

Response to the Productivity Commission Draft report on Disability Care and Support

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working
with the
community

1. Introduction

One in five adults in Australia suffer from the effects of a mental illness in any twelve month period with a life time prevalence of 45 per cent of adults expected to suffer [1]. Younger people surveyed had higher rates with 26% of people aged 16–24 years and 25% of people aged 25–34 years experiencing mental disorder in the previous twelve months.

There are high social and financial costs for people dealing with mental illness, from time out of the workforce to a loss of social inclusion when excluded from work or social engagement. The estimated cost of lost productivity due to employees dealing with mental illness was \$AU2.7 billion in 2007 [2]. In Australia a total of \$AU60 billion dollars is spent annually on disability pensions, of which \$16.8 billion is allocated to people with mental illness [3].

One quarter of people with a mental illness require on-going or regular support for their condition [4]. A significant number of families undertake the burden of care-giving for a family member with a mental illness [5]. RANZCP endorses the principles of the report, and commends the aims of this review of support and care for the disability sector with better efficacy for the disabled and their carers.

This response will **not** cover all aspects of the Productivity Commission's *Disability Care and Support* Draft Report (hereafter referred to as the Draft); rather it will focus on the immediate relevance of (long-term) mental illness and the National Disability Insurance Scheme (NDIS) and National Injury Insurance Scheme (NIIS).

2. About the RANZCP

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for the training, examining and awarding of the qualification of Fellowship to medical practitioners. There are approximately 2700 fellows of the RANZCP who account for approximately eighty-five per cent of all practicing psychiatrists in Australia and over fifty per cent of psychiatrists in New Zealand. There are branches of the RANZCP in each state of Australia, the ACT and New Zealand.

The RANZCP is a leader amongst Australasian medical colleges in developing partnerships with consumers and family and other carers in respect to excellence of service provision. The Board of Practice and Partnerships includes consumer and carer representatives from a variety of backgrounds who contribute extensively to the development and management of RANZCP programs and activities, and works together with the community to promote mental health, reduce the impact of mental illness on families, improve care options and supports, and ensures that the rights of people with mental health concerns are heard by mental health professionals. The expertise of the RANZCP Community Collaboration Committee, which includes a range of consumers and carers, has been used in the development of this submission.

3. Mental illness in relation to disability and the NDIS

Mental illness describes various diagnosable disorders that impact significantly on a person's emotional, cognitive or social capabilities; bipolar disorder, anxiety and depression are examples [6]. Mental health

outcomes can be compounded by a person's physical disability; the issue of co-morbid mental health and physical or intellectual conditions will also need to be addressed.

An individual's physical disability care and support needs would be covered under the NDIS, yet the effect of a mental illness can also be incapacitating. It is important to have clear guidelines for all government partners and agencies in order to streamline and clarify eligibility for disabled individuals including those with a debilitating mental illness. Mental illness tends to be less visible than other disabilities and therefore is not always included in disability services [4]. The NDIS will need to recognise the impact mental illness has on the individual, their carers, and family.

3.1 Issues of co morbid mental and physical conditions

If an individual has co-occurring physical and mental conditions it is probable they will endure more chronic and severe social, medical or emotional issues than if they only had one condition [1]. For some patients, the impact of a physical condition, such as Multiple Sclerosis, and anxiety or depression, would compound their life outcomes. An Australian survey in 2007 found that 11.7% of the population (1.8 million people) had both a physical disability and a mental disorder, 6.4% of the population had one disorder while 5.3% had two (or more) disorders [1].

Some mental disabilities have a high prevalence of co-morbid physical disability; for example one third of people with Autism Spectrum Disorder (ASD), have a brain injury condition and a number develop epilepsy [3]. ASD costs between \$4.5 and \$7 billion annually, including employment reduction, social service and carer costs with a life time cost of up to \$5 million per individual sufferer. Clearly an individual with co-morbid ASD and intellectual impairment that means they cannot function independently could be covered by the NDIS (if not a disability pension), however there would also need to be guidelines or criteria for those who need supported living but are able to work.

RANZCP supports the implementation of a co-ordinated set of guidelines for the health, mental health, aged and palliative care sectors for effective protocols to ensure people are covered for care and that referrals happen smoothly. There would need to be clear guidelines for any working relationship between the NDIS and its key sector partners.

3.2 Episodic nature of mental illness

Approximately one quarter of adult Australians suffer from a mental illness at any one time, meaning that a significant percentage of population are affected by the impact such a condition has [7]. One of the difficulties arising from various mental illnesses, for example depression and bipolar disorder, is that they are episodic in nature, with stable and unstable periods even with treatment or medication [7]. The Draft recognises the indistinct lines between the applicability of the NDIS to mental illness.

Given the episodic nature of mental illness, it can be difficult to hold down a job, meaning the individual's income can be unreliable or interrupted if they have to withdraw from employment to manage their condition [7]. In 2006 mental illness was estimated to have cost 20 billion dollars, including loss of productivity and participation in employment. Provision would need to be made to allow individuals to recover from an episode of illness and to maintain a viable financial position. RANZCP understands that mental illness conditions would not necessarily come under the realm of the NDIS except in severe debilitating psychiatric cases, for example paranoid schizophrenia, where on-going care and support was required. RANZCP also acknowledges that clinical counselling would not fall under the guidelines of the NDIS but would point out the debilitating aspects that long term mental illness can bring.

3.3 Mental health is currently underfunded

In recent years the funding for mental illness has not been sufficient to address the needs of those affected; while the approximately 13 per cent of the total health burden relates to mental illness, only 6 per cent of the national health budget is allocated to expenditure on mental illness [3]. The Federal Government pledged an extra \$1.9 billion between 2006 and 2011 for the mental health care budget across various areas, from suicide prevention, early intervention and prevention work to community support for families dealing with mental illness [6]. The cost for disability support pensions for persons with a mental illness is estimated at \$4 billion dollars with a total \$10 billion spent on social services, health and welfare [6].

Only 2.4 per cent of all Australians need a carer, with half of those suffering from a mental illness [8]. The burden on the families of individuals with a mental illness is immense however the financial and emotional costs are difficult to gauge. Kulkarni (2010) gives the example of bipolar disorder with \$1.59 billion per year in direct costs for the patient; the indirect hidden costs for the family can include loss of earnings, family dispute costs and treatment required by affected relatives.

3.4 Early Intervention and prevention key to better outcomes

The Draft recognises the importance of improving outcomes for people with a mental illness through the use of early intervention and prevention programs. Given the elevated rates of youth mental illness in Australia [1, 9], it is imperative to focus on the needs of younger people and children to reduce social and economic costs while better support outcomes for those dealing with mental illness [10]. Less is known about prevention of the on-set mental illness than other conditions, such as heart disease [3].

Early intervention with effective treatments can have positive outcomes, however there needs to be a focus on established and more persistent mental health conditions. Studies have shown that even best practice treatment applied to 100% of the population with mental illness, would still only avert 40% of the burden of disease [8]. This underscores the importance of prevention and early intervention. Kessler Berglund et al [11] report that 50% of all serious mental health and substance use disorders commence by age 14. Thus, prevention orientated interventions targeted to young people have the capacity to generate greater personal health, social and economic benefits than interventions at any other time of the lifespan.

Early and preventative interventions show promise in reducing the burden of mental illness, particularly in young people. Much of the strongest evidence to date is for interventions that improve protective factors or reduce risk factors demonstrated through research to be closely related to mental disorders [12]. RANZCP supports the Draft's promotion of early intervention and prevention programs for improving outcomes for the mentally ill.

3.5 A Social Model of Disability

RANZCP agrees that there would need to be clear guidelines on assessment criteria for eligibility and endorses the Draft report's suggestion of individualised support packages to allow for the episodic nature of mental illness, with periods of incapacitation. Those individuals with an on-going or long-term debilitating mental health condition would be covered under the NDIS, whereas those people not 'permanently' impacted would have less clear cut eligibility. It is important to define how individuals with a debilitating mental illness, especially those whose illness is episodic, will be catered for under the NDIS.

The Draft recommends that the insurance be designed around people with a disability developing their own support packages. The NDIS could follow the social model of disability to allow the mentally disabled to determine their own future and care plan. The social model of disability would allow for more self-determination by disabled individuals and their carers/family. The model emerged from the United Kingdom in the early 2000's [13], and concentrates on providing the necessary tools to remove the barriers for disabled individuals in areas including housing, transport and education [14].

'Self-directed care' is an example of an inclusive care model for the disabled run by the United Kingdom charity In Control [13]. It is a new system that identifies resources for each individual and empowers consumers to decide how this resource is used to meet their needs. It began with social care and money in social services but it is quickly becoming about health, education and other services. This allows people to be in control of the support they need to live their life as they choose. Besides the UK, USA, Canada, The Netherlands and Germany, have similar models.

The UK model has been operating successfully for several years in the disability sector and has more recently been introduced by the Western Australian Government's Department of Health and Ageing in the aged-care sector. The RANZCP would be pleased to take a leading role in developing similar activities in the mental health sector. A patient-focused social model of disability would be recommended for use with the NDIS as it lets the affected individual (and their family) make important decisions about their care and treatment.

4. Recommendations

There is the need for a more integrated system with national funding and assessment guidelines for mental health patients plus increased funding invested in support and services for a group not generally recognised or sufficiently provided for. The RANZCP makes the following recommendations for the NDIS draft report:

- Establishment of guidelines for assessment criteria for DNIS eligibility, developing further the report's suggestion of individualised support packages to allow for the episodic nature of mental illness, where there are periods of incapacitation
- Recognise the needs of individuals with co-morbid physical and mental health conditions, and to deal with them appropriately.
- Use of a co-ordinated national tool, such as the NDIS, to assess the needs of mentally disabled people to improve access to resources and clarify eligibility criteria, meaning that more individuals can be better supported.
- Development of clear guidelines for any working relationship between the NDIS and its key sector partners to ensure that the NDIS achieves its potential to streamline funding and assessment of disabled mental health patients
- Support early intervention and prevention programs in mental health to save financial outlay and improve outcomes for individuals with a mental illness
- Use of a social model of disability support to facilitate outcomes for the mentally ill and their carers by allowing them to participate in their own health care decisions

5. References

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