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## Service development for intellectual disability mental health: a human rights approach

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### Abstract

**Background** People with intellectual disability (ID) experience higher rates of major mental disorders than their non-ID peers, but in many countries have difficulty accessing appropriate mental health services. The aim of this paper is to review the current state of mental health services for people with ID using Australia as a case example, and critically appraise whether such services currently meet the standards set by the Convention on the Rights of Persons with Disabilities.

**Methods** The literature regarding the current state of mental health services for people with ID was reviewed, with a particular focus on Australia.

**Results** The review highlighted a number of issues to be addressed to meet the mental health needs of people with ID to ensure that their human rights are upheld like those of all other citizens. Many of the barriers to service provision encountered in Australia are likely also to be relevant to other nations, including the culture of division between disability and mental health services, the inadequate training of both disability and mental health

workers in ID mental health, and the lack of relevant epidemiological data. None of these barriers are insurmountable.

**Conclusions** Recommendations are made for adopting a human rights-based approach towards the development and provision of mental health services for people with ID. These include improved policy with measurable outcomes, improved service access via clear referral pathways and the sharing of resources across disability and mental health services, and improved service delivery through training and education initiatives for both the mental health and disability workforce.

**Keywords** health service evaluation, human rights, intellectual disability, mental health services, public health

### Introduction

The United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) (UN 2006a,b), entered into force in 2008, affirms that all persons with a disability must enjoy the same fundamental human rights and basic freedoms as do those without a disability. The Convention makes explicit that people with a disability are bearers of

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rights, a move away from attitudes viewing people with a disability as objects of charity requiring medical treatment and social protection. The UN CRPD has consequently been hailed as a paradigm shift in the way that society understands the issues that confront people with a disability, away from a social welfare response and towards a rights-based approach (Kayess & French 2008).

Article 25 of the CRPD specifies the right to health for people with a disability. The right to health is indispensable for the enjoyment of other rights (UN ECOSOC 2000); however, significant social determinants usually underpin inequities in health (CSDH 2008). Much of Article 25 bears specific relevance to the provision by signatories of equitable health services and health outcomes for people with a disability. In particular, Article 25(a) and (b) of the CRPD requires States Parties to 'Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons' and to 'Provide those health services needed by persons with disabilities specifically because of their disability', while Article 25(c) of the CRPD requires signatories to provide services 'as close as possible to people's own communities, including in rural areas' (UN 2006a). Article 25(d) mandates that 'health professionals (are) to provide care of the same quality to persons with disabilities as to others'. Moreover, according to Article 33 of the CRPD, States Parties should develop independent mechanisms 'to promote, protect and monitor implementation of the present Convention' [CRPD Article 33(1), UN 2006a]. This speaks directly to the need to evaluate health services, access and outcomes for people with a disability. Only through such evaluation can the implementation of the CRPD and the adoption of a rights-based approach to health be measured.

In developed nations, one group with measurably poorer health status and outcomes compared with the general population is people with intellectual disability (ID). The inequitable health status of people with ID is particularly evident in the area of mental health. The point prevalence of mental illness in this group has been estimated to be about 40% (Einfeld & Tonge 1996; Cooper *et al.* 2007), but estimates have ranged from 10% to 60% (Einfeld *et al.* 2011) and have been reported to be as

high as 80% (Borthwick-Duffy 1994). Prevalence is much higher in people with ID compared with the non-ID population, being around three to four times that for people without ID in both child and adolescent populations (e.g. Einfeld & Tonge 1996; Dekker *et al.* 2002; Emerson 2003; see also Rojahn *et al.* 2010; Einfeld *et al.* 2011 for reviews) and in adults (e.g. Cormack *et al.* 2000; Cooper *et al.* 2007). Yet despite their increased risk of mental illness, only a small minority of people with an ID receives appropriate treatment (McCarthy & Boyd 2002; Dekker & Koot 2003; Einfeld *et al.* 2006).

Such mismatches between mental health needs and access to mental health services reflect barriers to effective mental health care. Barriers may relate directly to the person's ID such as features that complicate clinical assessment (Costello & Bouras 2006) or may be carer-related, as access to mental health services is often dependent on families and advocates recognising the signs of mental illness (Costello & Bouras 2006). Additional barriers such as transport difficulties (Krahn *et al.* 2006) are practical or service-related, such as increased difficulty finding a doctor (Krahn *et al.* 2006); a lack of skilled clinicians in ID mental health (Donner *et al.* 2010); and 'diagnostic overshadowing', that is, incorrectly attributing symptoms to the person's ID (see Borthwick-Duffy 1994 for a review). Finally, some barriers are systemic, such as poverty (Emerson 2007) and limited education (Ouellette-Kuntz 2007).

In order for health and mental health care for people with ID to be aligned with a human rights framework, sustained systemic improvements are required at multiple levels (Krahn *et al.* 2006). Given the paradigmatic shift intended by the CRPD, any reform to policy and practice in health care for people with a disability that is undertaken by States Parties should embrace a rights-based approach. This paper reviews the current state of mental health services for people with ID, using Australia as a case example of a nation at the cusp of rapid development in ID mental health services, and suggests avenues for change through a rights-based approach. We have chosen to focus on mental health, as the mental health needs of people with an ID have historically been poorly met yet have enormous implications for their quality of life. The intersection between mental health and disability

services therefore provides an ideal context to measure a State's Parties progress towards upholding the principles of the Convention.

As the principles underpinning human rights are universal, we argue that the recommendations made may be useful for other States Parties in the process of developing and expanding mental health services for people with ID.

## Methods

A literature review was conducted using the Ovid Medline and Psycinfo databases. Search terms included 'intellectual disability' or 'developmental disabilities' combined with any of the terms 'mental disorders', 'psychiatry', 'mood disorders', 'health services', 'health status', 'mental health services' and 'delivery of health care'. Articles were selected primarily for their relevance to the provision of mental health services and broader health services to people with an ID in Australia. However, articles that discussed this issue in an international context were also included to provide a framework in which to compare and contrast the issue. Over 100 abstracts were analysed. Those that focused on people with ID within other specific populations (e.g. Indigenous Australians); discussed specific issues relating to mental illness and a framework for service provision; and those relevant to Australian health services and the ID population were selected for this review. Some literature cited in other articles was also reviewed by the two lead authors and included where relevant. In order to maximise literature germane to the Australian experience, searches were also conducted using the names of authors known in the ID health and mental health field within Australia. Literature from the authors' existing collections was also accessed, for example that relating to the CRPD itself, and policy documents specifically relating to Australian mental health and disability services. The literature reviewed dates from 1994 to March 2012.

## Results

The literature review highlighted a number of inequities in the current status of mental health services for people with ID in Australia. These are summarised below.

## Public mental health services

Australia has a system of universal health care funded by Commonwealth and State Governments. A parallel fee-for-service system of private specialist and hospital care services a minority of Australians, but is largely inaccessible to those with ID and complex needs. A very small number of clinicians or services act as tertiary consultants in ID mental health in the public sector. Mainstream public mental health services therefore have core responsibility for meeting the full spectrum of mental health needs of people with ID. There are no specific inpatient facilities for people with ID and admissions occur to general mental health facilities, with care being provided by staff who have limited or no experience in working with people with ID. With very few exceptions, no specific ID mental health teams exist in Australia.

Repeated calls have been made for improved services and increased academic and clinical expertise and resources in the area of ID mental health (e.g. Parmenter 1988; HREOC 1993). In 2007, New South Wales (NSW) Department of Health and NSW Department of Ageing, Disability and Home Care (ADHC) in collaboration with the NSW Council for Intellectual Disability, responded by proposing the *NSW Health Service Framework to Improve Health Care of People with Intellectual Disability* (NSW Health 2007, formally published in 2012). The Framework promotes a five-tiered structure aiming comprehensively to address the health needs of people with ID, and includes a specialist ID health clinic model. While the Framework conveys potential for improved service provision and policy, the estimated cost of full implementation is substantial (NSW Health 2009), raising concerns about its realisation. Despite this, a number of smaller-scale developments in NSW have resulted from the Framework. For example, in 2010 the Clinical Network for Intellectual Disability was established as part of the Agency of Clinical Innovation. The Agency of Clinical Innovation is a board-governed statutory health corporation that reports to the NSW Minister for Health and the Director-General of NSW Health, effectively placing an organisation privy to health service and policy development in a position to champion the health needs of people with ID. Another laudable develop-

ment arising from the Framework is the funding of three small ID health pilot projects in urban, regional and rural NSW, which include comprehensive evaluation and monitoring strategies.

Also in NSW, a *Memorandum of Understanding (MoU) on the provision of services to people with an intellectual disability and mental illness* (NSW Government 2010) was forged between two State Government agencies providing disability and health services, replacing the 1990 Joint Protocol in *The Provision of Mental Health Services to People with Developmental Disabilities* (NSW Government 1990). The aim of the updated agreement is to recommit these agencies to 'improving access to disability and mental health services and improve treatment outcomes' (NSW Government 2010, p. 7). The MoU aims to foster collaboration between the two agencies in the form of sharing expertise, case-by-case troubleshooting, and the provision of joint staff training.

Service developments are not limited to NSW. The state of Victoria has developed a tertiary dual-disability service for those with ID and co-occurring mental illness. In Queensland also, positive developments include the provision of limited funding for tertiary health consultancy services and the establishment of a Forensic Disability Service. Despite developments in these particular jurisdictions, large gaps in service provision remain across Australia. Namely, the lack of standardised competency and expertise within mainstream inpatient and community mental health settings is of serious concern.

In Australia, the proposed National Disability Insurance Scheme (NDIS) currently under negotiation may catalyse enhanced mental health services for people with ID. The NDIS promises a cross-jurisdictional commitment to proactive policy and disability service development based on sound evidence and with the view to holistic and whole-of-life care for people with disability. It focuses on empowering people with disability with a more responsive service system, including individualised funding and affirming the right to effective supports that reflect needs (Australian Government Productivity Commission 2011). However, the NDIS will not address access to clinical mental health services as its focus is on the provision of disability-specific supports.

### Public health service workforce

The number of clinicians specialising in ID mental health per capita of the Australian population is small (Molony 1993), and anecdotally, appears inadequate to meet current needs. ID health and ID mental health are not mandatory components of undergraduate medical or allied health training, nor of postgraduate psychiatric training for doctors or nurses. The level of content selected by education providers varies significantly, with teaching in the area of ID falling below acceptable standards in half of Australia's medical schools (Lennox & Diggins 1999). Lennox *et al.* (2000) found Australian general practitioners intended to increase their attention to the specific health needs of people with ID in the future, suggesting that current expertise is lacking and training in this area is very much required. Moreover, numerous Australian surveys have found that both general practitioners and psychiatrists lack confidence in meeting the mental health needs of people with ID, believe their current training is inadequate, and have an interest in further education in the area (Lennox & Chaplin 1995, 1996; Lennox *et al.* 1997; Cook & Lennox 2000; Phillips *et al.* 2004; Edwards *et al.* 2007; Jess *et al.* 2008).

### Service evaluation

Australia's disability and health services lack a rigorous data collection system, making evaluation difficult. A voluntary disability register exists only in one State (Western Australia). In other jurisdictions the lack of epidemiological data on the prevalence of ID and mental illness hampers strategic planning and service evaluation (Molony 1993).

### Service access

An Australian study of children and young adults with ID found that fewer than 10% of those with clinically significant levels of psychopathology accessed mental health interventions over a 14-year period (Einfeld *et al.* 2006). In contrast, 34.9% of the general Australian population with a mental health problem receives interventions in a single year (Slade *et al.* 2009). A critical issue in many

countries, including Australia, is the under-development of mental health services for people with ID, a problem underpinned by political and historical paradigms (Krahn *et al.* 2006). In Australia, the process of deinstitutionalisation neglected to consider how the health care needs of people with ID would be met in community settings. Policy development in Australian States during the 1980s and 1990s oversaw the separation of mental health and ID services (Lawrence 2006) without allocating adequate resources for either, nor legislating provisions for those needing both services (Molony 1993). Thus, the disability sector has responsibility for human services, therapy and behavioural support, and the health sector for all health and mental health needs. Integrated care is hampered by a lack of provision for cross-sector work, the lack of a unified record system and tension over funding of services that lie at the borderland of either sector. Differing underlying philosophies furthers the divide. Whereas the medical model still underlies most mental health services, the disability sector moved away from this approach some years ago towards a community model (Parmenter 1988; Mohr *et al.* 2002). Disability services now emphasise person-centred planning, focused on supporting a person with ID with consideration of their unique circumstances, as opposed to a service-led model of care. This not only creates discordance between the sectors, but also means that eligibility of people with ID for particular services is restricted. For example, the presentation of mental disorder in people with ID is often atypical, resulting in exclusion from mental health services that use conventional diagnostic criteria to determine eligibility. In addition, each sector has its own training pathway, with staff unaware of the other sector's philosophy of care (Mohr *et al.* 2002). This creates a professional 'silencing' effect, and encourages segregation of assessment, treatment and management (Lawrence 2006). Furthermore, restricted funding for each service contributes to 'us versus them' struggles when disputes arise regarding service provision (Mohr *et al.* 2002). Indeed, families report needing to act as intermediaries between services that will not co-operate or communicate with one another (NSW Ombudsman 2011).

### Mental health policy

In the area of ID mental health, Australia's policies remain vague, and mental health targets are ill-defined. For example, the *National Mental Health Strategy* (DOHA 2009a) and the *National Disability Strategy* (COAG 2011) contain little specific acknowledgement of the issue of co-occurring ID and mental illness, nor do they specify milestones for improvement in this area. There is general acknowledgement that increased co-ordination is required. For example, the *Fourth National Mental Health Plan* (DOHA 2009b) states that those with ID and co-occurring mental illness are 'overlooked, and access to appropriate treatment for both disabilities is limited' (DOHA 2009b, p. 70). The document calls for 'a partnership approach' (p. 64) to service provision, and 'collaboration between agencies' (p. 28).

However, there is little elaboration, and without assigned responsibility and measurable outcomes, the recommendations are unlikely to elicit the action required to achieve these outcomes.

### Discussion

Despite some recent developments in mental health services, in Australia and elsewhere we are far from achieving a rights-based approach to service provision. The many barriers notably include historical service provision that encourages a dichotomous approach to service delivery; the limited training of clinicians in ID mental health; and the lack of cohesive cross-sector policy development capable of meeting the complex health and mental health needs of people with ID. In Australia, these barriers are specifically manifested in: the under-provision of public mental health services for people with ID; the lack of expertise within the public health service workforce; the insufficient monitoring and evaluation of services; and the way that policy is developed. The findings from the literature review are now discussed in relation to these areas, highlighting both deficits and recent progress in adopting a rights-based approach. The potential challenges and the implications beyond Australia, and the limitations to our review, are then considered.



## Intellectual disability mental health in Australia: strategies for a rights-based future

### *Public mental health services*

Article 25(a) and (b) of the CRPD requires States Parties to 'Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons' and to 'Provide those health services needed by persons with disabilities specifically because of their disabilities'. However, this aspiration does not match available services and expertise in Australia, as is recognised in the *Fourth National Mental Health Plan* (DOHA 2009b). Given Australia's commitment to uphold the CRPD, immediate action is required to fund a national network of specialised ID mental health professionals to ensure that people with ID are provided with health services tailored to their specific needs. In each health governance district there should be at least a psychiatrist, psychiatry trainee, specialist nurse and behavioural specialist psychologist who have a specialist focus on ID mental health. These professionals should both be part of mainstream mental health services and be located in specialist ID health teams for tertiary review of complex cases.

### *Public health service workforce*

The capacity of mental health services to treat and respond to the specialised health needs of people with ID depends on a skilled workforce. The results of this review suggest that under current workforce and training conditions in Australia, it is not feasible to expect 'health professionals to provide care of the same quality to persons with disabilities as to others' as mandated by Article 25(d) the CRPD. According to the literature, radical change is required to build a workforce that is able to provide such care. Accreditation of all medical, nursing, psychology and allied health courses should be contingent on the inclusion of ID health. For specialty trainees within psychiatry, ID mental health should be included as a core competency unit in basic training, and a sub-specialty stream should be established to support the development of a more highly skilled specialist workforce. A national funding stream is required in order to establish the latter positions. Efforts to train the existing health

and mental health workforce should be accelerated. Given the distances and low population density of Australia, training capacity would be enhanced by the establishment of a national training and education centre, and by the development of a rich array of online resources including interactive training modules with built-in self-assessment components. It is imperative that a human rights framework underpins all such material.

### *Service evaluation*

If Australia is to fully adopt a human rights framework in its provision of services to people with ID, data are required in order to monitor progress towards this goal. Article 33 of the CRPD specifically mandates that States Parties develop independent mechanisms 'to promote, protect and monitor implementation of the present Convention' [CRPD Article 33(1), UN 2006a]. Furthermore, any strategy regarding the right to health should include 'indicators and benchmarks, by which progress can be closely monitored' (UN ECOSOC 2000, General Comment 14, Para 43). The need for measurable health outcomes was also recognised in the European Manifesto on Basic Standards of Health Care for people with Intellectual Disabilities (Meijer *et al.* 2004), which included measurable outcomes at the levels of individuals (e.g. capacity to access mainstream services), service providers (e.g. achieving basic competencies in ID health; access to specialist resources where needed), and service structures (e.g. availability of specialists to back-up mainstream services; adoption of a multidisciplinary and a proactive approach). It was also identified as an area of Priority under Australia's *Fourth National Mental Health Plan* (Priority Area 5) but as yet comprehensive data collection is not in place. The international example set by the National Health Service in the UK demonstrates that data collection is useful in informing service improvements and outcomes in ID (Emerson & McGrother 2011). The development of such capacity, including linking data sets across disability and health services, should be a national priority – one that could possibly be implemented under the proposed NDIS.

### *Service access*

A core element of the right to health is the availability of, and access to, appropriate health services

(UN ECOSOC 2000; CRPD Article 25, UN 2006a). A key to improved ID mental health service access in Australia is building the capacity for joint work across disability and health services. As highlighted by the *MoU*, to which we have already referred, a dialogue has begun in one jurisdiction (NSW Government 2010). Yet at present there are no uniform processes in place for joint triage and timely interagency assessments, each a key element of collaborative services.

Several models offer guidance relevant to the Australian context, including creating new specialist services, providing additional training and resources to current mainstream services, and the integration of tertiary specialist services within the mainstream context. While Jess *et al.* (2008) found the specialist model for psychiatry training and service provision used in the UK had advantages over the generic model used in Australia, reviews by both Chaplin (2004) and Bouras & Holt (2004) suggest the evidence is inconclusive. However, Chaplin later suggested 'the weight of research is accumulating to suggest that provision of general psychiatric services without extra help is not sufficient to meet the needs of people with ID' (Chaplin 2009, p. 189). In the Australian context, separating specialist from mainstream services runs the risk of segregation and may impose unnecessary travel requirements on people with ID and their carers (NCOSS 2007). Equipping mainstream services to meet the mental health needs of people with ID while also providing tertiary back-up, consultation and additional resources is therefore preferable, and essential for improving local access to ID mental health services.

A unique consideration in geographically large nations like Australia is accessibility in rural and remote areas. Article 25(c) of the CRPD requires signatories to provide services 'as close as possible to people's own communities, including in rural areas' (UN 2006a). Presently, the few specialist mental health services for people with ID in Australia are mostly clustered on its densely populated eastern coastline. Those in rural areas report difficulties accessing specialist services, including mental health services (Iacono *et al.* 2004). Investment in outreach services and telehealth initiatives would substantially enhance local provision of services.

### *Mental health policy*

The UN ECOSOC's General Comment 14 on the Right to the Highest Attainable Standard of Health stipulates that this involves 'sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realising the right to health' (UN ECOSOC 2000, General Comment 14, Para 36). Proactive inquiry and policy development have been key to improvements in health care, education and funding for ID in the UK [see, e.g. Michael 2008, and the UK Department of Health *Valuing People* (2001) and *Valuing People Now* (2009)].

In nations like Australia, currently developing services for people with ID, a fundamental change in the way that both health and disability related policy is developed is required. Many people with an ID have needs that surpass the capacity of the disability sector, and thus policy in relation to service provision requires a 'whole of government' approach, with a common language between sectors (Townsend 2011). The formation of national and State-based ID health policy committees with professional, consumer and advocate representation is recommended in order to provide visible bodies for consultation on drafts of key policy and strategic documents. Australia's progress in health policy for another vulnerable population group of similar size, Indigenous Australians, may provide useful guidance. The COAG (2009) *Closing the Gap* initiative outlines specific and measurable targets for equitable outcomes for Indigenous Australians, accompanied by funded implementation strategies, and comprehensive evaluation and monitoring. A similar development in ID health and mental health policy would be equally commendable.

### Challenges and potential barriers to change

Our recommendations for improving Australia's ID mental health services in line with a human rights approach include: changes to the mental health system to ensure services are provided by a suitably skilled mainstream workforce; that services are evaluated and monitored; and that policy is developed in a manner that is accountable to this population group.

It is clear that the financial consequences of such reform to ID mental health services will be substantial. Beyond financial resources, a great cultural change is required. The divide between the disability and mental health sectors must be bridged, and a 'whole of government' approach is required to ensure the sharing of resources and joint planning. However, given that inequities in health arise from inequities in society (CSDH 2008; Marmot 2011), reform of Australia's mental health services depends also on broader political and societal change, and on stewardship of this issue. The recent developments surrounding the NDIS signify hope for such a change. There is a key role for mental health professionals in guiding this change and in championing the development of effective health service models. Advocacy by community-based consumer groups is also integral to this change.

#### Implications beyond Australia

This Australian case study highlights a number of implications of the CRPD that may be relevant for other signatories to the Convention. There is general consensus that further research is required to inform policy and service development in this area (Townsend 2011). In particular, Cooper & van der Speck (2009) point to the lack of epidemiological data regarding mental illness in people with ID as a great hindrance to understanding of this issue. Likewise, Yen *et al.* (2009) highlight the need for research on preventing mental illness in people with ID. The issues relating to health professional training and equity of access echo concerns expressed in many nations (Ouellette-Kuntz *et al.* 2005).

Furthermore, the development of policy and models for mental health services must be tailored to local cultures, particularly given the influence of a society on the lives of those with ID (Emerson *et al.* 2008). The implications of the CRPD for other States Parties will therefore differ according to the current state of mental health services, the policies in place for people with ID, and the available resources.

In nations currently developing better services for people with ID, like Australia, the primary implication of the CRPD is in ensuring that new policy

and new service development proactively embraces its principles. Many of the challenges discussed above will hold direct relevance for similar nations, such as the inclusion of explicit targets for meeting the mental health needs of people with ID within policy, the expansion of curricula for medical and allied health professionals, and gaining political commitment to enhanced financial resources for ID mental health.

Even in those States Parties where policy and services for people with ID are already better developed (such as the UK), the CRPD holds direct relevance for policy makers and service providers. Such nations must strive to ensure that the rights of people with a disability remain at the forefront of the national health care agenda, and that policy remains consistent with current knowledge in the area of ID mental health.

For middle- and particularly low-income States Parties still in the process of developing health services and health policies in general, specific policy regarding the health of people with ID may currently be lacking (see, e.g. the reviews by Mercadante *et al.* 2009 and Njenga 2009), and access to disability services and health services in general may be poor (Mercier *et al.* 2008). In States Parties where resources are limited, development of policy and services to address the mental health of people with ID may occur in line with broader developments in population health care, and disability services in general. The challenge in upholding the CRPD will be ensuring that the rights of people with disability are proactively included within such broader developments. However, as Emerson *et al.* (2008) point out, stigma surrounding disability can still prevail in such nations, meaning that a rights-based approach to service delivery is some way off. Furthermore, not only do many low- and middle-income countries currently lack public funding for disability services (Mercier *et al.* 2008), but meeting the needs of people with a disability in the poorest nations will require a much larger and better trained workforce compared with that currently available to them (Ericsson *et al.* 2008). The current state of services for people with ID in some of the world's poorer nations highlights the need for all States Parties to work together to address the health of people with ID globally (Emerson *et al.* 2008).



### Limitations of the current review and avenues for future research

The major limitation of the current review is that there were relatively few articles on the use of a human rights framework in the provision of mental health and health services for people with ID in Australia, or elsewhere. It is possible that using different search terms would have generated different articles and research. However, given that multiple search terms were used it is unlikely that the conclusions would have differed greatly. Indeed, the small number of publications on this topic highlights that the paradigm shift intended by the CRPD is, as yet, incomplete. It also demonstrates that this is an issue that requires more in-depth analysis and could certainly benefit from further research.

### Conclusion

This paper has used Australia as a case study to highlight the need for, and possible mechanisms to, improve mental health services for people with ID in line with a human rights framework. The recommendations made for improving Australia's public mental health services; the mental health service workforce; service evaluation; service access; and the development of mental health policy for people with ID, are relevant for other States Parties to the CRPD. Although it is clear that such reform to mental health policy and service provision for people with ID will require a substantial financial investment, it is our hope that nations like Australia will embrace this opportunity at a political and at a social level, including dedicating appropriate funding to improve specialist services, building the expertise of the workforce and working across portfolios to make a human rights-based approach to service delivery a reality. For, as the World Health Organisation succinctly put it, achieving health equity 'is the right thing to do, and now is the right time to do it' (CSDH 2008, p. i).

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