



NCOSS Conference Paper
Working Together for Mental Health



**Cross Government and
Cross Sector Approaches**

David Coyne, Regional Manager, Service
Development and Planning Metro West, DADHC

© D. Coyne 2003

Council of Social Service of NSW (NCOSS)

ph: 02 92112599 f: 02 9281 1968 e: info@ncoss.org.au

w: www.ncoss.org.au m: 66 Albion St, Surry Hills NSW 2010, Australia

DADHC has been asked to present at the workshop 'Mental Health and Intellectual Disability'. The initial presentation will be approximately 10-15 minutes duration, followed by facilitated discussion and question and answer time. Other speakers are Jim Simpson, NSW Council for Intellectual Disability and Associate Professor Stuart Einfeld.

The session will run from 2.30 pm to 3.45 pm and DADHC was asked to frame the speech to address the following key areas:

WHAT DOES A WHOLE OF GOVERNMENT/SECTOR RESPONSE MEAN IN THIS AREA?

- A whole of government response is one that assists people, in this case with mental health and disability issues, to access all relevant mainstream departments and services, rather than promoting a separate service system as the only response. It is also one that acknowledges that a variety of Human Service departments will have a role in the lives of people who approach DADHC with these issues.
- It requires an integrated response from Human Services departments: Health, Education, Housing, and Transport etc. This is a core component of DADHC's strategic directions and its commitment to facilitating relationships with other human service departments and others in the service system such as NGOs.
- It is promoted by facilitating communication/referral mechanisms. Areas that DADHC is currently working on involve improving referral mechanisms, using common referral forms/tools, making use of electronic communication systems across Human Services (through the Better Service Delivery Program) and working to establish accessible, recognised entry points for accessing information.
- It requires functioning partnerships between agencies. This will need to be endorsed at the most senior levels in order for it to take effect through working relationships established at the local level. Unless both levels are fully engaged in the process, it is unlikely to be successful.

Currently there are a range of issues that limit the successful implementation of this response. These include:

- People with the dual diagnoses of intellectual disability and mental illness have in the past been shunted between service agencies on the basis that the other agency has prime responsibility.
- This situation has improved markedly with closer interaction between senior managers of relevant departments and in policy development. However, at the local level there are significant difficulties in establishing effective working collaboration between the relevant services.
- This is not necessarily because of deliberate unwillingness, but often because of lack of resources, including the number of staff available, their training, and ability to care for such people.
- Another key element is a fear of workers that they do not have the competence to deal with an issue that they believe belongs to another type of service. Confidence that such workers would have the support of a professional from the other service would go a long way to address this issue.

MENTAL HEALTH / INTELLECTUAL DISABILITY / HACC SERVICES WORK TOGETHER, WHAT OTHER SERVICES NEED TO BE INVOLVED?

Note: In this context the term 'dual diagnosis' is used to indicate people with a diagnosis of intellectual disability and mental health issues rather than any other combination of issues. Any successful whole of government approach needs to take note of the significance of the following statistics and issues:

- 4 in 10 young people with an intellectual disability have significant mental health problems. 1 in 10 young people with mental health needs also have an intellectual disability.
- There is a significant relationship between poverty and intellectual disability and mental illness. In Britain 52% of children with a dual diagnosis are living in poverty and of those living in poverty, there is a 1.7 times greater incidence of mental health problems.
- These factors impact on school readiness, language and skill development and a sense of control over one's environment.
- People with a dual diagnosis require access to a range of services which may include community mental health, acute care, forensic, crisis support, counselling and one-on-one support from a psychiatrist.
- Undertaking assessments is often more difficult where a person has an intellectual disability or challenging behaviour.
- People with borderline personality disorders and severe intellectual disability find it especially difficult to access health services.

WHAT CURRENT PROGRAMS THAT TAKE A 'WHOLE OF GOVERNMENT' ARE THERE, ARE THEY WORKING WELL?

There are a range of processes and systems that support a whole of government approach. These include the Better Service Delivery Program's HSNet, as an information and referral mechanism using Service Link and Referral Link.

There are also a number of specific program initiatives that could serve as examples of good inter-departmental programs.

Example 1:

NSW Health, Dept of Housing and the NGO sector have entered into formal partnerships to provide the necessary accommodation and support services for people with mental illness. In May 2003, the Dept. of Housing provided \$8million for housing stock and NSW Health provided \$5million for support services. Three NGOs were selected to provide the support services for 100 high support places across the State, including such remote areas as Broken Hill. The model of support is that

- Housing provides the accommodation,
- The Area Mental Health Teams provide the clinical support services, and
- The NGOs provide the high support services (8-10 hours per day), with links to others support programs (e.g. day programs).

The model of accommodation is:

- Principally individual accommodation unless otherwise requested by the applicant(s)
- Not group homes,
- In various accommodation styles (e.g. flats, units etc.)

This partnership is often referred to as Mental Health – HASI (Housing and Support Initiatives).

These do not relate specifically to people with the dual diagnoses of intellectual disability and mental illness but principally to people with a primary diagnosis of mental illness. DADHC would provide appropriate disability services on the basis of need.

Example 2:

DADHC has begun work with NSW Health and the department of Education and Training to identify some areas for improved responses through working together. Some of the areas for collaboration that are being explored include therapy, early intervention for young people at risk and better planning and support for young people when they leave school.

The HACC Program is also an important component of an integrated response because eligibility is based on functional impairment rather than a specific diagnosis.

ARE THERE THINGS THAT NEED TO BE IMPROVED, HOW CAN THIS BE ACHIEVED?

Major issues that need to be addressed in order to improve outcomes for people with a dual diagnosis include the following:

- **Inadequate interface with mental health services:** People with an intellectual disability and a mental illness are often within the intellectual disability system and do not get appropriate care for their mental illness. Many of the issues around mental health problems are simply put down to challenging behaviour. Medication regimes are often inappropriate with the result that medication becomes a quite serious issue. There is also a dearth of psychiatrists with the skills to understand the complexities of people with an intellectual disability.
- **De-institutionalisation was associated with a loss of professional support:** This is relevant for both people with an intellectual disability and people with a mental illness. This has been especially so in the areas of nutrition and specialised nursing. These specialties are not seen as particularly attractive and the professional courses themselves are more generalist with little opportunity to specialise. The average age of mental health nurses has been assessed as 50 years (approx.). The situation is compounded by the chronic shortage of nurses in general.
- **Poor medication control:** People with dual diagnoses being managed by intellectual disability services sometimes suffer due to the lack of medication management expertise in dealing with medication issues related to the mental illness.
- **Lack of early intervention strategies:** Many people with mental health problems, and also those with both mental illness and intellectual disability, are being cared for in the informal sector (i.e. their immediate families). They often do not seek help until there is a crisis, which is often then an acute episode which requires hospitalisation. Current support systems are not generally ready, from a preventative perspective, to support families to do some planning. A notable exception is Local Support Coordinators, who assist people to coordinate across issues and facilitate networks that successfully promote this preventative work. This is a model that is being more fully explored by the Department.
- **Buck-passing between service agencies:** Traditionally people with the dual diagnoses of intellectual disability and mental illness have been shunted between service agencies on the basis that the other agency has prime responsibility. While this is improving it is an area that needs more work.
- **Significance of location in the degree of service equity:** People with dual diagnoses in urban centres have better access to services than people in rural areas.

- **Difficulty in capturing unmet need:** There are significant problems of definition in relation to disability. There is poorer epidemiology information in relation to disability than for mental health. There can be a significant proportion of people in the community who are not accessing any care.
- **How to assist the hidden population not accessing care?** Advocacy and information, support to carers, the informal system – especially focused on those people with moderately complex needs - as distinct from high needs - who are more likely to be outside the care system until a crisis occurs. Support for these carers is a priority for DADHC.

WHAT MORE NEEDS TO BE DONE?

The evidence outlined earlier suggests that we need to focus on initiatives that:

- Reduce risk and build resilience
- Produce policy led interventions to reduce (in particular) child poverty¹
- Promote early intervention
- Provide effective education
- Ensure therapeutic support

The joint work being explored by DADHC and NSW Health will address many of these issues.

SUMMARY OF KEY ISSUES REGARDING MENTAL HEALTH SERVICE DELIVERY.

- The under representation for people with an intellectual disability in mental health services, which is an issue for both DADHC and NSW Health.

The need for

- Access to mental health professionals, support, services and advice for people with an intellectual disability and their family and carers.
- Appropriate access to health professionals with an understanding of intellectual disability and its impact on mental health and medication management.
- Appropriate diagnoses, so that mental health issues are not just seen as 'challenging behaviour'.
- Early intervention services and appropriate treatment.
- Ongoing professional training and development for disability professionals about mental health issues and the mental health service system.

DADHC has significant experience of people with manifest mental health issues being unable to access services. Particular concerns centre on the needs of people with serious/high risk behaviours, who may be at serious risk of self harm if the mental health system does not provide the same response as it does for people with no disability.

¹ Not a DADHC responsibility but a core component of an integrated response.