framework Tier 3 Units (Hospital and Community Mental Health Services).*
- *Specialist Disability Health Teams* to address the gaps in services. These specialist services would provide consultation, support and capacity building of mainstream MH services. Such enhancement funding should be recurrent and insulated from other demands from parent services. *These teams align with the proposed NSW Health Service Framework Tier 4 Units.*
- *The urgent establishment of a Clinical Network [as part of the Agency for Clinical Innovation].* This would provide support and clinical leadership to health professionals working with people with intellectual disabilities, coordinate the development of intellectual disability health services, and provide input into research, education and training. *This proposal aligns with the proposed Tier 5 Units of the NSW Health Service Framework, and would work together with the current UNSW Chair of Intellectual Disability Mental Health (A/Prof Julian Trollor) to enhance efforts in education and training.*

EARLY INTERVENTION THERAPY SERVICES FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

There are many reasons why there are problems for families accessing early intervention programs. Some of the problem is the workforce size, but there are also problems in the way that early intervention services are organised.

- *Problems with ADHC Early Intervention Services:*
  Children may wait for more than 12 months for therapy services although there is strong evidence for the importance of early intervention. Once therapy intervention has been established, this is generally of limited scope before the case is closed by ADHC. A new referral needs to be made to ADHC Intake for another episode of care. Continually opening and closing cases adds work.

  ADHC therapists may be involved in needs surveys and writing up needs assessments rather than undertaking therapy. Case workers are trained to do this, therapists are not.

  ADHC tends to recruit young graduates with limited experience. There is a lack of training and supervision and professional career pathways.

  The ADHC therapists appear to have significantly decreased workload (cases seen) than their hospital counterparts and there is also a system of case closure. More senior ADHC therapists have a very low or no caseload. The system of "cross-checking" of reports by a senior therapist AND a manager is very time-consuming.

- *Non Government Organisation service provision:*
  ADHC funds a number of NGO services which often results in multiple service provision within geographical areas, especially in metropolitan areas. This can result in overlap and inefficiencies in service provision. In some areas, the use of NGOs to provide early intervention therapy services has been successful.

  There is no consistency in terms of governance of NGOs. Potentially there would be significant variation in the quality of services provided by different NGOs.

  NGOs are aware of their client group needs in their community but may not be able to meet those needs within the funding agreement. NGOs are then required to access additional resources via fundraising to meet demand outside of the funding arrangements.

  NGOs may fail to attract appropriately experienced or skilled staff. This is a problematic issue which may be due to the remuneration of the positions and the lack of professional support and development within many of these agencies. This can often lead to NGOs providing services for less complex clients. The result is that clients requiring specialist therapy for severe physical disability or multidisciplinary care for complex conditions are often referred back to the public health system.

- *Pressures on NSW Health Early Intervention Services:*
  Early intervention screening, assessment and therapy services are provided by NSW Health for infants and children aged 0-4 years who display developmental delay. These children continue to receive Health therapy services until a diagnosis is determined. Upon diagnosis, these children are referred to the appropriate speciality disability agency. However, because they are considered to be receiving a current therapy service, they are often given a lower priority and will wait considerable lengths of time before the relevant agency assumes care.

  During this period, ADHC expect NSW Health to continue to provide ongoing treatment while children wait for intake. This impacts on caseload and negatively impacts on the ability to provide early intervention assessment and treatment for newly referred children.

  There have been no significant increases in NSW Health paediatric allied health services (Speech Pathology, Occupational Therapy, Physiotherapy, Counselling, Nutrition and Dietetics) services across NSW for many years, despite population growth, increased numbers of children surviving with complex medical conditions and growing community expectation.

- *Funding of Early Intervention Services:*
  In 2007, the Better Together initiative provided $6 million in additional funding to improve the delivery of services to people with a disability, their families and carers in a range of priority areas. ADHC managed this funding which resulted in significant enhancements to ADHC therapy services and provision of services from Non-Government Organisations. Despite continuing to provide a significant portion of therapy services to children with a wide range of disability diagnoses, NSW Health did not receive any additional funding.

  Notwithstanding the additional funding, staff and families often report minimal impact on the provision of early intervention services by ADHC.

  There is a fundamental issue with the determination of eligibility and funding for disability services particularly for children. ADHC define the eligibility and priority for their specialist disability therapy services utilising developmental/ psychometric/ functional criteria. However, there are a significant number of children with developmental delays who are either ineligible or are seen as a low priority and as such do not receive a service. As disability funding is directed and administered by ADHC, this is problematic for the provision of therapy services for these children.

Solutions:

- That the NSW Government and Treasury recognise that ADHC does not provide all of the early intervention services required by children with a disability and that a significant proportion of these services are provided by NSW Health. *Specific funding for disability needs to include consideration of the proportional demand on Health therapy services to meet unmet need.*

- Service outcome data for all services should be developed. *Potential partnerships between service delivery agencies (ADHC, NGOs and NSW Health) could be further developed with appropriate resourcing.*

7. *What are the most pressing issues and recommendations your organisation would like the Committee to consider as part of this Inquiry?*

ADHC Services:

- Overhaul of the intake model where clients are not discharged but can be reactivated. The client family should remain with the same case manager wherever possible. There should be seamless mechanisms for re-referral back to therapists etc. at time of need.
- A needs assessment by ADHC should not really be necessary when the referring agent such a Diagnosis and Assessment Team has provided a comprehensive multidisciplinary assessment and report of both child and families needs. The complexity of ADHC intake and related processes should be reduced.
- Prevention and early intervention need a long term commitment that is too often forgotten in light of more acute problems and changes in management. The option of the providing all early intervention therapy services for children through NSW Health and/or NGOs would provide significant benefits. New positions for therapists who provide health services should be allocated to the NSW Health Tier 4 multidisciplinary Disability Health Teams where there can receive adequate professional support and supervision.

Disability Health Services:

- Children with disabilities become adults with disabilities. There are already working, if suboptimal relationships between ADHC and Diagnosis & Assessment Health services for children, but only very patchy areas of cooperation between ADHC and Disability Health services for adults.
- The NSW Health Service Framework initiatives should be funded to provide for Tier 4 Disability Health Teams for the health care of persons with intellectual disabilities.

People with ID and Mental Health Disorders:

- There is an urgent need for increased funding for people with Intellectual Disabilities and Mental Health disorders.
- A comprehensive range of solutions including the formation of specific Intellectual Disability Mental Health Teams within Child and Adolescent Mental Health and Adult Mental Health Services, Specialist Disability Health Teams and the urgent establishment of a Clinical Network (as part of the Agency for Clinical Innovation) are outlined in the current submission.

Interagency Collaboration and Partnerships:

- There is a need to increase interagency collaborations and partnerships in the provision of services for people with complex health, mental health and developmental conditions.
- Examples of good collaboration such as the ACI Transition Model and Hospitalisation of ADHC patients at St George Hospital are outlined in ADIDD's original submission. The existing best practice models could be expanded to other areas and modified to meet the needs of the local communities. These models outline the benefits of multidisciplinary teams and the potential for significant cost savings through early intervention, diagnosis, assessment and ongoing management of health conditions related to their disabilities.