



**Karolinska
Institutet**

The challenges of designing disability income support policy for people with mental illnesses in Australia and Ontario

IWH Plenary

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Overview

- Rationale
- Methods
- Results
- Implications and way forward
- Acknowledgments
- Questions

Key definitions

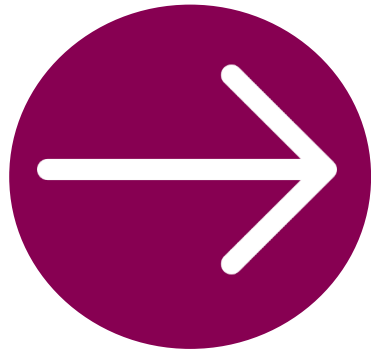
Disability income support is the main benefit payment of last resort provided by the government to those that are unable to work as a result of a physical, intellectual or psychiatric disability.

Mental illness is “... a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.”¹

¹ (American Psychiatric Association 2013)



Why study disability income support and mental illnesses?



Paradigm shift



Increasing burden



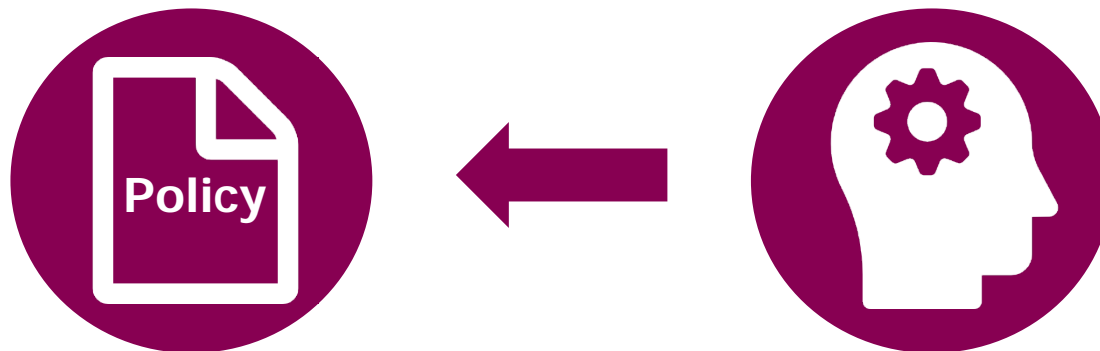
Cost

Comparing the DSP and ODSP

	Australian Disability Support Pension	Ontario Disability Support Program
Basic definition of disability	Severity threshold: Severe Duration: 2 years Work capacity threshold: 15 hours per week (8 hours for those under 35 years of age)	Severity threshold: Substantial Duration: 1 year Work capacity threshold: N/A.
Mode of assessment	Face-to-face	Paper-based
Gatekeeper	Job capacity assessors (local area)	Disability Adjudication Unit (based in Toronto)
Include non-medical factors (i.e. age, education, labour market factors)	No	Some factors – age, gender and education

Research questions

- How do policy-makers design the definition of disability and assessment process for disability income support?
- How are mental illnesses recognized in the above process?



Approach & Methods

- Constructivist grounded theory approach
- 45 informants who were or currently are involved in designing disability income support in Australia or Ontario



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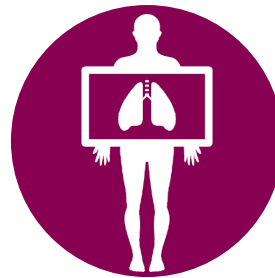


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Five challenges of designing disability income support for people with mental illnesses



Verifying duration



Proving an illness



(Un)differentiating
mental illnesses



Managing mental
illnesses



Separating the illness
from the person



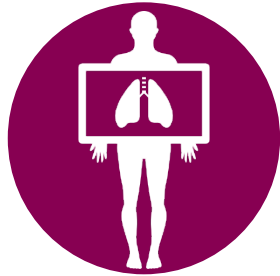
Verifying duration

“It [mental illnesses] really is just such a difficult issue to deal with, particularly if people at Centrelink or [Department of] Human Services are having to make judgments around someone's ability to work, which on one day there might be no chance in the world of turning up to work, yet another day they might be fine.”

Informant P-42 (A)

“You’re in or you’re out. You either have this condition or you don’t.”

Informant R-23 (O)



Proving an illness

“Well we [psychiatrists] don’t have tests like they do in the general hospital in the same way, blood tests for many things...for schizophrenia, there’s no sort of reliable test. I suppose you have rating scales but there’s no objective gold standard like there is in many physical conditions in general medicine.”

Informant D-36 (A)

“...what they’re [ODSP adjudicators] really looking for is almost a killer blow to your ability to do anything. So incredibly severe symptoms that stop you leaving the house, but if you have moderate symptoms which altogether mean that it’s just never going to work, the scoring makes that difficult.”

Informant D-28 (O)



(Un)differentiating mental illnesses

- Mental illnesses were spoken about as an umbrella category unless probed to speak about specific illnesses
- In Australia, the Impairment Tables – used to rate level of impairment for DSP – only have two related to mental health conditions out of 15 total tables
- In Ontario, the Disability Adjudication Framework provides guidance on how different types of mental illnesses are addressed



Managing mental illnesses

“...someone who is so severely impaired that they cannot work would get some kind of specialist support, and or specialist diagnosis, or specialist treatment, so that they had the greatest chance of living at their capacity.”

Informant P-35 (A)

“...It is very hard to get mental health services, particularly access to a psychiatrist, unless you are acutely suicidal or acutely psychotic or unless you have money.”

Informant P-44 (A)



Separating the illness from the person

View 1:

“...social factors should be able to be addressed. So it shouldn't be a disadvantage, we should be able to do something about social factors.”

Informant P-34

(A)

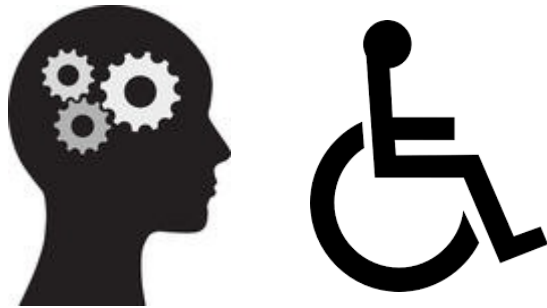
View 2:

“If I had a movie star with a very significant addiction, they may be disabled but they have so many means around them that if I can help them channel them they may not need to get assistance from the state to manage those things. Whereas somebody else who has lost everything, doesn't have anything, will need the state's assistance to make sure there's a roof over their head.”

Informant D-17 (O)

So what?

- Policy-makers distrust physicians' evidence to support DIS applications



Greater distrust of medical evidence about mental illnesses than somatic illnesses



Greater distrust of medical evidence from general practitioners compared to psychiatrists

McAllister A, Leeder SR. Distrusting doctors' evidence: a qualitative study of disability income support policy makers in Australia and Ontario, Canada. *Australian Health Review*. 2017 May 15. doi.org/10.1071/AH1609

General Practitioners (GPs) versus Psychiatrists

GPs lacking objectivity

“It’s a classic case, here’s [name] in their reception area, unemployed for ages, mid-50s, no prospect, depressed, got a back problem, asking the GP to help support an application for DSP. What’s the GP to do?”

Informant P-31 (A)



GPs lacking skills

“So they [GPs] were good at diagnosing conditions and telling about the prognosis but really, particularly GPs...there was a view [among policy makers] that they weren’t the people that was best – would have the best knowledge about whether or not people with disability could work”

Informant P-34 (A)

GPs lacking time

“...well if I was talking about GPs, I don’t know that they would feel as though they have the time to tackle that [mental health issues].”

Informant D-36 (A)

Way forward

- Focus research on the assessment process rather than the definition of disability
- Explore how other jurisdictions deal with the 5 challenges of mental illnesses – are there policy learning opportunities?
- Provide more formal training for physicians (e.g. Swedish model)
- More collaboration between policy-makers, researchers, and stakeholders (including physicians)

Acknowledgements

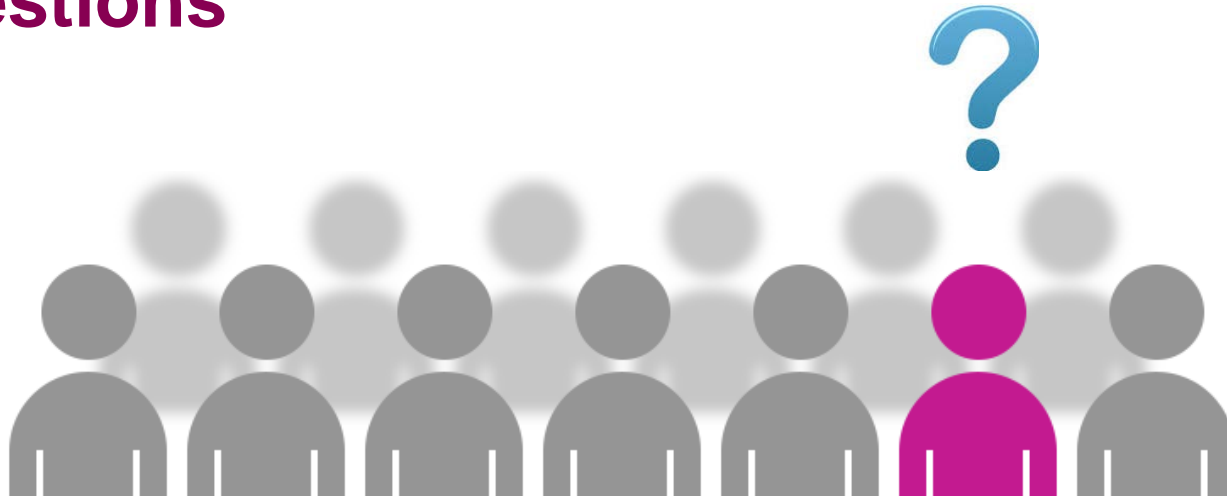
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Questions



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What do we already know about DIS design and mental illnesses?

- Most of the evidence is from the grey literature
- Current policy in Australia and Ontario is frequently based on negative assumptions about mental illnesses rather than evidence
- Problems relating to mental illnesses largely relate to interpretation of the definition rather than the definition itself

McAllister A, Hackett ML, Leeder SR. Disability income support design and mental illnesses: a review of Australia and Ontario. *Public Health Res Pract.* 2017;27(2):e2721715. doi: 10.17061/phrp2721715

Mental illnesses versus somatic illnesses

“...you can write these things however you want to...if I think that actually this isn't a good thing for my patient, I can undermine the level of disability that I write in that. Conversely, I know that it's very – well, it is not uncommon – for people to overdo the level of disability if they think that someone [with a mental illness] should be on the DSP.”

Informant D-29 (A)

“I have easily enough experience and expertise on this [mental illnesses] to be able to represent their situation, as I would if they had cancer or some other condition which the DAU [Disability Adjudication Unit] would probably accept from me...I think there's a couple of issues there, I think one is that they may have had bad experiences with family physicians [GPs] when it comes to mental illness, and I think, too, that they may see mental illness as a greyer area for diagnosis. They don't get blood test results or imaging results that prove that someone has a mental illness.”

Informant D-18 (O)