



Faculty of Medicine, The Department of
Developmental Disability Neuropsychiatry 3DN

Accessibility and quality of mental health services in rural and remote Australia

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About the Department of Developmental Disability Neuropsychiatry

The Department of Developmental Disability Neuropsychiatry (3DN) at UNSW Australia leads National and State developments in Intellectual and Developmental Disability Mental Health through education and training of health and disability professionals and by conducting research with a particular focus on the mental health of people with intellectual disability (ID). 3DN's vision is to work with people with ID and Developmental Disabilities (DD), their carers and families, to achieve the highest attainable standard of mental health and wellbeing. 3DN is led by UNSW's inaugural Chair of Intellectual Disability Mental Health, Professor Julian Trollor, who has over 20 years of specialist experience in the management of people with ID and complex health and mental health problems. He has extensive experience with a range of disability service providers and professionals, and has led or contributed to numerous legislative, policy and service reviews in the disability arena. More information about 3DN and the Chair IDMH can be found on our website: <http://3dn.unsw.edu.au/>.

Context

People with ID represent about 1.8% of the Australian population, or approximately 400,000 individuals (1). People with ID experience very poor physical and mental health compared to the general population. They often have complex support needs, which arise because of complexity at the person level, at the service level, or systems levels. The prevalence of mental ill health is at least two to three times higher in people with ID compared to the general population (2). Many people with ID experience a high degree of complexity and an atypical profile and presentation of mental illness (3), thus requiring a high level of psychiatric expertise, and coordinated approaches between services. The poor health and mental health status of people with ID, and commitments to address these problems, have been clearly articulated in the National Disability Strategy (4). Further priorities to address the mental health needs of people with ID were determined at the first National Roundtable on the Mental Health of People with Intellectual Disability (5), and in subsequent documents such as the NSW Mental Health Commission's 10 year strategic plan (6) and the 5th National Mental Health and Suicide Prevention Plan (7).

Despite the over-representation of mental illness in people with ID, access to mental health services is limited and falls far short of that for the general population. In a current multi-

disciplinary partnerships for better health project funded by the NHMRC (see Link <https://3dn.unsw.edu.au/project/national-health-medical-research-council-partnerships-better-health-project-improving-mental>) we work together with key mental health, disability, education, justice and consumer agencies to improve mental health outcomes of people with ID. Key findings thus far include: much higher admission rates, length of stay and associated costs of mental health admissions for people with ID in NSW, compared to people without ID; lack of explicit identification of people with ID in mental health policy in Australia, despite the high vulnerability to mental disorders in this group; and lack of recognition of the specific needs of people with ID in clinical care settings, including lack of awareness about adaptations to clinical approach in mental health services and professionals. These preliminary findings highlight the need for potential solutions that begin with the consideration of the needs of people with ID in all aspects of health policy and services development.

Issues

1. Findings from our data linkage project have indicated a higher proportion of the population have ID in rural and remote areas (1.5%) compared to metropolitan areas of NSW (1.15%). Further, ID is over-represented in Aboriginal peoples, who themselves are more geographically dispersed and proportionally over-represented in rural and remote locations.
2. There are very few specialised services for people with ID and mental illness. The few that are available are in major metropolitan regions; compounding the lack of access for people with ID in rural and remote Australia.
3. Travel for people with ID and their carers to access services in metropolitan areas is also difficult. Factors that contribute to travel difficulties and associated stress for people with ID and their carers include mobility and behavioural issues, in addition to associated financial strain (which is already a major issue in this group)
4. Without access to specialist services for people with ID and mental illness, the burden of care is left to the person's general practitioner (GP). Australian GPs have reported a lack of skills and training in the area of ID mental health (8, 9), and audits of Australian medical education curricula indicate that enhancements in this area are needed (10, 11). Further, GPs in rural areas of Australia see a higher proportion of patients with ID (12), but our study of practice characteristics indicates

that these GPs are overwhelmed by administrative rather than medically-related demands (13). As a result, GPs are less able to get to the many health needs of people with ID, including to preventative health needs.

5. Direct discussion with local health districts (LHDs) and public health networks (PHNs) in rural and remote locations has emphasised the need for improved access for these populations, including for Aboriginal people with ID.

Solutions

1. Funding the development of specialised capacity and skills in a core workforce within each rural and remote LHD mental health service, with support and training from specialised metropolitan ID health or mental health teams.
2. Ensuring that people with ID and their health needs form a core part of the needs assessment and response of each rural and remote PHN.
3. Funding the further development of links between highly specialised health teams in metropolitan areas and rural and remote LHDs, i.e. a hub and spoke model.
4. Supporting the development of a state-wide quaternary service in ID mental health in each state or territory which is able to provide highly specialised review in situations where there is a controversy over diagnosis or management. This should service should include outreach and technological strategies (e.g. telepsychiatry) to ensure access for people living in rural and remote areas.
5. Ensuring mandatory training in ID mental health for all front line mental health staff based in regional remote areas through our free e-learning portal nationally. This can be accessed at <http://www.idhealtheducation.edu.au/>.
6. Consider funding to implement our ID Mental Health Core Competencies and to use the accompanying toolkit in staff development in regional ad remote areas. The Core Competencies Framework and accompanying toolkit can both be accessed through our Department website at <https://3dn.unsw.edu.au/idmh-core-competency-framework>.

Concluding remarks

People with intellectual disability are more likely to experience mental ill health than the general population and are also overrepresented in rural and remote areas where access to appropriately equipped services is limited. We thank the Senate for this opportunity for input into this important issue. In this submission we have highlighted a number of issues and potential solutions. Should you wish to discuss the content of this submission please do not hesitate to contact us. We can be contacted by phone on (02) 9931 9160 or by email, j.trollor@unsw.edu.au.

Sincerely,

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