
M The intersection with mental health

Consistent with the experience in other Western countries, mental illness of some degree is common in the Australian population. Mental illness encompasses a diverse range of behavioural and psychological conditions of varying expected durations. The most common include anxiety disorders (such as agoraphobia), affective or mood disorders (for example, depression) and substance use disorders (such as alcohol dependence). The National Survey of Mental Health and Wellbeing 2007 (NSMHW) is the most recent comprehensive measure of Australia's mental health. According to that survey, one in five Australians aged 16–85 years experienced one of these more common mental illnesses in the preceding 12 months. This is equivalent to around 3.2 million people.

Mental illness also includes conditions that are uncommon among the population ('low prevalence' conditions), such as schizophrenia, bipolar disorder and other psychoses, though these were not specifically counted in the NSMHW. Some estimates suggest that these conditions affect another 2 to 3 per cent of the adult population. These illnesses are often serious, and are the traditional focus of state and territory mental health services. According to the Department of Health and Ageing (2010d), they account for most of the costs of specialised mental health care in Australia.

As is the case with other health conditions, mental illness does not always result in disability. Only half of the individuals who reported mental illness as their primary condition in the 2009 Survey of Disability Ageing and Carers (SDAC) reported that they had a disability.

Among those who reported having a disability, the group requiring significant and enduring support needs are the target of funded supports by the NDIS (tier 3). Those with relatively short-lived conditions and less severe disability will typically receive assistance from the health system. That said, some people may benefit from tiers 1 and 2 of the NDIS.

Given the focused role of the NDIS in this area, this appendix considers:

- how many individuals have significant and enduring psychiatric disability

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- the care and support needs of this group, and what role the NDIS and the mental health sector would play in meeting those needs
 - how the division of responsibilities might work in practice.

M.1 Estimating the number of individuals with significant and enduring support needs

This section presents an estimate of the number of people with psychiatric disability who would receive funded supports under the NDIS. This number is used to inform the Commission's estimates of the costs of the scheme. As noted elsewhere in this report (chapter 16 and appendix H), this is a statistical exercise, not a description of eligibility. Actual eligibility and funding under the NDIS would be determined by reasonable needs for funding, as measured by specialist assessment tools.

The Commission used several proxies to assess the number of people in the NDIS and its costs. The Commission has drawn from the SDAC (2009), advice from experts in this area and epidemiological evidence.

SDAC is an imperfect source of information on the relevant group

The 2009 SDAC identifies just under 120 000 individuals with a *primary* mental or behavioural disorder as having daily core activity limitations (under age 65 years). Individuals with psychiatric disability form a subset of that group. Excluding those individuals with intellectual disability, Alzheimer's, autism and other developmental disorders (which are accounted for elsewhere in the Commission's estimates) brings that number to around 25 000.

While employing SDAC data is a reasonable approach for most people with disabilities, it provides a particularly poor measure of those with significant and enduring psychiatric disability:

- As part of the survey process, individuals are asked whether the limitations they experience have lasted, or are likely to last for six months. For many conditions such as quadriplegia or intellectual disability, this is not problematic, since these conditions are lifelong. But with respect to psychiatric disability, SDAC captures a significant number of individuals with conditions (such as many cases of depression) that give rise to disability, but where disability tends to be relatively short-lived.
- On the other hand, SDAC does not capture well those individuals who have significant, non-core activity limitations.

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- The low prevalence of severe and enduring disability means that the reliability of any estimates in this area is particularly low.

Given the particular limitations of the SDAC data in capturing individuals with significant and enduring psychiatric disability, the Commission has explored other ways of more accurately estimating the number of people in this group. (While some participants suggested that the number could be as high as 200 000, the Commission's analysis and evidence from experts suggests a more conservative figure.)

Estimates based on the number of current service users

Given severe rationing and classification problems, most state and territory data on the number of people with psychiatric disability accessing disability supports are ill-suited as a basis for estimating the Australia-wide group of people needing supports. However, data on Victorian service users is more informative.¹ In Victoria a distinct system is responsible for delivering psychiatric disability rehabilitation and support services. As the Victorian Government observed:

An NDIS would only cover those people with psychiatric disability who require a high level of support for the duration of their lives or for a number of years. As an indication, noting that there is potentially a significant level of unexpressed demand for psychiatric disability support, 6,520 people received PDRSS Home-Based Outreach Support (of a total 14,421 PDRSS clients) in 2008-09. Of these 6,520 clients, it is estimated that 60 per cent have been receiving support for more than one year, but only 28 per cent have been receiving support for more than three years. (sub. DR996, p. 63)

Home-based outreach services are designed to provide support to individuals living in their own homes or other community residential settings. It includes training in social and living skills provided in the person's home, with a focus on the activities and interactions of everyday life. Given the emphasis on re-skilling, many individuals go on to require lower level supports (such as group supports). Extrapolating the number of service users in Victoria suggests that there might be around 26 000 individuals nationwide who require home-based outreach services (many of whom may require lesser supports after an initial investment in rebuilding skills). A much smaller share would be long-term users of outreach services (around 7360).

But as the Victorian government also noted, 'there is potentially a significant level of unexpressed demand' (p. 63). Clearly, these estimates would be an absolute lower bound.

¹ Less than 2000 people accessed non-employment disability supports under the NDA outside of Victoria (AIHW 2010d table 10.1).

Australian Government estimates of those with severe, persistent and complex needs

The Australian Government has undertaken modelling to estimate the number of individuals with ‘severe, persistent and complex’ needs. These are individuals who:

- have a severe and enduring mental illness (usually psychosis)
- have significant impairments in social, personal and occupational functioning that require intensive, ongoing support
- require extensive health and community supports to maintain their lives outside of institutional care.

According to estimates included in the most recent Commonwealth budget statements, there are ‘around 60 000’ individuals who meet these criteria (Roxon et al. 2011). This is around 0.4 per cent of the adult population, or 12 per cent of those adults with severe mental disorders.

Having consulted with experts involved in deriving these estimates, the Commission considers that the 57 000 people identified also closely approximate those individuals likely to require individualised supports under tier 3 of the NDIS.

Based on discussions with these and other experts in mental health planning, the Commission has assumed the following distribution of support needs.²

- Around 10 per cent of the individuals identified (almost 6000 people) would have ‘intensive’ support needs. These individuals require intensive assistance with activities and instrumental activities of daily living, such as maintaining personal hygiene, dressing, cooking, laundry and shopping. These individuals would also require accommodation-based supports and many would be in ‘group’ homes or other forms of supervised accommodation. In the past, these individuals were long-term patients within psychiatric hospitals.
- Around 25 per cent (14 000 people) would have ‘high’ support needs. These individuals may have histories of long-term hospitalisation and tenancy instability. They would often have limited familial and social networks and experience very low levels of community participation. Absent support, these individuals would struggle to live in the community, and would be at high risk of hospitalisation or becoming homeless.
- around 10 per cent (close to 6000 people) would have ‘medium’ support needs. These individuals would require assistance with living skills such as cooking,

² The Commission has been guided by discussions with a range of experts, including Bill Buckingham and Professor Harvey Whiteford. We are very grateful for their valuable advice.

cleaning, shopping, laundry and budgeting, as well as accessing community services.

- The majority of individuals, around 55 per cent (around 31 000 people) would have ‘low’ support needs.³ These are people for whom a small level of weekly support would assist them to live successfully in the community. The support provided by the NDIS would form part of a broader package, which would include ongoing clinical care provided by the mental health sector. These individuals might require assistance with such things as accessing community activities, budgeting or their weekly shopping. These individuals have support needs similar to others with cognitive impairments, such as those with milder intellectual disability.

The order of magnitude is consistent with other information. As a comparator, studies and analyses of people seen by state and territory mental health services suggest that, of the 300 000 individuals treated annually, around 15 per cent or 45 000 are high frequency service users.⁴

M.2 The scope of services

People living with mental illness need access to a range of services from across government. These include health and clinical care services, education, training and employment opportunities, and community support. For the reasons outlined in chapter 5, the NDIS would not displace mainstream services. Hence, education and training would remain the responsibility of the relevant state departments, clinical care would rest with the mental health sector and (open) employment services would be funded by the Commonwealth through a range of existing programs.

Rather, the NDIS would have a role in meeting community-based, disability support needs. This would include supports such as home-based outreach, day programs and other forms of group support, as well as respite services. In some cases, it would also include accommodation-based supports.

This separation of roles is consistent with current practice in states such as Victoria, and was also suggested by a number of participants (box M.1).

³ The share of individuals with low support needs is consistent with the share of HASI users who receive a low level support package (56% as reported in McDermott et al. 2010). In Victoria, a much larger share of individuals receive a low level support package.

⁴ Advice from the Department of Health and Ageing based on work undertaken as part of the Mental Health Service Classification and Costs Project.

Box M.1 **Participants' views on the separation of roles**

Victoria's specialist mental health sector currently provides a range of non-clinical supports similar to those proposed to be funded under Tier 3 of an NDIS. Most of these supports are provided by Victoria's non-government Psychiatric Disability Rehabilitation and Support Services (PDRSS) sector. PDRSS focus on addressing the impact of mental illness on a person's daily activities and the social disadvantage resulting from psychiatric disability. Key PDRSS programs include Home-Based Outreach Services, Day Programs, Adult and Youth Residential Rehabilitation services, Supported Accommodation Services, Mutual Support and Self Help and Planned Respite Services. (Victorian Government, sub. DR996, p. 62)

MI Fellowship's view is that the services that would sit within the NDIS are readily identifiable. As with other people receiving entitlements under the NDIS, services provided would include rehabilitation and recovery focussed support and care. Clinical care would be provided through the health system, pharmaceuticals through the MBS and social and public housing by state and territory governments. Medicare would fund clinical services provided by private psychiatrists and general practitioners. Allied health professionals would also be clearly a health system responsibility. (Mental Illness Fellowship Victoria, sub. DR1042, pp. 10–11)

The mental health sector has the clinical expertise and is best placed to provide clinical treatment and acute or ambulatory mental health care. However, there are many services that are currently provided by the mental health sector that are the same or similar to those provided to people with other disabilities and that are included in the scope of the NDIS, including day programs and supported accommodation. (NSW Ombudsman, sub. DR897, p. 2)

Clear lines of responsibility will need to be established. An evaluation of the FaHCSIA Targeted Community Care Mental Health Initiatives found that 'the pressures on acute mental health services have sometimes led to less than optimal approaches to client care'.

We have found constraints exist with working with government bodies, as it has been our experience that they appear somewhat reluctant to work with us in the NGO sector. They appear overworked and often refer clients to PHaMs in order to exit them from their books, without utilising the best approach for clients. We ensure that we find the most sustainable outcome for clients; however we have found it very difficult to work with government departments, as they often do not have the time or inclination to provide a long-term solution to clients, through developing an integrated case management approach. (prepared for FaCHSIA by Courage Partners 2011, p. 120)

Accommodation

Suitable accommodation is central to promoting quality of life and recovery of functioning for people living with a mental illness. A spectrum of accommodation

services is needed, including tenured housing, supervised community residential units, crisis and respite places. While the general boundaries between the NDIS and the mental health sector outlined above are relatively clear, there are some complexities around the provision of some forms of accommodation.

States and territories have developed a range of specialised, community-based residential services to replace the historical functions of standalone psychiatric hospitals. But this process is incomplete and there are major disparities between the states and territories in the level and mix of psychiatric beds provided to their populations. As the Department of Health and Ageing noted:

Extensive reductions in the size of standalone psychiatric hospitals occurred in the 30 years preceding the National Mental Health Strategy, decreasing the number of beds by about 22,000. Few alternative services were developed to replace the role of the hospitals during this period ... Development of specialised mental health residential services in the community has not progressed at the same pace. These services substitute for the role previously fulfilled by stand alone hospitals. (2009d, pp. 6–7)

While residential services are often based in the community, they are not all analogous to ‘group homes’, for which the NDIS would have responsibility. Some are heavily clinical in nature and so would remain outside the scope of the scheme. As an example:

- The Victorian Government funds community care units. These offer a structured residential environment in a community setting with on-site 24 hour clinical staffing. They provide ongoing clinical interventions and aim to enhance people’s daily living skills. While the service is intended to be rehabilitative, clinical needs are paramount (Victorian Government, 2007, p. 8). *Such services would remain outside the scope of the NDIS.*
- In some states, NGOs are funded to provide residential rehabilitation units. These units aim to improve functioning within a residential setting, but cater for individuals who do not require on-site clinical services. (Such services are typically provided by visiting health professionals or through local community mental health centres). The length of stay is up to two years. *Such services would form part of the NDIS service offering.*

Table M.1 outlines some indicative responsibilities. But the type of community-based residential services offered differs considerably between states. So the precise boundaries will need to be articulated in a series of MOUs between the NDIS and state and territory mental health and housing authorities.

All MOUs should embody a set of principles to ensure that:

- individuals are directed to the most appropriate service given their care and support needs
- services funded by the different parties are sufficiently integrated so that individuals can move between them as their needs change.

Table M.1 **Accommodation options for people with disability arising from mental illness**

Suggested stakeholder responsibilities

| | <i>Disability Support</i> | <i>Clinical Support</i> | <i>Housing</i> |
|--|---------------------------|-------------------------|--|
| Short-term Highly Supported Accommodation | | | |
| <i>Acute inpatient</i> | Mental health sector | Mental health sector | Mental health sector |
| <i>Adult prevention and recovery care (PARC)</i> | Mental health sector | Mental health sector | Mental health sector |
| Long term/Permanent Supported Accommodation | | | |
| <i>Secure Extended Care Units Community Care Units</i> | Mental health sector | Mental health sector | Mental health sector |
| <i>Residential rehabilitation (clinical base)</i> | Mental health sector | Mental health sector | Mental health sector |
| <i>Resident rehabilitation (non-clinical)</i> | NDIS | Mental health sector | Agreement to be reached between NDIS and state housing authorities |
| Permanent independent living (limited support) | | | |
| <i>Social housing</i> | NDIS | Mental health sector | State housing authorities |
| <i>Private rental</i> | NDIS | Mental health sector | Private sector |

M.3 Some practical considerations

The importance of coordinating and integrating clinical and non-clinical services was acknowledged by all governments in the COAG National Action Plan on Mental Health (2006–2011) (COAG 2006b, pp. 3, 5). The NDIA will need to closely coordinate the provision of disability supports with clinical supports provided by the mental health sector. In doing so, the NDIA will need to facilitate communication and avoid duplicating roles.

One possible area of overlap relates to the role of case managers (appointed and funded by mental health) and NDIS local area coordinators. Overlap already exists

between mental health case managers and ‘key workers’ in the community-managed mental health sector.

The role (and use) of case managers varies between states. In Victoria, they tend to be qualified health professionals responsible for ‘coordinating and ensuring all activities related to the consumer’s wellbeing are met’. Among other things, their role includes:

- assessing, planning and providing individualised treatment and care
- coordinating services
- guiding the consumer and carers through the system
- monitoring and reviewing risk and the intensity of case management
- accessing multidisciplinary input as needed
- linking the consumer and carers to other community supports and agencies (North Western Mental Health Alliance, 2009).

Some of these roles would be similar to those of local area coordinators under an NDIS. As part of the MOU process, the roles of case managers and local area coordinators should be made clear. The MOU should also canvass how the two will work together to provide a coordinated system of care, including processes for joint planning and information sharing. Participants generally favoured a streamlining of roles:

If the two services of ‘support’ and ‘health’ could be integrated through a liaison officer or case worker (a kind of ‘one stop shop’) that would be excellent. (blueVoices member, Beyondblue, sub. DR785, p. 4)

Examples of shared arrangements already exist and could inform arrangements in this area. As Beyondblue noted:

System-level initiatives could be introduced to help facilitate and incentivise a team-based approach to care across the disability and mental health sectors. The Team Care Arrangement system for the treatment of chronic disease in primary care, demonstrates a potential model that could be adapted to improve coordination by providers. Appointing central case managers/care coordinators to work across the mental health sector and the NDIS will ensure that holistic care is provided, and the patient and their carer will not experience any gaps or perceptions of ‘service silos’ between the sectors. (sub. DR785, pp. 3–4)