# Meeting the mental health care needs of people with intellectual disability

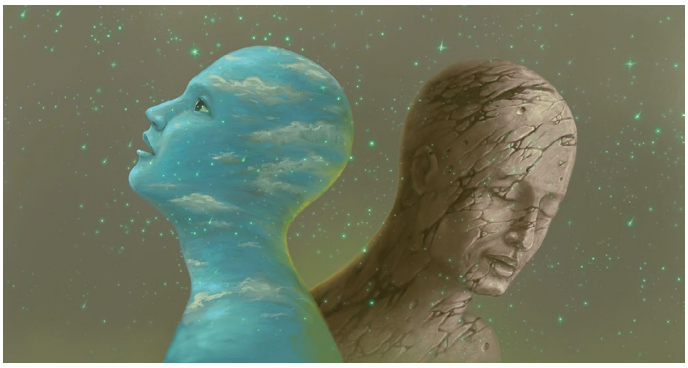
John Allan[1,2]

Consistent national mental health policy and planning are needed to adequately care for their special needs

Mental health care for people with an intellectual disability has a chequered history in Australia, marked by barriers to access and services that have often been ill prepared to meet their needs. Rates of mental and physical illness among people with intellectual disability are higher than for the general population and deserve specific treatment systems.[1] The study by Srasuebkul and colleagues in this issue of the *MJA* highlights the disproportionate number of people with intellectual disability in the Australian public mental health system and the considerable associated costs.[2] This money could instead be used to establish a more appropriate care system, but reforms on several levels are needed.

People with intellectual disability were once cared for in mental health services; following de-institutionalisation, most can fortunately now live in the community. State-run specialist intellectual disability services often abandoned the medical model in favour of a rights-based care approach.[3] An unintended consequence was that many mental health services lost the staff who could properly manage people with intellectual disability, particularly those whose behaviour was challenging, and began to regard people with intellectual disability as outside their area of responsibility.[4] The restrictive practices, stigmatisation, and lack of understanding that people with intellectual disability and their families experienced reinforced their view that these services were not appropriate for their care.[5] Changes to government policy and funding arrangements for mental health services excluded people with intellectual disability alone, obscuring the adequacy of care for people with dual disability.[4,6] Popular opposition to the medicalisation of mental problems and lack of recognition of mental illness in people with intellectual disability by clinicians has perpetuated the problem.

The introduction of the National Disability Insurance Scheme (NDIS) further exposed deficits for people with intellectual disability seeking mental health care. In bilateral agreements with the federal government regarding individual support packages under the NDIS,[7] many states have exhausted their financial capacity for specialist behavioural support and case management. While people with disability have undoubtedly achieved more control of their own futures, gaps in service provision, particularly crisis support, can lead to unnecessary hospital admissions for mental health care. Shifting roles and funding arrangements between jurisdictions has increased policy confusion about which agencies are responsible for specific aspects of care.



The study by Srasuebkul and colleagues[2] drew on a large linked dataset[8] to identify people with intellectual disability who used public mental health services in NSW during 2014–15, as there is no routine data identifier for people with intellectual disability. The proportion of people using public mental health services who had an intellectual disability (6.3%) was more than five times that of their overall population proportion (1.1%). The mean numbers of treatment days for ambulatory and admitted care were each twice as high for patients with intellectual disability; the costs per person were two and a half times as high as for patients without intellectual disability, and accounted for 12% of total public mental health service expenditure.

The data analysed by Srasuebkul and colleagues were collected just after the start of the NDIS, but are nonetheless consistent with more recent experience. State and national health and mental health policies have generally been characterised by inadequate recognition of the specific needs of people with intellectual disability and a failure to describe the changes required to meet their needs.[9]

Following its recent comprehensive review of Australian mental health care, the Productivity Commission recommended reforms of mental health services, housing, justice, workplaces, and funding arrangements.[10] While acknowledging that people with intellectual disability were at particular risk of mental health problems, examining this aspect was beyond the scope of the inquiry.[10] Neither the Productivity Commission report nor the 2017 Council of Australian Governments Health Council national mental health and suicide prevention plan[11] made specific recommendations regarding people with intellectual disability, although many of their recommendations might be broadly relevant.

Given the findings of Srasuebkul and colleagues[2] and the considerable costs of long hospital admissions, a more comprehensive policy approach is needed. Both the promised National Roadmap for improving the health of Australians with intellectual disability[12] and the renewal of the NDIS, with a focus on people with intellectual disability,[13] need to be considered together alongside mental health policy. Mental

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health policy for people with intellectual disability needs a focused approach that also involves their families; it should be values-based (ie, based on the individual and their personal strengths), acknowledging the diversity of and change in their needs across life. We need specialised intellectual mental health services linked with other agencies; we need to improve the skills of those providing the care, as well as our understanding of the relevant epidemiology, outcomes, quality of care, and research.[3,6]

The federal and state governments should endorse within five years a national framework of mental health care for people with intellectual disability that encompasses all tiers of government and all health care sectors. It must include tools for joint planning, investment, and service development and education, and be directed at key problems, such as the misalignment of NDIS support and individual health needs, the basic skills of relevant health care workers, and barriers to joint working arrangements. It should be suitably funded, but the report by Srasuebkul and colleagues[2] indicates we should also examine the effectiveness of mental health care expenditure.

There is some hope. In Victoria, a specialist multidisciplinary dual disability service, with an emphasis on strong engagement with young people and their families, has been successful.[14] But without a consistent national policy, how will more people receive what they need?

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