

Conjoint Professor Anne Duggan
Chief Executive Officer
Australia Commission on Safety and Quality in Health Care

Sent via email: nsqhssthirdedition@safetyandquality.gov.au

28 September 2026

Dear Professor Duggan,

**Submission on the National Safety and Quality Health Service (NSQHS)
Standards (third edition – initial draft)**

Here is our submission. We would welcome the opportunity to discuss our recommendations further and should you require further information, please do not hesitate to contact Jim Simpson at 0418 635630 or at jim@cid.org.au

We also seek to work with the Commission to ensure there is reasonable inclusion of issues for people with intellectual disability in the Guide for Hospitals which we assume will accompany the new Standards.

Sincerely,



Jim Simpson AO
Senior Advocate | Driving Change,
National Centre of Excellence in Intellectual Disability Health Centre,
Council for Intellectual Disability



Scientia Professor Julian Trollor AM, FAHMS
Director, National Centre of Excellence in Intellectual Disability Health
NHMRC Leadership Fellow

UNSW Medicine and Health, UNSW Sydney

Ursula Taylor

Coordinator Advocacy and Policy | Driving Change Team

National Centre of Excellence in Intellectual Disability Health

Council for Intellectual Disability Ursula Taylor

About us

The National Centre of Excellence in Intellectual Disability Health ('the Centre') is an important initiative supported by the Australian Government Department of Health, Disability and Ageing. The Centre is a consortium of nine organisations, including:

1. UNSW Sydney,
2. Centre for Disability Studies (University of Sydney),
3. Council for Intellectual Disability,
4. Down Syndrome Australia,
5. First Peoples Disability Network,
6. Queensland Centre of Excellence in Intellectual Disability and Autism Health
7. Queenslanders with Disability Network,
8. The Kids Institute and,
9. University of Melbourne.

It also includes another 56 health and disability organisations as partners and collaborators.

The Centre thus brings together an extraordinary range of experience and expertise in the health of people with intellectual disability – from lived experience, family, advocacy, clinical and research perspectives.

The vision of the Centre is to ensure that the 560,000 people with intellectual disability in Australia receive the highest attainable level of healthcare.

The review of the standards is a key opportunity

The current review of the National Safety and Quality Health Service Standards is a vital opportunity to address the stark health inequalities facing Australians with intellectual disability, to redress the ongoing “systemic neglect” that the Disability Royal Commission described them as experiencing in the Australian health care system.

We made a comprehensive submission to the initial consultation on the review of the standards and are pleased that some of the points we emphasised have been incorporated to some degree in the draft Standards now being consulted on. However, having consulted widely across the Centre, we see a considerable number of further enhancements as needed if the final standards are to meet the commitments of Australian Governments in response to the Disability Royal Commission - that the revised Standards will “ensure equal access to health care services for all people with disability throughout life”. See further “Fulfilling Government commitments in response to the Disability Royal Commission” below.

We have formulated 21 key points for this submission. You will note that these key points are adopted in various other submissions you will have received.

We now set out those key points with additional backing/commentary to them:

Key points

1. **There are approximately 560,000 people with intellectual disability in Australia.**

The standards therefore need to address the needs of this significant section of the community. The interaction between an intellectual disability and deficiencies in accommodations to meet their needs place people with intellectual disability at inherent risk in hospital settings.

2. **A very strong research base shows that people with intellectual disability experience extreme disadvantage in the Australian health care system. This includes twice the usual rate of potentially avoidable deaths, four times the rate of potentially preventable hospitalisations and dying 27 years earlier.**

See Appendix for a detailed summary of the research base.

There are multiple causes of the health inequalities facing people with intellectual disability, starting with communication barriers between clinicians and consumers. An intellectual disability impedes a person's ability to communicate, from mildly through to a person having no verbal communication. Clinicians in turn commonly lack skills and training in maximising communication with a consumer who has intellectual disability.

We in no way downplay the disadvantage experienced by people with other disabilities. However, as the ACSQHC User guide for the Health Care of People with Intellectual disability states, people with intellectual disability have poorer health outcomes compared to people with other disabilities. (Page 6 of User Guide)

Further, as a recent systematic review of attitudes of healthcare professionals found, the greatest challenges in healthcare professionals' attitudes towards persons with disabilities "were observed in relation to intellectual disabilities, where ambivalence, paternalism, and the underestimation of patients' competencies occurred more frequently (Radlińska et al., 2026)"

3. Most hospital clinicians have minimal undergraduate or continuing education in the needs of people with intellectual disability. They commonly show inadequate understanding of their needs and often show unconscious bias concerning their needs and quality of life.

In Australian medical schools, there is only a median of 2.55 hours of mandatory intellectual disability content (J. N. Trollor, Ruffell, et al., 2016). The majority of nursing schools offer no intellectual disability content (J. N. Trollor, Eagleson, et al., 2016).

There is a range of accessible and succinct online training modules for existing health professionals focused on key necessary skills in working with consumers who have intellectual disability, for example [Just Include Me - Inclusive Health Care eLearning - Council for Intellectual Disability](#) and [Course: QC84 Easy Health](#). However, our recent enquiries showed that, while modules were positively reviewed by users, the take-up rates were low, 500 health professionals in two years for the Council for Intellectual Disability modules.

The ACSQHC User guide for the Health Care of People with Intellectual Disability (the ID User Guide) states (at page 7):

- Barriers to appropriate healthcare for people with intellectual disability include direct and indirect discrimination and negative attitudes leading to misdiagnosis or delayed diagnosis, with the person's symptoms being attributed to their intellectual disability,

and in turn leading to preventable hospitalisations, chronic disease and early mortality.

- Cognitive biases towards people with intellectual disability include assumptions about a person's quality of life, their ability to gain new skills and their capacity to participate in health care planning. Cognitive bias may influence decisions about providing proactive treatment, rehabilitation, preventative health care and end-of-life care.

4. Hospital clinicians do not routinely think about people with intellectual disability when faced with broader expressions like “equity”, “disability”, “cognitive disability” or “cognitive impairment”.

That is our collective experience based on years of lived, advocacy and clinical experience.

5. The evidence base therefore clearly indicates that the Standards need to include a specific focus on people with intellectual disability.

6. We welcome the inclusion of a section on “Equity” in the Introduction to the draft Standards. However, for that section to have impact, it requires at least a succinct subsection focused on each equity population, including specifically people with intellectual disability. The section on people with intellectual disability should reflect paras 2-4 above and other key aspects of disadvantage experienced by people with intellectual disability in the health system.

We recommend a section on people with intellectual disability should read as follows:

People with intellectual disability experience profound health disadvantage that is currently unaddressed by the Australian health care system. This includes twice the usual rate of potentially

avoidable deaths, four times the rate of potentially preventable hospitalisations and dying 27 years earlier.

In hospital, people with intellectual disability are at risk due to factors including communication barriers with clinicians, stressful care environments, mistaken assumptions about quality of life and that symptoms relate to the disability, and clinicians having received no or minimal training in meeting their needs.

Additional points:

We agree with most of what is said in the section headed Equity on page 11 of the draft standards. However:

- The standards should adopt a definition of “equity”. A leading definition is that of the World Health Organisation https://www.who.int/health-topics/health-equity#tab=tab_1
- We are concerned with the following sentence on page 11 of the draft standards: "Equity means that the NSQHS Standards are applied consistently in health services every day across Australia, so every patient receives the right care, every time. " Equity is about making adjustments and purposively designing health services to better meet the needs of marginalised populations . The danger in expressing the aim as “consistency” is that is understood as a uniform approach. An aim that calls for uniformity like this in the standards does not set hospitals up to make adjustments and manage diversity in their systems. We recommend that the sentence be reworded as: “Equity means that the standards are applied in a manner which ensures the distinct specific needs of each individual are considered.”

7. The Standards should require hospitals to give ongoing and specific consideration to the needs of people with intellectual disability and each other equity population in implementing relevant Standards.

This should include

- a. A requirement to focus on intersectional needs, for example needs of a First Nations person with intellectual disability.**

- b. A requirement to identify and avoid disadvantage related to stigma.**
- c. A need to act on relevant ACSQHC user guides, including the Standards User Guide for the Health Care of People with Intellectual Disability, and the Standards User guide for Aboriginal and Torres Strait Islander Health.**

It is very important that the standards include a focus on intersectional needs. A person may have particular and intersecting needs and disadvantage related to multiple sources of identity including race, cultural background, disability, gender, sexual identity and so on. There is an obvious danger in just focusing on a person's needs related to the aspect of a person's identity that stands out to a particular clinician.

- 8. We welcome draft Standard 1.10 c. which requires hospitals to have organisational systems to “provide equitable access to health care for people with a disability and identify and action the need for reasonable adjustments”. However, this requirement is too general so that there will be tendency to focus on physical and sensory disability and not intellectual disability. The Standard should be reworded to read:**

Provide equitable access to health care for people with intellectual, physical, sensory and other disabilities and action the need for:

- Reasonable adjustments**
- Steps to counter conscious and unconscious bias**
- Avoiding diagnostic overshadowing, specifically the assumption that symptoms relate to a person's disability rather than to a health condition.**

Our experience is that diagnostic overshadowing is all too common in

hospitals. A decline in function or challenging behaviour is assumed to be caused by the person's disabilities when in fact there is an acute and undiagnosed medical condition which is hidden behind a communication barrier between consumer and clinician.

- 9. "Reasonable adjustments" are fundamental to providing equitable care to people with disability but hospital personnel commonly have very limited understanding of them. An additional Standard should be created along the following lines:**

Reasonable adjustments

Hospitals should ensure reasonable adjustments to meet the needs of people with disability by having systems to:

- **Identify consumers with disabilities including their types of disability and intersectional needs.**
- **In conjunction with the person and their families, carers and disability support providers, identify reasonable adjustments the consumer needs in relation to matters including communication, time needed for interactions, support for decision making, comfortable environments, waiting times, behaviour support, and support and sedation for intrusive treatments.**
- **Provide identified reasonable adjustments.**
- **Train clinicians in identifying and providing reasonable adjustments.**
- **Monitor and audit to assess whether reasonable adjustments have been made.**

Reasonable adjustments should include designing the hospital environment in a way that maximises physical and cognitive access. See 15 below.

The [Single Digital Patient Record \(SDPR\)](#) currently being piloted by NSW Health includes routine identification of disabilities and needs for reasonable adjustments.

We could also direct the Commission to a range of other tools currently available to document the reasonable adjustments an individuals needs, for example [My Health Matters folder - Council for Intellectual Disability](#).

10. The need to identify and act on reasonable adjustments should also be restated in draft Standards 2.04 and 2.05 (clinical assessments and plans of care).

11. The draft Standards do not but should include requirements for trauma informed care including in relation to trauma resulting from medical treatment.

The Commission's ID User Guide notes the elevated likelihood of trauma in health care for people with intellectual disability. (page 28)

The [Intellectual Disability Health Capability Framework | Australian Government Department of Health, Disability and Ageing](#) highlights 'responding to trauma' as a key capability for health services to work in a way that sensitively considers and responds to the greater likelihood that a person with intellectual disability may have experience of trauma, including health care related trauma.

A widely accepted definition of trauma-informed care comes from the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA states, "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies,

procedures, and practices, and seeks to actively resist re-traumatization” .
[Trauma-Informed Approaches and Programs | SAMHSA](#)

The [National Centre of Excellence in Intellectual Disability Health](#) will shortly release The Trust Guide which has been developed by Consortium member the [Queensland Centre of Excellence in Intellectual Disability and Autism](#) to guide health workers, services, and systems working with adults with intellectual disability and trauma.

12. Behaviours of concern (2.11 and 2.12) – There should be specific requirements in relation to:

- a. Use of positive behaviour support.**
- b. The need to comply with legal requirements for consent or authorisation of restrictive practices.**

Rather than just responding to behaviours of concern, positive behaviour support focuses on identifying and meeting the underlying causes of the behaviour, for example a person’s difficulty communicating their needs or discomfort with a noisy and crowded environment. “It focuses on improving a person’s quality of life by understanding the reasons behind their behaviour and identifying ways to meet their individual needs”.

[Understanding behaviour support and restrictive practices | NDIS Quality and Safeguards Commission](#)

A similar approach is now expected in aged care. See the [Behaviour support plans – fact sheet](#) of the Aged Care Quality and Safety Commission.

Restrictive practices that involve physical or mechanical restraint or confining a person to a particular place such as a hospital ward are potentially unlawful as an assault or false imprisonment in the absence of consent by or on behalf of a consumer. There are varying legal and policy requirements around Australia to address this issue. See for

example [Minimising Restrictive Practices Clinical Guideline](#) South Australia, [Fact sheet - Restrictive practices and guardianship](#) (NSW Civil and Administrative Tribunal), Mental Health and Wellbeing Act 2022 Victoria, [Use of Restrictive Practices in Non-Authorised Healthcare Settings Policy](#) WA.

The health care standards should require compliance with whatever authorisation regime applies to local hospitals.

13. Recognising and responding to acute deterioration (2.16-2.18) – A consumer’s “usual baseline” should be documented on admission to avoid diagnostic overshadowing. All too often, deterioration is not adequately recognised because hospital staff assume a person’s presentation relates to their disability.

The Commission’s ID User Guide acknowledges this point, saying it can be difficult to identify the relevant signs of acute deterioration in a patient with intellectual disability, particularly if the clinician does not know the person well and the person is not able to communicate their pain or distress (page 68). This issue would arise similarly for consumers with other cognitive and mental health impairments.

14. Coordinated and connected care (2.19- 2.22) –

- a. There should be specific inclusion of any “disability support services” in the list of those to be involved in coordination of care. All too often, this does not occur to the detriment of a person with disability.**
- b. There should be a specific requirement for hospitals to liaise with disability support services and families to**
 - i. clarify the disability support needs of a consumer and whether these have significantly altered as a result of a health condition, and**

ii. resolve arrangements to meet those needs both in hospital and on discharge.

As the Commission's ID User Guide says, transition of care points are potentially high risk for people with intellectual disability due to essential information not being passed on, including information about disability support needs, communication needs, behavioural supports and comorbidities (page 67).

A common false assumption at the point of hospital discharge is that group homes and other disability supported accommodation are staffed by nurses. In fact, most supported accommodation staff have little or no health care training. This false assumption can lead to post discharge health care not being administered or arranged.

A chronic and vexed issue is who is responsible for meeting disability support needs when a person with disability is hospitalised. The National Disability Insurance Agency tends to see this as the responsibility of the hospitalⁱⁱⁱ which in turn may see itself as lacking requisite staff and staff skills to meet the disability support needs of people with high disability support needs. Conversely, some hospitals may be reluctant to allow disability support workers to provide support in hospital. In any case, the result may be that the consumer's physical, communication and psychological support needs are not met resulting in physical neglect, trauma and "behaviours of concern". It may be beyond the scope of the standards to resolve these systemic issues. However, there should at least be an obligation for hospitals to identify disability support needs and collaborate with disability providers and families to make arrangements for the needs to be met.

15. Safe environments – Standard 3.01 should be extended by:

- a. Amending the Purpose statement to encompass accessibility.**
The Purpose statement should read, “Care environments are safe, accessible, culturally welcoming and therapeutic.
- b. Including requirements to:**
 - i. Provide hospital environments that will minimise anxiety and maximise psychological comfort for individuals.**
 - ii. Where appropriate, offer ambulatory and outreach models of care.**

Accessibility is fundamental to hospitals meeting the needs of people with disability, and not just physical access, also cognitive access for people with intellectual and other cognitive disabilities.

People with intellectual disability will often find hospital environments very stressful due to factors including unfamiliarity, sterile design, noise and busy, crowded atmospheres. This can lead to anxiety and “behaviours of concern”.

Thoughtful environmental design and reasonable adjustments for individual consumers can address these challenges, including consideration of ambulatory and outreach models of care.

16. Health care record systems (3.04) – These should record any disability and related needs for reasonable adjustments. (The Single Digital Patient Record currently being piloted by NSW Health incorporates this feature.)

17. Medicines safety and quality (3.10-3.12)- There should be a requirement to comply with relevant authoritative guidelines such as the ACSQHC Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard.

The Commission's ID User Guide note that people with intellectual disability have heightened risk of medication error and polypharmacy, and adverse effects from medication and the use of psychotropic medications for behaviour (pages 28 and 41).

18. The glossary should be amended to include definitions of the following expressions which will not routinely be understood in hospitals:

- a. Reasonable adjustments**
- b. "Disability" and different kinds of disability including "intellectual disability"**
- c. Positive behaviour support**
- d. Diagnostic overshadowing**

"Reasonable adjustments" are changes or modifications to clinical processes, the environment or the system/organisation, which help reduce the barriers that people face in accessing and using services (Moloney et al., 2021).

The Commission's ID User Guide says, "A reasonable adjustment is an action a service provider takes to ensure that the person can fully participate in a service or activity and receive the full benefit of that service or activity." (NDIS, n.d.) (page 7)

"Intellectual disability" is defined in the Australian Government's [National Roadmap for Improving the Health of people with Intellectual Disability](#) as follow: "Intellectual disability is traditionally seen as a form of developmental disability characterised by impaired cognitive abilities and reduced ability to manage common demands of day-to-day life (adaptive functioning). A person with intellectual disability may have difficulty with thinking skills that impact planning, problem solving, abstract thinking and learning. They may also

experience difficulties with communication, social skills and independently managing daily activities.”

“Positive behaviour support” (PBS) is an evidence, values, and rights based approach. It focuses on improving a person’s quality of life by understanding the reasons behind their behaviour and identifying ways to meet their individual needs. This may include strategies such as:

- teaching the person new skills
- making changes to their environment
- providing guidance and assistance to the person's support team.

[Understanding behaviour support and restrictive practices | NDIS Quality and Safeguards Commission](#)

“Diagnostic overshadowing” is the assumption that a consumer’s symptoms are a manifestation of their disability without properly exploring any underlying health condition.

See <https://www.intellectualdisability.info/changing-values/diagnostic-overshadowing-see-beyond-the-diagnosis>

19. “Substitute decision maker” is defined in the Glossary as a person authorised to make decisions for a person “who has lost decision-making capacity”. This incorrectly indicates that capacity is an all or nothing concept. The words “who has lost decision-making capacity” should be replaced by “who lacks capacity to make a particular decision”.

20. The definition of “bias” should be elaborated on to explain both conscious and unconscious bias.

We suggest adding the following words to the definition: “Bias can be conscious or it can be unconscious. Conscious bias refers to biased attitudes that you are aware of, while unconscious bias draws upon

attitudes, stereotypes, and experience that a person holds (Möller et al., 2024)."

21. Like the existing Standards, the new Standards should be accompanied by a Guide for Hospitals which has to be considered by hospitals implementing the Standards and by accreditation agencies. The existing intellectual disability User Guide is a valuable document but does not carry sufficient authority to be routinely considered by hospitals and assessors. Considerable material related to people with intellectual disability should be incorporated into the new Guide for Hospitals.

Fulfilling Government commitments in response to the Disability Royal Commission

We submit that action on our recommendations is necessary to compliance with the response of Australian Governments to the DRC final report.

DRC Recommendation 6.31(a) was to embed the right of people with disability to good health care in key policies and in legislation – the Australian Charter of Healthcare Rights, the National Quality and Safety Health Service Standards and Community Healthcare Standards

Recommendation 6.31 of the DRC report relevantly said:

Embed the right to equitable access to health services in key policy instruments

a. The Australian Commission on Safety and Quality in Health Care should:

.....

- review and revise the National Safety and Quality Health Service Standards and the National Safety and Quality Primary and

Community Healthcare Standards to provide for the delivery of safe and high-quality health care for people with disability

- as part of this review, consider how the national standards support equal access to health services for people with disability throughout life, including (but not limited to) prevention and health promotion, diagnosis and early intervention and rehabilitation services.

In the 2024 [Joint government response to the Disability Royal Commission | Australian Government Department of Health, Disability and Ageing](#) the Governments, they said “Accept” to this recommendation and stated:

Governments are committed to ensuring key policy instruments and plans support an inclusive Australian society that ensures people with disability have access to health care services that address their needs. The Australian Government, through the Australian Commission on Safety and Quality in Health Care and in consultation with Commonwealth and State and Territory health governments, will develop a plan to update key policy instruments to ensure they articulate the requirements for safe and equitable access to health services for people with disability.

In their 2025 update on action, the governments said:

The ACSQHC will continue to undertake wide consultation with key stakeholder groups and the public when developing the third edition of the Standards and supporting resources to ensure equal access to health care services for all people with disability throughout life.

[Disability Royal Commission Progress Report 2025 | Australian Government Department of Health, Disability and Ageing](#)

Complementarity of other submissions to the review

Before lodging this submission, we have had the benefit of reading some other submissions that have been lodged with the Commission. We see as very valuable complements to what we have said:

- The **submission of Developmental Disability WA** including its emphases on:
 - The need for explicit Disability Health Actions to ensure that hospitals are accountable against clear measurable expectations for equitable treatment of people with disability.
 - The need for services to implement a consistent disability identifier and data system to monitor disability access, safety, experiences and outcomes.
 - DDWA's observation that "A health service could potentially comply with the third edition as currently drafted without knowing how many people with disability it serves, without measuring their health outcomes or experiences, without systematically identifying and providing reasonable adjustments, without involving people with disability in service design, and without demonstrating that its workforce has the capability to provide disability-inclusive care."
- The **submission of Children's Healthcare Australia** including its emphases on:
 - Partnerships with families and "child and family centred practice".
 - Transition of health care from paediatric and adult services.

Appendix – research on health inequalities for people with intellectual disability

In Australia, approximately 560,000 people with intellectual disability face stark health inequalities and multiple barriers to accessing health care that meets their needs. With their close families, over two million people are affected.

The NSW data linkage work of the Department of Developmental Disability Neuropsychiatry, UNSW (now incorporated into the National Centre of Excellence in Intellectual Disability Health), explores the health outcomes for people with intellectual disability. These linkage studies were based on approximately 1.1% of the NSW population who were identified as having intellectual disability. In the absence of any available source of population health data at a national level, NSW findings can be taken as nationally representative. Below is a summary of some of the findings.

In comparison to the general population, health outcomes for people with intellectual disability are characterised by:

- Premature mortality with average at death occurring 27 years earlier (Florio & Trollor, 2015)
- More than double the proportion of potentially avoidable deaths at 38% (J. Trollor et al., 2017)
- Four times the rate of potentially preventable hospitalisations (PPHs) (J. C. Weise et al., 2021).
- PPHs for acute conditions being up to 8 times higher and PPHs for vaccine-preventable conditions up to 3 times higher (J. C. Weise et al., 2021).

Compared to people in the general population, health service interactions for people with intellectual disability are:

- Over-represented, with hospitalisations and emergency presentation rates being twice as high (Li et al., 2018).
- Costly, with admissions being on average twice as long and twice as expensive (Li et al., 2018)
- Inefficient, with higher rates of re-presentation to emergency departments and inpatient units following discharge from mental health facilities, even for first-ever admission (Li et al., 2018).

Even with a clear clinical pathway for epilepsy and seizure admissions, there are significant disparities. Age-standardised admission rates per 100,000 people are 21 times higher, with longer admissions and higher readmission rates within 30 days (Liao et al., 2022)

Australians with intellectual disability are also less likely to have their preventative health care needs met through primary care compared to the general population (J. Weise et al., 2016) This contributes to high acute care service use (J. Trollor et al., 2016)

People with intellectual disability are over-represented in every compartment of the acute health care system, experiencing very high rates of emergency department presentation and physical and mental health admissions, and with substantially higher associated costs. Despite only representing 1.1% of the NSW population, identified people with intellectual disability comprise 4% of people using ED services, 4% of people using inpatient non-mental health services, and over 6% of inpatient mental health services (Figure 1).

Furthermore, despite this over-representation, people with intellectual disability receive ineffective care characterised by repeated presentation to acute care after mental health inpatient stays (Li et al., 2018)

Figure 1. Percentage of NSW Health Service Users with INTELLECTUAL DISABILITY per compartment, FY 2014/15



Mental health

Mental health conditions account for 24% of the non-fatal burden of disease in Australia (Australian Institute of Health and Welfare, 2019) and are leading causes of disability and morbidity. Intellectual disability is associated with substantial over-representation of mental illness.

In NSW, 76% of people with intellectual disability experience mental health disorders (as against 38% in the general population), including serious mental illnesses 16% (as against 5% in the general population) (Arnold et al., 2025).

Available data suggests overrepresentation for most mental health disorders, including schizophrenia, affective disorders, anxiety disorders and dementia, of 2-3 times that of the general population (Einfeld & Tonge, 1996; Morgan et al., 2008; J. N. Trollor, 2018).

The research of the Department of Developmental Disability Neuropsychiatry demonstrates the lack of capacity of professionals and systems to respond to this issue (J. N. Trollor, 2018). The research shows that people with intellectual disability are very high users of acute mental health services at greatly inflated cost (Li et al., 2018; Liao et al., 2022; Srasuebkul et al., 2021; J. Trollor et al., 2016) ; experience multiple barriers to mental health services and receive ineffective care characterised by repeat presentation to acute care after a mental health

inpatient stay (Liao et al., 2022) encounter professionals and services that are ill-equipped to meet their basic rights to access mental health care (J. N. Trollor, Eagleson, et al., 2016; J. N. Trollor, Ruffell, et al., 2016; J. Weise & Trollor, 2018; Whittle et al., 2019); and are usually excluded from mental health policy (Dew et al., 2018; Reppermund et al., 2018).

Findings and recommendations of the Disability Royal Commission

Based mainly on lived experience testimonies and research, the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (DRC) made this finding: “people with cognitive disability have been and continue to be subject to systemic neglect in the Australian health system (Royal Commission into Violence, 2020)”.

The Royal Commission made wide ranging recommendations including that the Australian Commission on Safety and Quality in Health Care (ACSQHC) review and revise the National Safety and Quality Health Service Standards and the National Safety and Quality Primary and Community Health Care Standards to provide for the delivery of safe and high quality health care for people with disability and align with the scope of the Commission’s proposed right to equitable access to health services (Recommendation 6.31a) (Royal Commission into Violence, 2020).

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