



Northern Territory Mental Health Coalition

Submission to the Productivity Commission Inquiry:

The Social and Economic Benefits of Improving Mental Health

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Contents

<i>Northern Territory Mental Health Coalition</i>	3
<i>Summary</i>	4
<i>1. Introduction</i>	8
<i>2. Northern Territory context</i>	9
<i>3. Key areas for action</i>	14
<i>3.1 Key areas for action – specific health concerns</i>	15
3.1.1 Prevention and early intervention	15
3.1.2 Suicide and self-harm	16
3.1.3 Comorbidities	19
<i>3.2 Key areas for action – workforce</i>	20
3.2.1 Aboriginal mental health workforce development	20
3.2.2 General Practitioner training	21
3.2.3 Peer workers	21
3.2.4 Cultural safety.....	22
<i>3.3 Key areas for action – social determinants</i>	23
3.3.1. Housing.....	23
3.3.2. Employment and income support	25
3.3.3 Justice	27
<i>3.4 Key areas for action – coordination and integration</i>	27
3.4.1 Integrated mental health services	27
3.4.2. Cross-sectoral, non-clinical services	29
3.4.3 NDIS interface with mental health services	30
<i>3.5 Key areas for action – funding arrangements</i>	32
3.5.1 Government allocations for mental health.....	33
3.5.2 Funding arrangements	34
<i>4. Conclusion</i>	35
<i>5. Bibliography</i>	38
<i>ATTACHMENT 1: Improvement Plans (an extract from Mental Health & Suicide Prevention Service Review 2017)</i>	41
<i>1.1 NT system improvement plan</i>	41
<i>1.2. Darwin Region</i>	45
<i>1.3 Alice Springs Urban, Central Australia Northern, Southern and Central Districts</i>	62
<i>1.4 Barkly Region</i>	73
<i>1.5 Katherine Region</i>	80
<i>1.6 East Arnhem</i>	91

Northern Territory Mental Health Coalition

The Northern Territory Mental Health Coalition (the Coalition) is the peak body for community managed, mental health services in the Northern Territory. As a peak body, the Coalition ensures a strong voice for member organisations and serves as a reference point for governments on issues relating to the provision of community mental health services. The Coalition has a network of 200 individuals, organisations and stakeholders across the Northern Territory, including 35 member organisations.

The Coalition provides advice and policy input into mental health service provision and associated challenges to all levels of government as well as contributing to national mental health networks and associated peak bodies. As a member of Mental Health Australia and member of Community Mental Health Australia, the Coalition contributes a perspective on the provision of effective and accessible mental health services in the Northern Territory.

The Coalition would like to thank its members, and the broader NT Social Services Sector, who contributed to the development of this submission through research, consultations via email, phone or meetings, and participation in a meeting held on 15 March 2019.

We acknowledge the Larrakia people, the Traditional Owners of the land on which we live, work and walk.

Summary

The Coalition welcomes the opportunity to contribute to the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health. We support the Commission's view that there are many factors in addition to mental health services that can improve mental health and lead to greater economic participation, enhanced productivity and economic growth.

As the peak body for the Northern Territory (NT) community mental health sector, the focus of our submission is on the NT, its diverse population, vast distances, thin economy and the complexities inherent in delivering adequate and appropriate services in such an environment.

The Coalition seeks to facilitate an accredited and supportive mental health system across the NT where community mental health is available for all Territorians:

- that encompasses the full spectrum of prevention, early intervention and treatment
- in their local area with low/no barriers to access
- that is fully integrated with other services
- staffed by trained, knowledgeable people including peer workers
- at the times of the day/week/year when support is most needed
- in a culturally safe, respectful manner inclusive of participants, families and communities; and
- that demonstrates long-term trust, consistency and commitment.

There are a range of complex, interrelated factors that impact on the accessibility and quality of mental health services in rural and remote communities in the Northern Territory. However, the accessibility and quality of mental health services cannot be considered in isolation from the significant socio-economic disadvantage and intergenerational trauma experienced by many Aboriginal and Torres Strait Islander communities in the NT.

The mental health burden of disease is much higher in the NT compared to national average. In the NT mental health conditions contribute to 16.3% of the burden of disease, compared to 7.4% in Australia as a whole¹. Young Territorians are overrepresented within mental health services compared to other age groups, with young people aged between 15 and 24 years constituting 25% of all community based clients, despite being only 15% of the population. Almost a quarter (23.3%) of Aboriginal Territorians experience high/very high psychological distress, almost twice national average of 11.8%.²

Upstream social determinants, such as poverty, unemployment, drug and alcohol use, family violence, chronic disease and ongoing grief and loss due to higher rates of mortality and imprisonment, are central to the disproportionately high rates of suicide and psychological distress experienced by Aboriginal and Torres Strait Islander people in the NT.

¹ Department of Health (2016) Primary Health Networks Mental Health and Suicide Prevention Needs Assessment Northern Territory PHN <https://www.ntmhc.org.au/wp-content/uploads/2016/09/2016-NT-PHN-Needs-Assessment-Mental-Health-and-Suicide-Prevention.pdf>

² Australian Bureau of Statistics. (2016). Causes of Death. Available at <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3303.0> cited in Department of Health (2016) Primary Health Networks Mental Health and Suicide Prevention Needs Assessment Northern Territory PHN <https://www.ntmhc.org.au/wp-content/uploads/2016/09/2016-NT-PHN-Needs-Assessment-Mental-Health-and-Suicide-Prevention.pdf>

These issues heighten the need for accessible and high-quality mental health services, and for whole-of-government strategies to address entrenched socio-economic disadvantage.

The scarcity of services across the spectrum of low to high intensity, is a significant cause of low access rates amongst rural and remote communities in the NT. The widely dispersed, and comparatively small, rural and remote population of the NT is supported by a mental health system that is skewed towards high-intensity services; which are often under-resourced; and tasked with providing mental health care across vast, isolated regions. It is notable that the Barkly region alone is larger in size than the state of Victoria, yet its many remote communities are serviced primarily by a small number of NT Department of Health and non-government mental health practitioners based in the hub town of Tennant Creek.

Available evidence demonstrates that there are significant economic, as well as social benefits for investing in prevention and early intervention and focusing on young people's mental health³. However, in many remote communities across the NT, low-intensity prevention and early intervention services are largely unavailable, with child and adolescent services being particularly under-resourced across the NT.

This submission primarily addresses the Productivity Commission's terms of reference that examine:

- the effectiveness of current programs and initiatives across all jurisdictions to improve mental health, suicide prevention and participation, including by governments, employers and professional groups
- how sectors beyond health, including education, employment, social services, housing and justice, can contribute to improving mental health and economic participation and productivity.

Mental health service providers, no matter how well-intentioned, are struggling to meet the demands on their services, and to fill clearly recognised gaps. The uncertainty associated with short-term funding cycles results in a sector which is not equipped to invest in building the long-term partnerships necessary for integrating between services and across professions. Reaching out beyond the mental health sector is even less likely.

New initiatives such as the roll out of the NDIS have compounded the uncertainty, particularly among people who find that they are not eligible for an NDIS package, but without program funding for service providers to meet their needs.

Our recommendations for key areas for action are:

1. Greater investment in prevention and early intervention in the NT. Elements should include:
 - Community based prevention and early intervention activities in a place-based manner with community members guiding, leading and managing the support for

³ Mental Health Australia and KPMG 2018 Investing to Save: the economic benefits for Australia of investment in mental health reform. Final Report. <https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018>

- people living with mental illness and in keeping with their culture obligations and practices
- Prevention activities should focus on families, and children from birth onwards
 - Early intervention activities work with the individual and their families, with children and youth high priority groups
 - Prevention and early intervention activities need to link seamlessly with local clinical and community resources
 - Monitoring and evaluation of prevention and early intervention activities to aid identification and promulgation of effective activities that can reduce engagement with the acute mental health and justice systems.
2. Urgently invest in prevention of self-harm, suicide and in mental health supports for young people and for the 30% of Territorians who live outside greater Darwin in culturally appropriate models, with community guidance.
 3. Invest in and build a dual diagnosis strategy and capacity in the NT that is integrated with the mental health system and primary health care model.
 4. Invest in priority areas in mental health workforce development, including:
 - Continue to invest in Aboriginal mental health workers
 - Mental health training for GPs
 - Develop a mental health peer support force
 - Develop cultural competency in mental health
 - Develop competencies to respond to the support needs of the LGBTI population
 - Continue to develop trauma-informed practices
 - Develop accredited training in suicide intervention
 - Continue to develop dual diagnosis
 5. Invest in housing initiatives
 - expand housing options for people with mental illness.
 - support an extension of tenancy support programs specifically tailored to people experiencing mental illness to prevent homelessness.
 - fund the Housing Accommodation Support Initiative (HASI) beyond the trial period and roll out across the Territory (following the evaluation)
 - housing programs that are culturally appropriate, and community-driven from concept to design
 6. Invest in systems and communication channels to create an integrated NT mental health system in which:
 - there is an effective 'no wrong door' entry system, which is not limited by eligibility criteria, distance or service availability
 - community mental health support is provided for individuals beyond the medical sphere.
 7. Resource both the community mental health sector and the Department of Health, NT Government's specialised mental health services across the NT.

8. Establish funding arrangements that:
- adopt the Northern Territory Government and Non-Government Community Services Statement of Principles in all mental health and suicide prevention agreements, and continue to provide 5 & 3 year funding agreements to service providers
 - support the development of collaborative client focused co-designed programs
 - invest in coordination and collaborative partnerships across the sector
 - encourage the NT Primary Health Network to move to long term sustainable funding agreements

1. Introduction

The NT Mental Health Coalition (the Coalition) welcomes the opportunity to contribute to the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health. We support the Productivity Commission's view that there are many factors in addition to mental health services that can improve mental health and lead to greater economic participation, enhanced productivity and economic growth.

As the peak body for the NT community mental health sector, the focus of our submission is on the NT, its diverse population, vast distances, thin economy and the complexities inherent in delivering adequate and appropriate services in such an environment.

This submission draws on the Mental Health and Suicide Prevention Service Review prepared in 2017 by the Coalition on behalf of the NT Primary Health Network (NT PHN). A recent submission co-written with the Queensland Mental Health Alliance to the 2018 for the Senate Parliamentary Committee on Community Affairs Inquiry into the accessibility and quality of mental health services in rural and remote Australia will also inform this submission.

This submission primarily addresses the Productivity Commission terms of reference that examine:

- the effectiveness of current programs and initiatives across all jurisdictions to improve mental health, suicide prevention and participation, including by governments, employers and professional groups
- how sectors beyond health, including education, employment, social services, housing and justice, can contribute to improving mental health and economic participation and productivity

The submission sets out the Northern Territory (NT) context, key areas of action (structured around the issues and questions raised in the Productivity Commission Issues paper, conclusion and bibliography).

The Coalition recognises that the Productivity Commission Inquiry does not intend to assess the National Disability Insurance Scheme (NDIS) which has been the subject of other Productivity Commission reviews. This submission raises issues arising from the transition to the NDIS where they interface with mental health.

Submissions to the Inquiry from a number of organisations and services providers in the NT and through collaborations provide additional information to the Inquiry and supported by the NT Mental Health Coalition.

2. Northern Territory context

There are significant socioeconomic factors that contribute to the burden of poor mental health in the Northern Territory (NT), including poorly integrated health and community services, overcrowded and poorly maintained housing, high burdens of chronic physical ill-health and mental⁴, high levels of homelessness, overt and institutional discrimination, intergenerational trauma and directly experienced trauma, relatively low levels of educational attainment, and varied employment opportunities.

Upstream social determinants, such as poverty, unemployment, drug and alcohol use, family violence, chronic disease and ongoing grief and loss due to higher rates of mortality and imprisonment, are central to the disproportionately high rates of suicide and psychological distress experienced by Aboriginal and Torres Strait Islander people in the NT. These issues heighten the need for accessible and high-quality mental health services, and for whole-of-government strategies to address entrenched socio-economic disadvantage.

The scarcity of services across the spectrum of low to high intensity, is a significant cause of low access rates amongst rural and remote communities in the NT. The widely dispersed, and comparatively small, rural and remote population of the NT is supported by a mental health system that is skewed towards high-intensity services, which are often under-resourced and tasked with providing mental health care across vast, isolated regions. It is notable that the Barkly region alone is larger in size than the state of Victoria, yet its many remote communities are serviced primarily by a small number of Northern Territory Department of Health and non-government mental health practitioners based in the hub town of Tennant Creek.

In many remote communities across the NT, low-intensity prevention and early intervention services are largely unavailable, with child and adolescent services being particularly under-resourced across the NT.

Population and remoteness

The population of the NT in 2016 was 245,000 people including about 140,000 people in the greater Darwin region^{5 6}. Long term population growth rates are estimated to lead to a 1.4% increase to 375,000 residents by 2046, with the sensitivity of projections resting on the actual rate of interstate migration⁷. The Territory's estimated resident population decreased by 0.2% to 247,159 in the year to 30 September 2018.⁸

⁴ Al-Yaman F. The Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people, 2011. *Public Health Res Pract.* 2017;27(4): e2741732.

⁵ NT Government Department of Treasury & Finance. Northern Territory Population Projections (Dec 2017 Release) Preliminary Update <https://treasury.nt.gov.au/df/economic-group/population-projections>

⁶ NT Government Department of Treasury & Finance. NTPOP Summary (2014) – TOTAL REGIONAL POPULATIONS

⁷ NT Government Department of Treasury & Finance. Northern Territory Population Projections (Dec 2017 Release) Preliminary Update <https://treasury.nt.gov.au/df/economic-group/population-projections>

⁸ NT Government Department of Treasury and Finance (2019) ECONOMIC BRIEF Population September quarter 2018 https://treasury.nt.gov.au/_data/assets/pdf_file/0006/670893/Population-2018-September.pdf

In 2016, over 74,500 Aboriginal and Torres Strait Islander people live in the NT, with nearly 60,000 (80%) residing in remote and very remote areas. Around 54,000 Aboriginal people live in 73 remote Aboriginal townships (not including those living on more than 350 outstations/occupied homelands), of which 28 have a population over 400 people. Of these 28, only six are within 250 km of a regional centre via all-weather road.

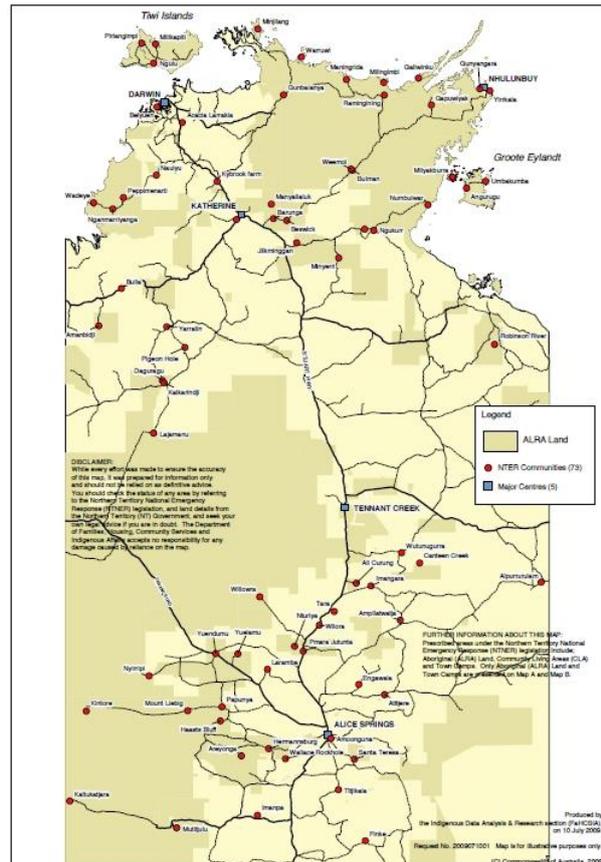
NT mental health burden

The mental health burden of disease is much higher in NT compared to the national average. In the NT mental health conditions contribute to 16.3% of the burden of disease, compared to 7.4% in Australia as a whole⁹. Mental health issues are often under-reported or under diagnosed in the NT.

Young Territorians are over represented within mental health services compared to other age groups, with young people aged between 15 and 24 years constituting 25% of all community based clients despite being only 15% of the population. This age group accounted for 24.6 % of admissions to mental health inpatient facilities¹⁰.

In 2016-17, the AIHW reported that schizophrenia was the most prevalent primary diagnosis (32.2% of primary diagnoses) for patients in the community mental health system. The national average for schizophrenia as the primary diagnosis was 18.8%. Depressive and anxiety disorders constituted 13% of primary diagnoses in the NT¹¹.

The NT Primary Health Network reports that the overall population in NT with high/very high psychological distress is less than national average (8.1% vs 11.8% respectively), the Aboriginal and Torres Strait Islander high/very high psychological distress is almost twice national average at 23.3% vs. 11.8% respectively.¹²



⁹ Department of Health (2016) Primary Health Networks Mental Health and Suicide Prevention Needs Assessment Northern Territory PHN <https://www.ntmhc.org.au/wp-content/uploads/2016/09/2016-NT-PHN-Needs-Assessment-Mental-Health-and-Suicide-Prevention.pdf>

¹⁰ Department of Health (2016) Primary Health Networks Mental Health and Suicide Prevention Needs Assessment Northern Territory PHN

¹¹ Australian Institute of Health and Welfare Mental Health Services in Australia Table CMHC.14: Community mental health care service contacts, by principal diagnosis in ICD-10-AM groupings, states and territories, 2016–17

¹² Australian Bureau of Statistics. (2016). Causes of Death. Available at <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3303.0> cited in Department of Health (2016) Primary Health Networks Mental Health and Suicide Prevention Needs Assessment Northern Territory PHN <https://www.ntmhc.org.au/wp-content/uploads/2016/09/2016-NT-PHN-Needs-Assessment-Mental-Health-and-Suicide-Prevention.pdf>

Aboriginal and Torres Strait Islander people are nearly three times as likely as non-Indigenous people to experience high or very high levels of psychological distress (respectively 1 in 3 compared with 1 in 9).¹³

The Productivity Commission Issues Paper provides an estimate of the mental health status of the Australian population. The figure extrapolates these estimates across the NT geographical regions to provide a view of the prevalence of mental health issues across the NT. The figures are not adjusted for the known disparities in mental health prevalence associated with higher levels of mental health among Aboriginal peoples and people living in remote and regional areas.¹⁴

Mental health services

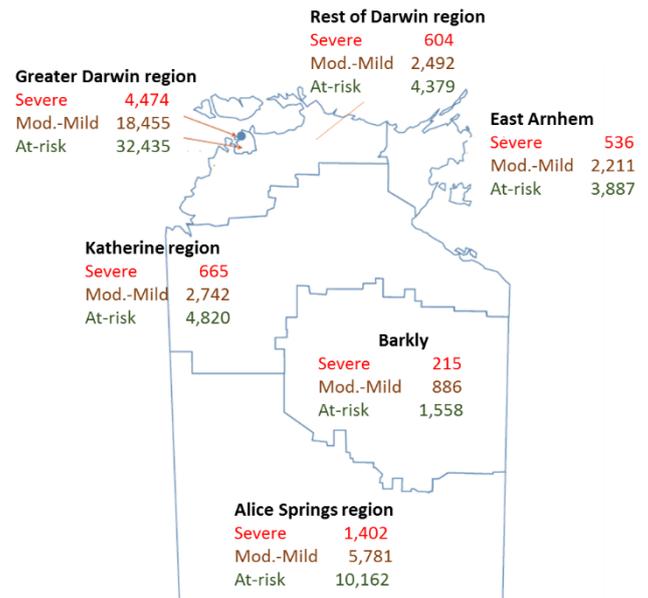
In the NT there are few mental health professionals outside the acute mental health sector, with mental health professionals largely concentrated in the larger centres of Darwin and Alice Springs.

The AIHW¹⁵ reports that in 2016, there were 20 psychiatrists (17 FTE clinicians), 198 mental health nurses (183 FTE clinicians) and 184 registered psychologists (116 FTE clinicians) working in the Northern Territory.

Mental health services in the NT are characterised by

- lack of equity (there are a broader range of services and supports available in Darwin than anywhere else in the NT). Anybody living in regional and remote areas, and Aboriginal people living in remote areas, need to travel for treatment and then suffer social isolation and emotional/spiritual impoverishment from being away from country
- lack of a Territory-wide focus on Aboriginal mental health. Some Aboriginal Community Control Health Organisations (ACCHOs) have limited Australian Government funding to provide social and emotional wellbeing programs (primarily to support Stolen Generations), and may have integrated these with mental health programs
- long-term underinvestment in community infrastructure, especially in remote and regional areas, and ongoing financial constraints
- difficulties in employing and retaining mental health professionals in regions, especially outside Darwin, and within thin labour markets

Distribution of mental health in NT population



¹³ National Mental Health Commission, 2018: Monitoring mental health and suicide prevention reform: National Report 2018. Published by: National Mental Health Commission, Sydney.

<https://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards.aspx>

¹⁴ Productivity Commission (January 2019) The Social and Economic Benefits of Improving Mental Health - Issues Paper

<https://www.ProductivityCommission.gov.au/inquiries/current/mental-health#issues>

¹⁵ Australian Institute of Health and Welfare Mental health services in Australia—Mental health workforce Last updated 22 March 2019

<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce>

- fragmented and short term funding arrangements which reduce certainty and the ability to build long-term collaborations.

Mental health support is very restricted outside the major centres of Darwin, Katherine and Alice Springs, despite the high prevalence of mental health concerns and psychological distress in remote and regional communities, and among Aboriginal and Torres Strait Islander people.

There are limited inpatient facilities across the NT with less than 50 mental health beds available in total, with no facilities available in remote areas¹⁶. At the end of 2018 in Darwin there were 18 inpatient beds, 8 high security inpatient beds, 5 youth inpatient beds, and in Alice Springs there were 12 inpatient beds.

The average number of public sector mental health hospital beds is much lower in the NT than the national average. The Northern Territory has only 17.5 public sector specialised mental health hospital beds per 100,000 population and no private sector specialised mental health hospital beds. The NT has fewer mental health hospital beds than any other state/territory and in 2016-17 was much lower than the national average at 17.5 vs 29.4 respectively.¹⁷

In terms of community mental health patients per 1,000 population in 2016-2017, NT has a much higher rate (30.2/1,000) than any other state/territory and national Australian average (17.2/1,000).¹⁸ The rate of community mental health care service contacts for males of all ages in the NT was 350.2/1,000, 296.6/1000 for females and 324.3 for the population as a whole. For Aboriginal Territorians the rate has grown by an average of 4.2% from 2012-13 to 441/1000 in 2016-17¹⁹.

In the NT in 2016-17, community services provided 63,544 days of treatment, of which 16.5% were for children and adolescents, and 78% for the general population. There were 13,925 three month community care periods²⁰. In the NT, all of the reported treatment is for individual contacts, with no group contact reported; 62% had patients present and 38% patients were absent.²¹ Ninety percent of contacts with community mental health services in the NT in 2016-17 were voluntary and 10% involuntary, compared to 86% and 14% respectively for Australia as a whole.²²

¹⁶ Northern Territory Medicare Local. (2014). The Northern Territory Medicare Local Health Atlas 2014

¹⁷ Australian Institute of Health and Welfare Table FAC.13: Public sector specialised mental health hospital beds per 100,000 population, by hospital type and program type, states and territories, 1992-93 to 2016-17 <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-care-facilities>

¹⁸ Australian Institute of Health and Welfare Mental health services in Australia Table CMHC.1: Community mental health care service contacts, patients and treatment days, states and territories, 2016-17. Data is reported by TEMHS and CAMHS

¹⁹ AIHW Mental health services in Australia Table CMHC.3: Community mental health care service contacts, by sex and age group, states and territories, 2016-17; Table CMHC.10 Community mental health care service contacts per 1,000 population, by Indigenous status, states and territories, 2005-06 to 2016-17

²⁰ AIHW Mental health services in Australia Table CMHC.12: Community mental health care treatment days and care periods, states and territories, 2016-17

²¹ AIHW Mental health services in Australia Table CMHC.19: Community mental health care service contacts, by session type and participation type, states and territories, 2016-17

²² AIHW Mental health services in Australia Table CMHC.25: Community mental health care service contacts, by mental health legal status, states and territories, 2016-17

The regional needs assessment conducted for the NT Primary Health Network²³ identified shortfalls in trauma-informed child and adolescent services, forensic services and Low Intensity Mental Health Services. In every region, the mental health system was described as unresponsive after-hours and on weekends, with the exception of hospital emergency departments. In very remote areas, communities rely on over-stretched public Central Australian and Top End Mental Health Services, greatly restricted to provision and support around pharmacotherapy. In some areas, police transport people experiencing acute mental health crises to hospital.

The review for the NT Primary Health Network observed that remote psycho-social rehabilitation programs, such as Personal Helpers and Mentors (PHaMs) are operating beyond capacity, sometimes struggling to assist people to meet their basic physiological needs for food, shelter and safety. Nonetheless, these programs are essential to keep participants from slipping through the cracks, and complementary to more intensive services²⁴.

Over 6.5% of General Practice (GP) consultations include mental health concerns (depression 4.2% and anxiety 2.2% of GP encounters in 2015-2016).²⁵ However people can be excluded from support via GPs where there is no bulk billing GP service available (see box). In addition, the Coalition's members report their participants encounter widely differing levels of mental health related skills among GPs, even among GPs who prepare GP Mental Health Management Plans.

eHealth video consultation is available in remote clinics (connected by dedicated NT Government communication lines) and supports people with mental illness who are under the care of a NT Government remote health clinic. Shortages of specialists participating the eHealth consultations reduce access for remote people. eHealth consultations are not possible in remote regions without NBN or high-quality satellite connections (city-based specialists can claim through Medicare for Skype enabled consultations however this is difficult to achieve, even between Alice Springs and Darwin).



No Bulk billing

There is no bulk billing General Practice in Katherine and no private GP at all in Tennant Creek, impeding access to health care for low-income Territorians. For people not able to afford GP fees and who do not access, and/or are not eligible to access the Aboriginal Community Control Health Organisations, the only choice is to drive north (3½ hours) from Katherine to access a bulk billing practice, or 5 hours to Alice Springs for those in Tennant Creek. The Coalition's members and other services report that this is a significant impediment for their participants who often have poor physical health as well as mental health challenges.

²³ NT Mental Health Coalition (NTHMC) 2017 Mental Health and Suicide Prevention Service Review (unpublished)

²⁴ NT Mental Health Coalition 2017 Mental Health and Suicide Prevention Service Review (unpublished)

²⁵ Britt H, Miller GC, Henderson J, Bayram C, Harrison C, Valenti L et. al. General practice activity in Australia 2015-16. General practice series no. 40. Sydney: Sydney University Press, 2016. Table 7.4 <http://sydney.edu.au/medicine/fmrc/publications/books/GP-series/index.php>

Mental health states can change rapidly and often arise outside business hours. Mental health concerns can be alleviated, heightened states and disturbances can be lowered for the individual and community most effectively if trusted, skilled support workers are available and accessible. Individuals and families need accessible supports at these times, particularly if self-harm or suicide ideation are present.

The NT Mental Health Access Team (MHAT) phone line operated by NT Government is available 24/7 however resources are low, and face to face acute episodes of mental ill-health often handled initially handled by police, ambulance and air-transfers (which involve sedation). Other phone support services such as Lifeline, ReachOut and beyondblue are publicised however may not be accessible or culturally appropriate owing to poor phone/internet connections in communities. Lifeline Australia recently trialled a text-based service in Alice Springs between 6pm and 10pm each evening²⁶. The trial showed some promise, but the restricted hours may have limited take-up. Anecdotally young people liked the sense of anonymity of the service and found it responded to their needs. Language barriers, lack of access to technology and/or credit, cultural barriers and hesitancy to speak about their distress to an unknown person may also prevent access.

Online chat/email services are available; however, a smartphone is the most likely device to use for access²⁷ as computer and internet penetration at home in the NT is believed to be among the lowest in Australia. Access to chat/email by smartphone can be restricted by lack of phone credit for the individual in need.

In the NT, the expansion of digital therapies represents a welcome boost to the service mix, however in the consultations for the NT Primary Health Needs, needs analysis, many service providers warned against overestimating the efficacy of digital mental health therapies in remote areas. Cultural and linguistic diversity, coupled with limited access and uptake of web-based services, limits the potential of widespread use of digital therapies in much of the NT. Continued investment in locally developed, low-intensity treatment options that are culturally and linguistically appropriate, and which build upon local community capacity, are favored by much of the remote sector. To this end, digital therapies should supplement rather than replace, remote, practitioner-based services.

3. Key areas for action

In 2017, the Coalition consulted broadly on behalf of the NT Primary Health Network with mental health service providers, funders, carers and consumers in order to develop regional improvement plans grounded in the issues, needs and potential solutions identified by stakeholders²⁸.

The improvement plans include practical actions that can be progressed in the short-to-medium term, as well as aspirational, longer-term goals and broad trajectories for system reform that require long-term planning and collaboration between NT Primary Health Network, Territory and Commonwealth governments, the NGO and ACCHO sectors and

²⁶ <https://www.lifeline.org.au/projects/lifeline-text>

²⁷ Sensis. 2017 Sensis Social Media Report

https://irp-cdn.multiscreensite.com/535ef142/files/uploaded/Sensis_Social_Media_Report_2017-Chapter-1.pdf Accessed: 30 March 2019

²⁸ NT Mental Health Coalition 2017 Mental Health and Suicide Prevention Service Review (unpublished)

their respective peak bodies. Improvement areas are listed by time frame rather than order of priority. The regional improvement plans are attached to this report in order to provide the Productivity Commission with an overview of the extent of work required to improve mental health outcomes in the NT (see Attachment 1).

3.1 Key areas for action – specific health concerns

This section describes issues related to mental health that would improve wellbeing, participation and productivity, focussed on interventions involving the health sector.

3.1.1 Prevention and early intervention

Prevention and early intervention are critical to avoiding both short-term and long-term costs to the community and to avoiding shifting costs from funders to providers and across time. Prevention and early intervention lower lifetime costs relative to later treatment and chronic difficulties across all life domains. Benefits from early intervention and support include enhancing individual life skills and reducing involvement in the acute mental health system and the justice system.

Opportunities for preventing mental ill-health would be improved in the NT from investments in:

- consistent support services being available to individuals
- availability of family focused supports and or peer supports
- support for families and children in their first 1,000 days of life
- support and resources directed to remote communities with small populations
- additional safe places to withdraw from violence and disturbance for families and for men (see box)
- support for children in out-of-home-care to prevent mental health concerns, and to enable early intervention^{29 30}
- access to prevention and early intervention for foster families and kinships carers to support children in their care
- uniform availability of trauma informed care and support across the NT.



Safe Places needed

The lack of safe places to withdraw from violence and disturbances for families and for men has recently meant that people dealing with mental health concerns have been unable to be safe and stable in some communities. Families have had to stay in a violent environment, heightening trauma, mental health concerns which has a flow on effect to people's engagement in community life, education and work

Save the Children:
Personal Communication, March 2019

Prevention and early intervention have demonstrated economic benefits as well as improving individual quality of life. KPMG estimated the return on investment for cognitive behavioural therapy as an early intervention as 1.1 in the short term, and 9.1 in the longer

²⁹ Royal Commission into the Detention and Protection of Children in the Northern Territory (2017)
<https://www.royalcommission.gov.au/royal-commission-detention-and-protection-children-northern-territory>

³⁰ Anglicare NT, March 2019. Personal Communication

term; with the return on investment for early intervention in psychosis as 2.5 in the short term and 8.6 in the long term.³¹

Recommendation 1:

Greater investment in prevention and early intervention in the NT. Elements should include:

- Community based prevention and early intervention activities in a place-based manner with community members guiding, leading and managing the support for people living with mental illness and in keeping with their culture obligations and practices
- Prevention activities should focus on families, and children from birth onwards
- Early intervention activities work with the individual and their families, with children and youth high priority groups
- Prevention and early intervention activities need to link seamlessly with local clinical and community resources
- Monitoring and evaluation of prevention and early intervention activities to aid identification and promulgation of effective activities that can reduce engagement with the acute mental health and justice systems.

3.1.2 Suicide and self-harm

In the NT in 2017, 51 people died by suicide, the highest NT level over the last 10 years, except 2014³². This equates to 1 person dying by suicide each week and 20.3 deaths per 100,000 people (the whole of Australia rate was 12.6 people dying by suicide per 100,000 population). Over the five-year period (2013 to 2017):

- 235 people died by suicide in the NT (162 males, 73 females)
- 30 young people aged 5-17 years died by suicide (13% of NT total). Seven were children aged 5-14 and 23 were young people aged 15-17 years.
- Of the 30 young lives lost, 8 were from greater Darwin, and the remainder from elsewhere in the NT; 24 were young Aboriginal and Torres Strait Islander people, and 6 were non-Indigenous young people.

When all child (0-14 years) suicide deaths are combined for years 2011-2015, the NT reported the highest jurisdictional rate of child deaths due to suicide, with 13.6 deaths per 100,000 persons, compared to 2.2 deaths per 100,000 persons for this age group for Australia as a whole.³³

Factors contributing to suicidal behaviour in young people include socio-economic disadvantage, impulsivity, contact with youth justice, mental illness and mental health problems (including depression, anxiety, personality disorder, substance use disorders), sexual orientation, childhood adversity, family conflict and/or breakdown, disengagement from school, social and geographical isolation, personal vulnerabilities, exposure to stressful

³¹ Mental Health Australia and KPMG 2018 Investing to Save: the economic benefits for Australia of investment in mental health reform. Final Report. <https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018>

³² ABS 2018 3303.0 - Causes of Death, Australia, 2017 Intentional self-harm, key characteristics <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3>

³³ Australian Bureau of Statistics (2016) 3303.0 - Causes of Death, Australia, 2015 cited in Department of Health NT Suicide Prevention Strategic Framework 2018-2023 <https://digitallibrary.health.nt.gov.au/prodjsui/bitstream/10137/7055/1/Northern%20Territory%20Suicide%20Prevention%20Strategic%20Framework%202018-2023.pdf>

life circumstances, and social, cultural and contextual factors.³⁴ An important factor for the NT is children in out-of-home-care. The rate of children in out-of-home-care in the NT was almost double (16.2 per 1000 children) the national rate (8.6 per 1000 children), with almost nine out of every 10 children placed in out-of-home-care being Aboriginal.³⁵ These factors are often compounded by low rates of help-seeking, and difficulties accessing services.

There are important gender differences in suicide-related behaviour in young people. Young men have higher rates of completed suicide, and females' higher rates of other suicidal behaviours (thinking, planning, attempting). Similar to the rest of Australia, approximately three out of four (76%) calls to Kids Helpline from NT in 2015 were from females, with one in four (23%) from males. The top three reported concerns of young Territorians were mental health problems, family relationship issues and emotional wellbeing.³⁶

Across Australia the rate of suicide death for Aboriginal and Torres Strait Islander peoples is twice that of the broader population.³⁷ For Aboriginal people in the NT the suicide rate from 2012-2016 is considerably higher (26.4 per 100,000 people) compared to that for the broader NT population (14.4 per 100,000).³⁸

High incidences of trauma, homelessness and over-crowded housing, domestic and family violence, drug and alcohol use, unemployment, poverty, chronic disease and low life expectancy are the backdrop to mental health and wellbeing in many Aboriginal communities in the Northern Territory. To this end, a wide range of community services and programs – including within the youth, family violence, primary health care and education sectors - need to be considered as integral to a systems-based approach to suicide prevention across the NT.

Suicide prevention activities must commence with community knowledge building, through to connected-up pathways and referrals, to improvements to discharge with support and follow-up in community. These activities are needed across the NT, in settings involving youth, families, workers and older people.

³⁴ Beautrais, A. (2000) Risk Factors for Suicide and Attempted Suicide among Young People. *Australian & New Zealand Journal of Psychiatry*, 34, 420-436 cited in Department of Health NT Suicide Prevention Strategic Framework 2018-2023
<https://digitallibrary.health.nt.gov.au/prodjsui/bitstream/10137/7055/1/Northern%20Territory%20Suicide%20Prevention%20Strategic%20Framework%202018-2023.pdf>

³⁵ Australian Institute of Health and Welfare (2017). *Child protection Australia 2015–16. Child Welfare series no. 66. Cat. no. CWS 60.* Canberra cited in Department of Health NT Suicide Prevention Strategic Framework 2018-2023
<https://digitallibrary.health.nt.gov.au/prodjsui/bitstream/10137/7055/1/Northern%20Territory%20Suicide%20Prevention%20Strategic%20Framework%202018-2023.pdf>

³⁶ yourtown (2016). *Kids Helpline: Insights 2016: Statistical Summary Northern Territory: Insights into young people in Australia* cited in Department of Health NT Suicide Prevention Strategic Framework 2018-2023
<https://digitallibrary.health.nt.gov.au/prodjsui/bitstream/10137/7055/1/Northern%20Territory%20Suicide%20Prevention%20Strategic%20Framework%202018-2023.pdf>

³⁷ Steering Committee for the Review of Government Service Provision (SCRGSP), *Overcoming Indigenous Disadvantage: Key Indicators 2014*, Productivity Commission, Canberra cited in Department of Health NT Suicide Prevention Strategic Framework 2018-2023
<https://digitallibrary.health.nt.gov.au/prodjsui/bitstream/10137/7055/1/Northern%20Territory%20Suicide%20Prevention%20Strategic%20Framework%202018-2023.pdf>

³⁸ Australian Bureau of Statistics. (2017). *3303.0 – Causes of Death, Australia, 2016* cited in Department of Health NT Suicide Prevention Strategic Framework 2018-2023
<https://digitallibrary.health.nt.gov.au/prodjsui/bitstream/10137/7055/1/Northern%20Territory%20Suicide%20Prevention%20Strategic%20Framework%202018-2023.pdf>

The NT Mental Health Coalition supports the National Mental Health Commission statement in December 2018 following the National Suicide Prevention Summit³⁹.

“Greater community engagement and participation in both treatment and prevention was also highlighted, as was the need to implement measures aimed specifically at Aboriginal and Torres Strait Islander communities.”

The development of community-led suicide prevention initiatives should be supported through partnerships with Aboriginal Community Control Health Organisations and community mental health services. Initiatives succeed when community ownership and drive is maximised, and long-term funding is provided to create stability and predictability.

Expansion of mental health first aid training, inclusive of suicide intervention and alertness capacities, is an essential step in up-skilling front-line community services, mental health services and the broader community to prevent suicide. Investment in best practice, evaluated training also creates the dividend of social change by promoting de-stigmatisation, help-seeking, and help-giving.

Increasing access to youth mental health services and low impact mental health services are also required to ensure that young people in particular, can connect with supports and services as early as possible. Improving processes around monitoring and following up referrals between mental health service providers is an essential safety net that is required to keep people from shuttling between services, becoming demoralised and ceasing to seek help.

The ATSIPEP Evaluation Framework for Indigenous Suicide Prevention Activity⁴⁰ is an invaluable resource that will support the expansion of suicide prevention program evaluation. A NT-specific guidance manual for the Evaluation Framework manual would ensure that evidence-informed approaches to engaging and collaborating with Aboriginal communities are imbedded in all evaluation of suicide prevention activities in Aboriginal communities in the NT.

Funding for, and implementation of, self-harm and suicide prevention and response programs need to be better coordinated in the NT to improve program effectiveness. Preventing self-harm and suicide in the NT should be informed by the ATSIPEP, the NT Suicide Prevention Strategic Framework 2018-2023,⁴¹ and the broad evidence resources available.⁴²

³⁹ National Mental Health Commission (Dec 2018), Next steps to reduce Australia’s suicide rate

<https://www.mentalhealthcommission.gov.au/media-centre/news/next-steps-to-reduce-australia%E2%80%99s-suicide-rate.aspx>

⁴⁰ Dudgeon P, Milroy J, Calma T, Luxford Y, Ring I, Walker R, Cox A, Georgatos G and Holland. C. 2016 Solutions that Work: What the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSIPEP)

https://www.atsispep.sis.uwa.edu.au/_data/assets/pdf_file/0006/2947299/ATSIPEP-Report-Final-Web.pdf

⁴¹ NT Department of Health (2018) Northern Territory Suicide Prevention Strategic Framework 2018-2023, <https://health.nt.gov.au/health-governance/suicide-prevention-strategy-review>

⁴² ConNetica (May 2016), Suicide in Australia – Key Facts

https://static1.squarespace.com/static/5858b2276b8f5be324ffefff/t/5898ff2f15d5dba05f6c9c9d/1486421825261/media_background - suicide-suicide_prevention_australia_may_24_final.pdf

KPMG estimates that the long term return on investment in assertive outreach programs aimed at preventing suicide is 1.8.⁴³

See the Aboriginal Medical Services Alliance Northern Territory (AMSANT) submission.

Recommendation 2:

Urgently invest in prevention of self-harm, suicide and in mental health supports for young people and for the 30% of Territorians who live outside greater Darwin in culturally appropriate models, with community guidance.

3.1.3 Comorbidities

Particular concerns in the NT is the absence of dual diagnosis services for people who have both a mental health and an Alcohol and Other Drugs (AOD) diagnosis.

Addictive AOD behaviours are regularly present for people dealing with mental health concerns and may have been long term methods of self-medicating for people not recognising poor mental health and/or not accessing mental health support or social and emotional wellbeing services. The NT Primary Health Network Alcohol and Other Drugs Needs Assessment⁴⁴ found that there are

“very few dual diagnosis treatment services in the Northern Territory and consumers with dual diagnosis report being turned away from both mental health and substance abuse services... Clinicians report a low number of people within the workforce who can offer dual diagnosis specialist support”.

The NT needs to commit to a dual diagnosis strategy in a similar manner to the Victorian model⁴⁵, Queensland and New South Wales. For example, the Victorian Government funds a Substance Use and Mental Illness Treatment Team (SUMITT) which is part of the Victorian Dual Diagnosis Initiative, that has strengthened the dual diagnosis capacity of staff in adult and youth mental health⁴⁶.

KPMG estimates a return on investment per person of 3.0 for collaborative care.⁴⁷

Recommendation 3:

Invest in and build a dual diagnosis strategy and capacity in the NT that is integrated with the mental health system and primary health care model.

⁴³ Mental Health Australia and KPMG 2018 Investing to Save: the economic benefits for Australia of investment in mental health reform. Final Report. <https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018>

⁴⁴ Northern Territory PHN (2017) Alcohol and Other Drugs Needs Assessment. Issue 3.9. Lack of access to evidence based dual diagnosis service responses. <https://www.ntphn.org.au/needs-assessments> Accessed: 30 March 2019

⁴⁵ Victorian Dual diagnosis online resource page <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/specialist-responses/dual-diagnosis> Accessed 28 March 2019

⁴⁶ Substance Use and Mental Illness Treatment Team (SUMITT) <https://www.nwmh.org.au/professionals/services/specialty-services/dual-diagnosis-sumitt> Accessed 28 March 2019

⁴⁷ Mental Health Australia and KPMG 2018 Investing to Save: the economic benefits for Australia of investment in mental health reform. Final Report. <https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018>

3.2 Key areas for action – workforce

This section explores areas of concern related to the workforce issues across the NT. Staffing is an ongoing constraint in the NT both for the Department of Health and the community mental health sector.

Skilled staff for remote communities is difficult to recruit and retain – impediments include the lack of housing for staff, isolation and difficulties with remote travel, high expense and low availability of professional development opportunities. Salaries for mental health staff in Aboriginal Community Control Health Organisations and non-government organisations are also at a lower, less competitive level than within the government sector (both Commonwealth and NT Government) and in organisations such as the NT Primary Health Network.

Employment opportunities for people living with a mental illness can play a large role in the ongoing rehabilitation and progress of people afflicted with mental illness who want to work⁴⁸ the research shows 6 out of 10 do succeed if given the appropriate supports.⁴⁹

The 2017 Mental Health and Suicide Prevention Service Review identified a number of areas to strengthen the mental health workforce across the NT⁵⁰. Priority areas included:

- Aboriginal mental health workers
- training for GPs
- strengthen the mental health peer support force
- develop cultural competency within program delivery
- develop competencies in responding to the support needs of LGBTI populations
- continue to work within the sector to develop trauma-informed practices
- training and develop of suicide intervention skills
- enhance dual diagnosis

3.2.1 Aboriginal mental health workforce development

A well trained, well supported and well-resourced Aboriginal mental health workforce is critical to the delivery of equitable, culturally engaged mental health care for Aboriginal people in the NT. In some rural and remote regions, the size of the Aboriginal mental health workforce appears to be in decline.

Expanding the Aboriginal mental health workforce requires investment in:

- pathways to certificate, degree and masters level training in mental health, social and emotional wellbeing and trauma informed disciplines
- formal recognition of existing skills, experience and knowledge from an Aboriginal cultural standpoint
- effective ways of working with schools, young people (and parents) and community leaders to develop pathways into the mental health workforce

⁴⁸ SAMHSA (2012) Uniform Reporting System, 2012 <http://www.samhsa.gov/dataoutcomes/urs/urs2012.aspx>

⁴⁹ McQuilken M, Zahniser JH, Novak J, Starks RD, Olmos A, Bond GR. (2003) The Work Project Survey: Consumer perspective on work. *Journal of Vocational Rehabilitation*; 18:59-68.

⁵⁰ NT Mental Health Coalition 2017 Mental Health and Suicide Prevention Service Review (unpublished)

- resourcing for ongoing professional development training and in-servicing (including in AOD treatment frameworks)
- opportunities for secondment to other work sites and program areas to develop breadth of experience (e.g. Top End Mental Health Services -Tamarind Centre and inpatient units)
- annual forums for Aboriginal mental health professional development
- organisations to support ongoing professional and cultural supervision
- opportunities to contribute to the identification and delivery of appropriate cultural competence training for non- Aboriginal staff
- opportunities and pathways for career progression into management roles and clinical roles
- access to opportunities to receive and provide mentoring and supervision
- Registered Training Organisations available to deliver culturally appropriate, accessible, accredited mental health training and education in the NT.

3.2.2 General Practitioner training

General Practitioners (GPs) are critical referral points into many community-based mental health services, and increasing sector-awareness amongst GPs is key priority for improving mental health system effectiveness in the NT. The Coalition recommends that mental health training is mandated for GPs, with a focus on:

- developing cultural competencies
- developing skills in suicide intervention
- competencies around responding to the support needs of the LGBTI population
- orientation around regional, cross-sector service availability (including supports for carers) referral pathways
- developing trauma-informed practice
- utilising Aboriginal mental health and social and emotional wellbeing assessment
- utilising the NT HealthPathways system and the Digital Gateway as they become available.

3.2.3 Peer support workforce

Peer workers are an emerging and essential part of the mental health workforce, as evidenced by the Fifth National Mental Health and Suicide Prevention Plan and the National Mental Health Commission's strategic and operational frameworks.

However, the NT lags other Australian states in policy adoption and operational fostering of the mental health peer support workforce. Many years ago, mental health peer support worker roles were based within Royal Darwin Hospital, but this program no longer exists and there is only one person employed as a consumer consultant with the Top End Mental Health Service.

In the Territory's community mental health services sector there are few formal peer support workers roles- its an emerging service model. Some are employed through organisations receiving Territory mental health program funding. But most of the emerging mental health peer support workforce have been funded under the PhAMS and PIR

arrangements which are transiting into the NDIS commercial and service delivery model. The NDIS does not include a peer support workforce and not included in the current pricing guide.

Yet the development of a peer support workforce is a major opportunity in improving the quality and reach of the NT's mental health services system. The Coalition is currently undertaking a Mental Health Peer Support Workforce Needs Assessment for the NT Primary Health Network.

The NT Mental Health Coalition continues to explore the opportunities for qualified peer work training for people with lived experience.

Although evidence is still emerging, the return on investment for effective peer workers appears to be in the order of \$3.50 per dollar invested⁵¹.

3.2.4 Cultural safety

NT mental health and social and emotional wellbeing services emphasise cultural safety in their services and in their staff and organisational training and development. Even with these efforts, Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse (CALD) backgrounds may not be comfortable accessing services. Institutional racism and unconscious bias can reduce help-seeking behaviours for people with mental health concerns and poor physical health.

Connecting in a person's first language is important when seeking mental health support. ACCHOs prioritise Aboriginal Health Workers in delivery of all health services and this enables cultural understanding and good communication skills. People from CALD communities or from remote communities where English is not commonly spoken, can find appropriate mental health support difficult to obtain. Interpreter services are available in the NT but are charged on a fee-for-service basis and require bookings to be made.

Recommendation 4

Invest in priority areas in mental health workforce development, including:

- Aboriginal mental health workers
- mental health training for GPs
- develop a mental health peer support force
- develop cultural competency within work practices
- develop competencies to respond to the support needs of the LGBTI population
- continue to develop trauma-informed practices
- develop accredited training in suicide intervention
- continue to develop dual diagnosis

The Northern Territory Mental Health Coalition supports the TeamHEALTH submission

⁵¹ Mental Health Australia and KPMG 2018 Investing to Save: the economic benefits for Australia of investment in mental health reform. Final Report. <https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018>

3.3 Key areas for action – social determinants

There are significant socioeconomic factors that contribute to the burden of poor mental health in the NT, including poorly integrated health and community services, overcrowded and poorly maintained housing, high burdens of chronic physical ill-health and mental illness, high levels of homelessness, overt and institutional discrimination, intergenerational trauma and directly experienced trauma, relatively low levels of educational attainment, and varied employment opportunities.

This section addresses several of the key social determinants. More detailed information is available in the submissions to the Productivity Commission Inquiry made by NT organisations with specific interests in housing, justice, Aboriginal health etc.

3.3.1. Housing

Stable, safe and well-maintained housing is a foundation for mental health. The NT has a disproportionate level of homelessness at 12 times the national average. Aboriginal people are one third of the Territory's population and are significantly overrepresented as 88.5% of all homeless persons. The 2016 Census shows 83% of homeless persons in the NT live in severely overcrowded dwellings, 71% of which are in remote or very remote areas.⁵²

Inadequate housing is a critical concern across the NT in urban, regional and remote locations. The rate of demand for homelessness services in the NT is 3 times that of other states and territories and the level of unmet demand is twice as high.⁵³

⁵² Australian Bureau of Statistics, 2016 Census of Population and Housing: Estimating Homelessness, 2016

⁵³ Australian Institute of Health and Welfare (AIHW), Specialist Homelessness Services Annual Report 2016-17. Those seeking support in the NT unable to be assisted (45.3%). This is twice as high as unmet request nationally (23%).

Fewer than 30 dwellings for people with mental illness are provided in community housing in Darwin, and there is no commitment to community or supported housing for people with mental health issues in other regional centres across the NT.

Overcrowding impacts on children and the elderly, who are often exposed to health risks and damage to the important attachment bonds critical to a child's development.⁵⁴ Living in overcrowded conditions does not support mental health at any age, even when prevention and early intervention actions are present.

Support to maintain tenancies is critical for people who are living with mental illness and should be expanded in the NT, beyond NT public housing tenancy support programs and the NT Housing Accommodation Support Initiative (HASI) trial in Darwin. Effective wrap-around support avoids further deterioration, supports community, lowers neighbourhood disturbance and reduces long term and ongoing costs to government and the community (see box).



Wrap around services

A person living with schizophrenia; residing alone in a three-bedroom house; was experiencing overwhelming depression and isolation. The was not feeling well enough to care for themselves and was neglecting their health and appearance. The person started sleeping on their lounge room floor as the person felt scared and alone in the house.

Through the support and advocacy of Anglicare, the NT HASI program the person was transferred to a more suitable accommodation located next to family, who became a supportive. Since the person engagement with Anglicare and the HASI program the person has started participating in programs in the community and is saving to buy new furniture for their home. There have been significant improvements in their confidence and interest in their self-care, general health and presentation. Additionally, the person has gained their learners driver permit.

NT Housing Accommodation Support Initiative (HASI) trial
Anglicare NT March 2019

Preventing homelessness is critical to support people living with mental illness. This issue and many other matters related to housing in the NT highlight the importance of maintaining good mental health and community support/participation in the NT.

Recommendation 5:

Invest in

- expand housing options for people with mental illness
- support an extension of tenancy support programs specifically tailored to people experiencing mental illness to prevent homelessness.
- fund the Housing Accommodation Support Initiative (HASI) beyond the trial period and roll out the program across the Territory (following the evaluation)
- housing programs that are culturally appropriate, and community-driven from concept to design

⁵⁴ Moore, T.G., Arefadib, N., Deery, A., Keyes, M. & West, S. (2017). The First Thousand Days: An Evidence Paper – Summary. Parkville, Victoria: Centre for Community Child Health, Murdoch Children's Research Institute. <https://www.rch.org.au/ccch/first-thousand-days/>

The Coalition supports the recommendations in the NT Shelter submission to the Productivity Commission Inquiry.

3.3.2. Employment and income support

Labour market conditions in the Territory remain thin. In the year to February 2019 the unemployment rate has risen, and employment levels have fallen in annual terms⁵⁵.

In the remote regions of the NT there are few opportunities for employment and self-generated income, and many people in remote Aboriginal communities rely on government payments including the Community Development Program (CDP).

The Department of the Prime Minister and Cabinet evaluation of the first two years of the CDP⁵⁶ highlights some damaging impacts and found that the program has not met the expressed goals of enhancing participant's employment prospects and community expectations.

Instead the reformed (and previous) CDP imposes punitive withdrawal of payments for people who have high compliance requirements, including the three quarters of CDP participants who have moderate to extreme barriers to employment. The impacts upon people with mental health concerns are demonstrated in the following quotes from the evaluation report.

Relatively high rates of penalties among participants with barriers to participation may, in part, be due to difficulties in navigating the CDP and compliance systems. Community members and stakeholders interviewed suggested this difficulty was contributing to increased stress, anxiety and mental health issues...

Health issues may also play a role in explaining why some, particularly Indigenous, CDP participants were more likely to be penalised for non-attendance. Stakeholders reported some participants had undetected health barriers due to lack of access to medical assessments. Despite the Australian Institute of Health and Welfare reporting, in Australia's Health 2016, a higher burden of disease among Indigenous people and those living in remote areas, rates of medical exemptions from mutual obligation requirements by DHS were lower in CDP regions than in non-CDP regions. Medical exemption rates were lowest for those living in very remote areas who identified as Indigenous.

There are no linkages between Community Development Program (CDP) and approaches to address mental health barriers to employment. It is essential that there is access for employee to counselling and mental health supports for employment programs including CDP.

⁵⁵ Department of Trade, Business and Innovation 2019 Monthly Labour Market Briefs – February 2019
<https://business.nt.gov.au/business/business-and-economic-data/nt-labour-market-information>

⁵⁶ Department of the Prime Minister and Cabinet (February 2019), An evaluation of the first two years of the Community Development Programme – Summary <https://www.pmc.gov.au/resource-centre/indigenous-affairs/evaluation-first-two-years-community-development-programme-summary>

The Coalition supports the work of the Aboriginal Peak Organisations Northern Territory (APONT) and the members of the Fair Work and Strong Communities Alliance⁵⁷ seeking an alternative to CDP.

Being unemployed and having few prospects of employment challenge mental health, particularly for young people and those in very remote areas, where there is limited access to employment support resources. Options for employing people with mental health concerns would improve if organisations providing Disability Employment Services (DES) had a greater mental health focus. Staff need training to work with, and support, people with mental health illness into the workforce in a manner which sustains their employment aspirations and engenders a sense of hope and success.

It would also be appropriate to pursue the Individual Placement and Support (IPS) model for open employment.⁵⁸ IPS relies upon a “place then train” model of employment (somewhat analogous to the Housing First model proven in the homelessness sector). A collection of links to evidence-based material regarding IPS is located on the website of the Western Australian Association for Mental Health (WAAMH).⁵⁹



Centrelink can be difficult to negotiate

Many people have found the Disability Support Pension (DSP) review process extremely difficult to navigate. A service provider reported people applying for benefits have been denied at the review process even though they have been on the DSP for years and their mental health condition has not improved.

Unfamiliarity with computers, low literacy and poor engagement skills when unwell can result in people being unable to use the electronic terminals and processes required by Centrelink. Limited support and heightened mood can lead to rudeness, aggression and disruptive behaviour, resulting in people being banned from Centrelink.

Additional, proactive follow-up support and mental health training should be available to ensure people with mental illness can be provided access to Centrelink in an equitable and timely manner.

Service provider: Personal communication, March 2019

Income support through Centrelink payments can be vital for people living with long term mental illness and for their carers. On a general level, people with mental illness trying to engage with Centrelink do experience difficulties (see box).

⁵⁷Fair Work and Strong Communities Alliance, Remote Development and Employment Scheme Proposal -

<https://www.fairworkstrongcommunities.org/>

⁵⁸ <https://www.centreformentalhealth.org.uk/what-ips> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5846108/>;

<https://www.naric.com/?q=en/rif/evidence-based-employment-programs-can-succeed-over-time-support-and-leadership>

⁵⁹ <https://waamh.org.au/development-and-training/individual-placement--support-ips/evidence-based>

3.3.3 Justice

The importance of early intervention and the justice system are addressed in the Australian Law Reform Commission's report: Pathways to Justice⁶⁰ and the report of the Royal Commission into the Detention and Protection of Children in the Northern Territory.⁶¹

In the 2013 Report Card the National Mental Health Commission called for greater efforts to evaluate prevention and early intervention efforts in mental health that are effective in avoiding subsequent engagement with the acute mental health and justice systems⁶². The Coalition and the community mental health sector in the NT are actively advocating for meaningful data collection and evaluation for this cohort.

See NT Legal Aid Service submission.

3.4 Key areas for action – coordination and integration

The Issues Paper recognises the difficulties for people with mental illness in pursuing their recovery in a poorly coordinated and integrated sector. This section describes measures that are needed to improve integration and coordination within the NT mental health sector, and between health and non-health service areas.

3.4.1 Integrated mental health services

A key challenge in the NT is to improve integration and coordination between health and non-health service areas and to improve coordination within the NT mental health sector. This is documented as a key improvement opportunity in each of the NT regions in the Mental Health & Suicide Prevention Service Review 2017⁶³.

Staff shortages, difficulty in recruitment and high staff turnover and the consequent loss of sectoral knowledge and relationships, contributes to creating a system that struggles to support people living with mental illness. The inadequate levels of staffing mean that responding to immediate client needs is the priority, and collaboration and integration become secondary concerns. Whilst there are strong informal networks, a greater focus on systemic improvement is needed to support greater integration.

In remote areas of the NT, services are fragmented with providers often operating in relative isolation from one and other. In most remote Aboriginal communities, the only consistent service provider is the Northern Territory Remote Health Centres or Aboriginal Community Controlled Health Organisations with specialist visiting mental health clinicians (often on rotation) on a monthly or quarterly basis. There is extremely limited access to psychosocial rehabilitation services. In most cases this has meant people and families living

⁶⁰ Australian Law Reform Commission, Pathways to Justice—Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples, Final Report No 133 (2017)

https://www.alrc.gov.au/sites/default/files/pdfs/publications/final_report_133_amended1.pdf Accessed: 19 March 2019

⁶¹ Royal Commission into the Detention and Protection of Children in the Northern Territory (2017)

<https://www.royalcommission.gov.au/royal-commission-detention-and-protection-children-northern-territory>

⁶²NMHC 2013 A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention

<http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2013-report-card.aspx>

⁶³ NT Mental Health Coalition, 2017 Mental Health and Suicide Prevention Service Review (unpublished)

with a mental illness frequently, have to retell their story to the visiting clinician, and in some cases end up with differing treatment plans depending on the clinicians involved.

Nonetheless there are examples of close integration and coordination between Aboriginal Community Controlled Health Organisations, mental health services, SEWB programs and services, community mental health services and NT Department of Health Central Australian Mental Health Service (CAMHS) and Top End Mental Health Services. The Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council's (NPYWC) Ngangkari Program is an example of a collaborative approach to client centred care between CAMHS and other regional mental health and SEWB services. This project has developed a range of resources drawing on the two-way knowledge model integrating clinical and traditional approaches to understanding and responding to mental ill health on the NPY lands⁶⁴.

Eligibility restrictions around age, diagnosis, chronicity of the mental health condition, geography, and tight referral criteria mean that the most appropriate supports are not always available to those who need them.

For example:

- Referral restrictions have limited the availability of residential short-term rehabilitation in Darwin and Alice Springs due to a public housing shortage and long wait lists.
- The NT Housing Accommodation Support Initiative (NT HASI) criteria includes case managed by Top End Mental Health services and currently living in public housing. The trial supports people who are in breach of their tenancy agreement and to potential stop homelessness.
- *headspace* Darwin is auspiced by Anglicare NT and offers services in Darwin region, Alice Springs is auspiced by Central Australian Aboriginal Congress with a focus on Social Emotional Well Being (SEWB) programs. A service in Katherine will commence soon and will provide an outreach service to surrounding Aboriginal communities. *headspace* supports young people from 12-25 years with bipolar disorder, schizophrenia, and other psychotic disorders, Tourette's, eating disorders, anxiety, depression, obsessive compulsive disorders, personality disorders and others. For young people who pass the 25 year age limit, support for chronic mental illness is through the NT Government's Mental Health Services, however these services are only able to support people in the top 3% of acuity. People with chronic mental illness fall through this gap⁶⁵

The Northern Territory Mental Health Coalition the Anglicare NT submission.

Given the relatively low NT population, and vast geographic areas it should be possible to implement a *no wrong door* approach to improvement integration and reduce fragmentation in the mental health system, to link systematically clinical and community mental health services and programs.

⁶⁴ <https://healthinonet.ecu.edu.au/key-resources/programs-and-projects/2298/>

⁶⁵ Anglicare NT: Personal communication. March 2019

3.4.2. Cross-sectoral, non-clinical services

There is increasing reliance on GPs as a conduit to mental health services and supports, and on access to individual psychological counselling as a primary response to mental health needs. Whilst these are welcome and effective for some people, more attention is required to ensure continuity of care and access to psychosocial rehabilitation to support and assist people in the longer-term in the community.

Improvements are required in relation to:

- building awareness of GPs and other mental health professionals about the non-clinical rehabilitation and support services in the local community, such as those provided by the community mental health sector
- developing referral pathways and understand available programs beyond the clinical space (see HealthPathways box)
- improving discharge practices and follow-up support for people leaving Emergency Departments or discharged from hospital inpatient stays, particularly for those who are at risk of further self-harm. As an example, organisations and service providers report young people are discharged after a suicide attempt without any documentation including discharge plans, wellness/recovery plans or any referrals being completed to appropriate service providers (either in community or major towns)
- ensuring people being discharged from hospital are not discharged into homelessness. For Aboriginal and Torres Strait Islander people a *return to country* program can be essential to ensure people are not stuck in urban centres and homeless in the “long grass” after a hospital stay.
- providing greater assistance to people accessing mental health or AOD residential services to avoid loss of their public or rental housing during their treatment. Currently the NT Department of Housing and Community Development has a 90-day



HealthPathways – currently limited to the clinical health system

The NT HealthPathways provides a locally developed clinical pathway website that supports clinical staff, particularly general practitioners, to support patients to navigate a complex local variation in referral pathways and management of conditions.

HealthPathways is designed for health professionals during a consultation, providing guidance for assessing and managing a patient with symptoms or a condition, with information on referral pathways to local health service providers across the NT.

The system currently appears to contain limited information and guidance about non-clinical services which may be useful to support an individual, their families to manage symptoms and or conditions including mental illness in the community. This in turn reduces opportunities for referrals to community-based services that can support the person and their family to live well in the community, helping to reduce deterioration, building skills and capacity, and lowering additional costs within the ‘medical’ health system.

NT PHN <https://www.ntphn.org.au/>, NT HealthPathways <https://nt.healthpathwayscommunity.org>, Mar 2019

property turnaround policy which provides little leeway for people who require more than a 3-month inpatient and residential rehabilitation stay or participation in a

lengthy AOD residential program. This policy only adds to homelessness

- enabling ongoing rehabilitation support for individuals returning to their communities following a therapeutic period in mental health inpatient services or AOD residential services through availability of local community mental health support workers⁶⁶
- enabling individuals who are able to access eHealth video conference support at their local clinics an effective clinical consultation accompanied by access to practical ongoing support from local peer workers or other supports to implement ongoing strategies to support wellbeing and engagement with treatment
- supporting young people in out-of-home-care with psychological treatment and ongoing support when 'in care', and with transitional/ongoing support tailored to the needs of the young person.⁶⁷
- access to transitional support programs for people exiting the justice system (remand or corrections settings) such as the North Australian Aboriginal Justice Agency (NAAJA) Throughcare Program (Top End-focused) or the Kungas Stopping Violence Program in Alice Springs⁶⁸.

The NT Mental Health Coalition believes there would be benefits from greater coordination between the NT Primary Health Network, and the federal and NT Departments of Health to minimise duplication, achieve clarity about respective responsibilities, and to ensure a commitment to evidence-based service delivery and ongoing sector development. By working more closely together the funding bodies will be able to build a suitable mix of clinical and community-based support services across the regions and population groups with the greatest need.

Recommendation 6:

Invest in systems and communication channels to create an integrated NT mental health system in which:

- there is an effective 'no wrong door' entry system, which is not limited by eligibility criteria, distance or service availability
- community mental health support is provided for individuals beyond the medical sphere.

3.4.3 NDIS interface with mental health services

The Coalition has been involved in the NDIS since its inception, supporting its members through the implementation of the NDIS for people with psychosocial disabilities, highlighting major concerns the NT is facing and potential solutions to the national arena through membership of Community Mental Health Australia and Mental Health Australia.

⁶⁶ Aboriginal Medical Services Alliance NT (AMSANT) (2016) Priorities for Aboriginal Primary Health Care in the Northern Territory <http://www.amsant.org.au/resources-2/publications/> Accessed: 30 March 2019

⁶⁷ Anglicare NT, Personal communication: 15 March 2019

⁶⁸ North Australian Aboriginal Justice Agency, Throughcare Program <http://www.naaja.org.au/our-programs/throughcare/> Accessed 19 March 2019

Announcements related to the NDIS pricing and program extensions made prior to the 2019 Federal budget were generally welcomed⁶⁹. The Coalition will continue to evaluate the impact of the changes and advocate for improvements.

In the Coalition's experience, interfaces between the NDIS and other service sectors remain underdeveloped. Mental Health Australia's report *Optimising Psychosocial Supports Project Report*. A collaboration of the NDIA, consumers and carers and representatives of the mental health sector have compared and contrasted the project evidence with the NDIA's evidence on psychosocial services under the NDIS.⁷⁰

There are significant service gaps emerging and it seems likely that additional effort is needed to prevent people falling through the gaps between the NDIS and other systems including mental health.

The Coalition is concerned that the NDIS has yet to develop a remote model that takes account of community needs and expectations, the complexities and costs associated with service delivery and thin markets when delivering services in rural and remote Aboriginal communities. Engagement with the Aboriginal Community Controlled sector and strategies to assist them to become NDIS providers are critical to cost-effective and culturally appropriate service delivery in remote areas.

Other issues of concern to the Coalition include:

- There are very few psychosocial disabilities supports, even in regional centres of the NT. Many people with a psychosocial disability, have to leave their communities to access these supports. Their mental health condition can then be affected by their social isolation and loss of connection to land and natural supports. This inequitable access disproportionately impacts on Aboriginal people.
- Low populations in remote areas, NDIS pricing and rules, inadequate or inappropriate NDIS plans and high service provision costs mean that it is not viable to maintain or establish mental health support provision in many very remote communities. A funding model is required to support a base level of infrastructure, skilled staffing, travel costs and organisational support to providers to deliver services in these settings.
- The skills and training required to work effectively with psychosocial disability are high. Mature judgement, cultural safety and excellent communication are all features of effective workers, over and above their qualifications. Workers exhibiting all desired skills are difficult to attract to the NT and are difficult to retain on the low NDIS pricing available. There is a substantial risk that the quality of psychosocial support will decline.

⁶⁹ <https://ministers.dss.gov.au/media-releases/4761>; <https://ministers.dss.gov.au/media-releases/4746>; <https://ministers.dss.gov.au/media-releases/4726>

⁷⁰ <https://mhaustralia.org/media-releases/optimising-psychosocial-supports-project-report>

- Testing eligibility to the NDIS is a difficult process, even when community mental health providers support people with mental illness.
 - Difficulties include obtaining evidence from treating clinicians about the functional impact upon the individual in their daily living, rather than simply diagnosis and treatment information. In addition, functional impacts that may be identified in metropolitan and urban settings may not be identified in remote settings simply because different (often much lower) resources exist in remote communities.
 - NDIA staff assessing eligibility requests for people with psychosocial disability need mental health knowledge, training and support in their decision making. The variability in skills of planners working with people with psychosocial disability results in supports being included in a plan for an individual that do not reflect their goals, ability or the availability of services. Assessors and planners need knowledge of the NT and the conditions/resources in different locations.
- Continuity of Support arrangements for people found to be ineligible for NDIS are still uncertain and this is disquieting for people with mental illness and for organisations supporting them.
- Carers supporting people with mental illness can be overwhelmed by the demands of advocating to the NDIS for their family member. It is important not to threaten the sustainability of carers, given their vital role at individual and community levels. The replacement cost of a primary mental health carer has been estimated at \$129,000 per annum.⁷¹

3.5 Key areas for action – funding arrangements

The Productivity Commission is seeking examples of sub-optimal outcomes arising from existing funding arrangements, and to identify how funding arrangement could be reformed in order to result in better outcomes and to facilitate coordination across the sector. This section sets out the Coalition's experience of the adequacy and effectiveness of funding for mental health in the NT.

Organisations providing mental health support need to work with communities over the long term, building trust, local workforce and community capacity. The Coalition's members have indicated that this means that government funding arrangements need to span many years, with on-going commitment over time. At a minimum, agreements covering co-designed services should extend for at 5 years (preferably longer) before any fundamental changes are suggested by government funders.

⁷¹Diminic S, Hielscher E, Lee YY, Harris M, Schess J, Kealton J & Whiteford H. The economic value of informal mental health caring in Australia: technical report. March 2017 for Mind Australia The University of Queensland, Brisbane.
https://www.mindaustralia.org.au/sites/default/files/Mind_value_of_informal_caring_full_report.pdf

3.5.1 Government allocations for mental health

The mental health sector across the NT are under resourced. In both NT Government services and the community mental health sector there is insufficient funding for the level of need, and staffing levels are consistently below the planned establishment levels.

Recurrent expenditure (\$'000) on Territory specialised mental health services, 2016–17⁷²

	NT
Specialised psychiatric units or wards in public acute hospitals	
Salaries and wages expenditure	19,451
Non-salary expenditure	3,161
Indirect expenditure	3,915
<i>Subtotal</i>	<i>26,527</i>
Community mental health care services	
Salaries and wages expenditure	21,644
Non-salary expenditure	2,541
Indirect expenditure	4,220
<i>Subtotal</i>	<i>28,406</i>
Residential mental health services	
Salaries and wages expenditure	4,916
Non-salary expenditure	708
Indirect expenditure	1,407
<i>Subtotal</i>	<i>7,032</i>
Other expenditure	
Grants to non-government organisations	4,316
Other indirect expenditure	2,784
Total state/territory expenditure	69,064
Per capita (\$)	280.57

In terms of total State/Territory funding spending for mental health in 2016-2017, the NT spent nearly 20% more per capita than the national average: \$280.57 vs \$232.64 respectively,⁷³ reflecting the high cost of service provision in the NT.

The Territory also receives fewer benefits through the Medicare system for mental health related services. In 2017-18, benefits paid for Medicare-subsidised mental health-related services averaged \$49 per person in 2017–18 nationally, while those in the Northern Territory were the lowest of any jurisdiction at just \$14 per person. Similarly, subsidies from the PBS/RPBS for mental health related drugs are lowest per capita for the Northern Territory (\$11 per person) compared to other jurisdictions and the national average of \$22 per person.⁷⁴

⁷² Australian Institute of Health and Welfare Mental health services in Australia Table EXP.1: Recurrent expenditure (\$'000) on state and territory specialised mental health services, states and territories, 2016–17 <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services>

⁷³ Australian Institute of Health and Welfare, Mental health services in Australia: Web report Last updated: 22 Mar 2019 <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services/specialised-mental-health-services-expenditure>

⁷⁴ Australian Institute of Health and Welfare Expenditure on Mental Health Expenditure on mental health services 2016-17 section <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services>

Available evidence demonstrates that there are significant economic, as well as social benefits for investing in prevention and early interventions and focusing on young people's mental health⁷⁵.

Recommendation 7:

Resource both the community mental health sector and the Department of Health, NT Government's specialised mental health services across the NT.

3.5.2 Funding arrangements

During the Coalition's consultation phase of the Mental Health & Suicide Prevention Service Review, service providers stressed the importance of collaborative approaches including funding to develop a regional approach to services delivery and co-design of programs that involve, carers, family, clients, where possible and service providers. They proposed developing flexible funding models that include:

- fostering innovative and efficient use of local and external resources
- ensuring responsiveness to local cultures and identified needs and
- building local capacity to enable sustainable service provision.

The Northern Territory Government and Non-Government Community Services Statement of Principles⁷⁶ provides a strong framework for partnership, accountability and working collaboratively towards the best possible outcomes for people who access services. The Statement of Principles should be reflected in mental health and suicide prevention service agreements.

The Coalition recognises the NT Primary Health Network is constrained in entering timely, long-term funding agreements due to their own funding frameworks.⁷⁷ The community mental health sector welcomes the possibility of three year funding agreements, as funding uncertainty has led to organisations restricting:

- recruitment and workforce development
- short term programs and services
- decreased ability to demonstrate sustained outcomes
- reduced opportunities to demonstrate effectiveness through evaluation opportunities. And external evaluation is not funded as part of service agreements

The community mental health sector is encouraged by the NT Department of Health's move to five year Service Agreements and notes that the NT Primary Health Network is working towards three year funding agreements. Longer-term funding arrangements will have a positive impact on staff retention, make programs more sustainable, and have a flow-on effect of strengthening cross-sectoral and inter-sectoral collaborations.

⁷⁵ Mental Health Australia and KPMG 2018 Investing to Save: the economic benefits for Australia of investment in mental health reform. Final Report. <https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018>

⁷⁶ NT Government, APONT, NTCOSS 2015 Northern Territory Government and Non-Government Community Services Statement of Principles https://nt.gov.au/_data/assets/pdf_file/0009/169380/ntg-ngo-statement-of-principles.pdf

⁷⁷ Northern Territory PHN Annual Report 2017-2018. (pages 22, 113) <https://www.ntphn.org.au/annual-report-17-18>

Competitive tendering and complex reporting and acquittal requirements are disincentives for formal collaborations and partnerships.

Collaborative, client-focused programs co-designed within the mental health sector are essential in order to support people living with a mental illness to enjoy the best possible quality of life. The Coalition continues to work with the NT Primary Health Network to co-design, implement and measure systemic improvements with an evidence based model that achieves best practice outcomes for people and their families living with a mental illness.

Investment in coordination and collaborative partnerships that achieve greater integration between the community mental health sector and clinical services is required to enable best practice treatment options. This may include mobile/outreach services for early intervention and treatment programs to reduce the pressure on hospital emergencies.

Recommendation 8:

Establish funding arrangements that:

- adopt the Northern Territory Government and Non-Government Community Services Statement of Principles in all mental health and suicide prevention agreements, and continue to provide 5 & 3 year funding agreements to service providers
- support the development of collaborative client focused co-designed programs
- invest in coordination and collaborative partnerships across the sector
- encourage the NT Primary Health Network to move to long term sustainable funding agreements.

4. Conclusion

Northern Territorians, particularly young people and Aboriginal people are disproportionately affected by mental ill-health.

The mental health burden of disease is much higher in the NT compared to national average. In the NT mental health conditions contribute to 16.3 per cent of the burden of disease, compared to 7.4% in Australia as a whole⁷⁸. Young Territorians are over represented within mental health services compared to other age groups, with young people aged between 15 and 24 years constituting 25% of all community based clients despite being only 15% of the population. Almost a quarter (23.3%) of Aboriginal Territorians experience high/very high psychological distress, almost twice national average of 11.8%.⁷⁹

This is consistent with other adverse outcomes within the social determinants lens/arena that includes housing, homelessness, the justice and child protections systems, education and employment opportunities. Physical health and good mental health are paramount to ensure a person's ability to contribute the economic security. It is also consistent with the

⁷⁸ Department of Health (2016) Primary Health Networks Mental Health and Suicide Prevention Needs Assessment Northern Territory PHN <https://www.ntmhc.org.au/wp-content/uploads/2016/09/2016-NT-PHN-Needs-Assessment-Mental-Health-and-Suicide-Prevention.pdf>

⁷⁹ Australian Bureau of Statistics. (2016). Causes of Death. Available at <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3303.0> cited in Department of Health (2016) Primary Health Networks Mental Health and Suicide Prevention Needs Assessment Northern Territory PHN <https://www.ntmhc.org.au/wp-content/uploads/2016/09/2016-NT-PHN-Needs-Assessment-Mental-Health-and-Suicide-Prevention.pdf>

adverse impact of long-term discrimination and the traumatic effects of colonisation and removal experienced by generations of Aboriginal people.

Upstream social determinants, such as poverty, unemployment, drug and alcohol use, family violence, chronic disease and ongoing grief and loss due to higher rates of mortality and imprisonment, are central to the disproportionately high rates of suicide and psychological distress experienced by Aboriginal and Torres Strait Islander people in the NT.

In the Northern Territory, mental health service providers, no matter how well-intentioned, are struggling to meet the demands on their services, and to fill clearly recognised gaps. The uncertainty associated with short-term funding cycles results in a sector which is not equipped to invest in building the long-term partnerships necessary for integrating between services and across professions. Reaching out beyond the mental health sector is even less likely.

New initiatives such as the roll out of the NDIS have compounded the uncertainty, particularly among people who find that they are not eligible for NDIS assistance, but without program funding for service providers to meet their needs.

The available evidence demonstrates that investing in prevention and early intervention, and in collaboration have significant positive returns on investment as well as addressing the burden of mental ill health.

This submission provides detailed information about the mental health services needs of Territorians, identified at the regional level. It also outlines key areas for action that the Coalition believes would lead to significant systemic improvement in mental health outcomes in the NT.

These include investing in:

- prevention and early intervention
- culturally appropriate models of prevention of self-harm, suicide and in mental health supports for young people and for people living outside Darwin
- building a dual diagnosis strategy and capacity that is integrated with the mental health system and primary health care model
- priority areas in mental health workforce development, including:
 - Continue to invest in an Aboriginal mental health workforce
 - Mental health training for GPs
 - developing mental health peer support workers
 - cultural competency within mental health practise
 - competencies to respond to the support needs of the LGBTI population
 - continue to develop trauma-informed practices
 - a credited training in suicide intervention
 - addressing housing and homelessness
 - expand housing options for people with mental illness
 - tenancy support programs specifically tailored to people experiencing mental illness to prevent homelessness
 - fund the Housing Accommodation Support Initiative (HASI) across the NT

- housing programs that are culturally appropriate, and community-driven from concept to design
- systems and communication channels to create an integrated NT mental health system in which:
 - there is an effective ‘no wrong door’ entry system, which is not limited by eligibility
 - criteria, distance or service availability
 - community mental health support is provided for individuals beyond the medical sphere.

Both the community mental health sector and the Department of Health, NT Government’s specialised mental health services across the NT need to be adequately resourced.

The Coalition also supports establishing funding arrangements that:

- adopt the Northern Territory Government and Non-Government Community Services Statement of Principles in all mental health and suicide prevention agreements, and continue to provide 5 & 3 year funding agreements to service providers
- support the development of collaborative client focused co-designed programs
- invest in coordination and collaborative partnerships across the sector
- encourage the NT Primary Health Network to move to long term sustainable funding agreements.

The Coalition believes that these investments and service delivery reforms are essential in order to achieve positive mental health in the Northern Territory where community mental health support is available for all Territorians:

- that encompasses the full spectrum of prevention, early intervention and treatment in their local area with low/no barriers to access
- that is fully integrated with other services
- staffed by trained, knowledgeable people including peer workers at the times of the day/week/year when support is most needed and
- in a culturally safe, respectful manner inclusive of participants, families and communities; and
- that demonstrates long-term trust, consistency and commitment

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ATTACHMENT 1: Improvement Plans (an extract from Mental Health & Suicide Prevention Service Review 2017)

(from NTMHC Mental Health and Suicide Prevention Service Review 2017)

1.1 NT system improvement plan

Northern Territory System Improvement Plan	Timeframe
<p><u>Improvement Area 1. Evaluation of Suicide Prevention Activities</u> NT PHN to commission the development of a Northern Territory-specific, evidence-informed guidance manual for evaluating the <i>impacts</i> and <i>outcomes</i> of suicide prevention activities.</p>	<p>Immediate < 12 months</p>
<p><u>Improvement Area 2. Evaluation of Suicide Prevention Activities</u> All funding for suicide prevention and postvention services/programs should include designated resources for program evaluation of <i>process</i>, <i>impact</i> and <i>outcomes</i> of activities. Evaluation of Aboriginal suicide prevention activities should utilise the ATSIPEP evaluation framework and NT Guidance Manual.</p>	
<p><u>Improvement Area 3. Service Co-design</u> NT Primary Health Network (NT PHN) to continue to ensure that the perspectives of people with mental illness and carers are imbedded in all mental health and suicide prevention service development.</p>	
<p><u>Improvement Area 4. Partnerships</u> The Northern Territory Government and Non-Government Community Services Statement of Principles to be referenced in the development of all mental health and suicide prevention service agreements.</p>	
<p><u>Improvement Area 5. System Reform Project Officer</u> NT PHN and the Coalition to explore the development of a full-time Project Officer position within Northern Territory Mental Health Coalition. The aim of this role would be to support, guide and inform the implementation of government reforms in the mental health sector and to act as a 'lynch pin' between community mental health service providers, consumer and carer representatives, ACCHOs and the NDIA and NT Primary Health Network. This role will play an instrumental role in developing implementation strategies for reform priorities including a stepped-care model and system redesign.</p>	
<p><u>Improvement Area 6. Service Agreements</u> In all mental health service agreements, NTPHN to consider inclusion of measurable quality and performance indicators related to:</p> <ol style="list-style-type: none"> i. Cultural safety in service/program delivery ii. Cultural competence of staff iii. Staff capacity to engage in suicide interventions with colleagues and service users iv. Staff professional development strategies that align with the National Practice Standards for the Mental Health Workforce that relate to LGBTI populations v. Staff professional development strategies that meet the specific needs of Aboriginal LGBTI community in ways that are culturally responsive. vi. Organisational capacity for trauma-informed practice 	<p>Medium-Term 12-36 months</p>

Northern Territory System Improvement Plan	Timeframe
<ul style="list-style-type: none"> vii. The inclusion of carers in care planning processes viii. Maintaining accuracy of organisational information in Health Pathways and local service directories (as they become operational) ix. Accessibility of services by public transport x. Development of purposeful collaborative relationships with key stakeholders and inter-facing service providers xi. Staff orientation practices that shorten ramp-up periods for staff effectiveness and promote staff retention <p>Wherever possible, existing accreditation and CQI processes that measure indicators should be used, to prevent duplication of measurement/data collection activities for providers</p>	
<p><u>Improvement Area 7. Service Funding</u></p> <p>NT Primary Health Network (NT PHN) to move toward securing 3-5-year funding for selected mental health and suicide prevention programs and services, in line with NT Government funding commitments. To be eligible for 3-5-year funding, organisations should demonstrate capacity to work towards the quality improvement areas outlined in Plan 4.</p> <p>Notification of funding renewal/cessation should be provided with the maximum notice possible (minimum 6 months).</p>	
<p><u>Improvement Area 8. Out-of-hours services</u></p> <p>There is a significant need for after-hours and weekend services across the Northern Territory. NT PHN to explore after-hours service models that meet the needs of each region.</p>	
<p><u>Improvement Area 9. Capacity-building CQI processes in the NGO sector</u></p> <p>Need: The NGO mental health sector plays a significant role in servicing Aboriginal people and communities, and there is a need the need to build the NGO sector's CQI capacities related cultural safety and cultural competency in service delivery.</p> <p>Plan:</p> <ul style="list-style-type: none"> - NT PHN to work towards facilitating cross-sector capacity-building relationships between Aboriginal Medical Service Alliance Northern Territory (AMSANT), the NGO sector and its peak body (the Coalition). - NTPHN to support and encourage organisations to share their skills, knowledge and capacities around CQI practices, through informal network meetings and cross-organisational mentor relationships. 	
<p><u>Improvement Area 10. GP Training</u></p> <p>Mandated training in mental health is needed for all GP's in the Northern Territory. Training should be inclusive of the following components:</p> <ul style="list-style-type: none"> I. Developing cultural competence II. Developing skills in suicide alertness, assessment and treatment III. Orientation around regional, cross-sector service availability and referral pathways IV. Developing trauma-informed practice V. Utilising Aboriginal mental health and social and emotional wellbeing assessment VI. Utilising Health Pathways (as it becomes available) 	

Northern Territory System Improvement Plan	Timeframe
VII. Utilising the Digital Gateway (as it becomes available)	
<p><u>Improvement Area 11. NDIS/Low barrier-to-service programs</u> Continuation of funding for low-barrier-to-entry programs that support people with mild-moderate mental illness is vital to ensuring continuity of care for people who are unlikely to be eligible for NDIS.</p>	
<p><u>Improvement Area 12. Suicide Prevention – LGBTI inclusiveness</u> Ensure that strategies, policies and procedures that are inclusive of, and responsive to the needs of LGBTI populations, including Aboriginal LGBTI people, are in place in all suicide prevention activities.</p>	
<p><u>Improvement Area 13. Suicide Prevention – LGBTI identifiers in data collection</u> NT Primary Health Network (NT PHN) to work the Northern Territory Government to ensure that LGBTI identifiers, including those specific to the Aboriginal LGBTI community, are included on the NT’s suicide register and in all standardised reporting on suicide.</p>	
<p><u>Improvement Area 14. Mental Health workforce development</u> NTPHN to continue to work with Northern Territory Mental Health Coalition, the NGO and Aboriginal Community Control Health Organisation (ACCHO) sector to explore opportunities for workforce development in the following priority areas:</p> <ol style="list-style-type: none"> i. Peer support ii. Carer peer support iii. Cultural competency iv. Trauma-informed care and practice v. Suicide intervention skills vi. Dual diagnosis (see AOD sector integration plan) vii. Competencies around responding to the support needs of LGBTI populations, in line with National Practice Standards for the Mental Health Workforce with Standard 3. (Meeting diverse needs) and Standard 4: (Working with Aboriginal and Torres Strait Islander people, families and communities) as one standard specific to the needs of the Aboriginal LGBTI community. 	
<p><u>Improvement Area 15. Suicide prevention training for frontline services</u> NT PHN to work with Northern Territory Government to increase mental health and suicide intervention training for frontline community services, including police, ambulance and hospital staff. Additional training should be determined by evaluation of current suicide intervention alertness capacities of services. Additional sectors identified for training include the building and construction sector</p>	
<p><u>Improvement Area 16. Suicide Prevention – Information sharing</u> NT PHN to review information-sharing practices between the Coroner’s Office and NGO sector following suicides, exploring options to improve communication with the NGO sector following suicide so to better equip the sector to respond appropriately and sensitively when attempted and/or completed suicide occurs.</p>	
<p><u>Improvement Area 17. Service Mapping</u> NT PHN to investigate collection of NT Department of Health, NGO and ACCHO client data sets in future mental health service mapping and needs assessments. This may require service agreements to specify collection of a minimum data set.</p>	

Northern Territory System Improvement Plan	Timeframe
<p><u>Improvement Area 18. Aboriginal mental health workforce development</u></p> <p>NT Primary Health Network (NT PHN) to engage in an analysis and dissemination of existing strategies and plans regarding:</p> <ul style="list-style-type: none"> - Pathways to certificate, degree and masters level training in mental health and social and emotional wellbeing disciplines - Formal recognition of cultural (including language) skills - Effective ways of working with schools, young people (and parents) and community leaders to develop pathways into the mental health workforce - Resourcing for ongoing professional development training and in-servicing (including in AOD treatment frameworks) - Opportunities for secondment to other work sites and program areas to develop breadth of experience (e.g. TEMHS Tamarind Centre and mental health inpatient unit) - Annual forums for peer-based professional development - Organisations to utilise workforce expertise, including the provision of cultural supervision for all non-local staff, including Fly-In, Fly-Out staff - Opportunities to contribute to the identification, delivery of appropriate cultural competence training for non- Aboriginal staff. - Opportunities and pathways for career progression into management roles, clinical roles. - Access to opportunities to receive and provide mentoring and supervision. 	<p>Long-Term 1-5 years</p>
<p><u>Improvement Area 19. Integration with the Alcohol and Other Drug sector</u></p> <p>In addition to their respective training and development needs, the NT's AOD and mental health workforce' require shared understanding and ability to implement treatment modalities and frameworks that overlap both AOD and mental health practice.</p> <p>System Improvement Plan:</p> <p>NT PHN to continue to engage with Association of Alcohol & Other Drugs Agencies Northern Territory (AADANT) and NT Mental Health Coalition in the development of a cross-sector strategic training plan to build the capacity of the AOD and mental health workforce' to provide shared care of people with dual diagnosis conditions. This plan would include:</p> <ul style="list-style-type: none"> - An evaluation of current dual diagnosis capacities within the AOD and mental health sectors <p>Development of a training strategy tailored to the needs identified in the evaluation and the social, cultural and linguistic contexts of the NT.</p>	

1.2. Darwin Region

1.2.1 Regional needs, priorities and opportunities

Stakeholder Perspectives	Regional needs and opportunities for system improvement
Priority Area: Service availability	
<p>Significant shortfalls in the availability of mental health services were described across the across the spectrum of primary, secondary and tertiary services in the Darwin region. Shortfalls were related to a) insufficient capacity of existing services or b) a total absence of treatment options.</p> <p>Frequently noted gaps in availability included:</p> <ul style="list-style-type: none"> - Specialised services for young people with complex needs related to psychological trauma. This population group experiences severe/complex mental illness, are often undiagnosed and commonly at high risk of suicide or self-harm upon first presentation to mental health services. This population group does not typically receive ongoing support from Territory mental health services. Neither headspace, nor the broader NGO sector currently has the capacity to effectively meet the needs of these young people. - Forensic youth mental health services in the Darwin region for young people with mental illness who have committed or are at risk of committing criminal offences. - Secure forensic adult mental health facilities. - Supported accommodation/affordable housing for people with severe and persistent mental illness. - Psychogeriatric services in Darwin presents a significant gap in service delivery for older people with mental illness. In some cases, people have had to travel interstate to access appropriate treatment. - Bed shortages in TEMHS inpatient unit (Cowdy Ward) have resulted in inappropriate transfer of patients to the secure Joan Ridley Unit (JRU), where preventable assaults have occurred. - Specialist clinical treatment for people with eating disorders and people with personality disorders. 	<p><i>Youth-Severe Services</i></p> <p>headspace - Darwin is well positioned to expand service delivery to the <i>youth-severe</i> population, both in terms of its clinical governance structures and capacity to engage young people. Development of this service(s) should consider:</p> <ul style="list-style-type: none"> - Formal linkages with key providers in the youth, out-of-home-care and child protection sectors to ensure integrated, wrap-around, trauma-informed care for high-risk young people with experiences of complex trauma. - Linkages with interstate providers of specialist treatment for young people with eating disorders and personality disorders. <p><i>Forensic Services</i></p> <ul style="list-style-type: none"> - Increased resourcing of youth and adult forensic services is an essential to reform of the youth/adult justice systems in the NT. - Formal linkages between Department of Corrections, TEMHS and Aboriginal mental health workers (including those employed by regional ACCHO's and NTG Remote Health Centres) would greatly enhance

<ul style="list-style-type: none"> - Specialist trauma-focussed psychological therapies and wrap-around care needed to address current issue of people cycling between crises and crisis support services. - Outreach counselling services for children and adolescents (during temporary closure of Mobile Outreach Support Plus (MOS Plus - <i>Territory Families</i>)) - Sub-acute care. Case management at TEMHS is a requirement of access to Papaya (Sub-acute Care Program), presents a service gap for people in need of intensive residential support, who are at risk of mental health deterioration/ hospital admission and who: a) community mental health services but are not engaged with TEMHS, or b) are not engaged with any services (and potentially experiencing homelessness). - Need exists for an intensive gambling addiction rehabilitation program to support people to re-establish daily routines (such as normal sleeping and eating routines) before progressing to less intensive counselling and rehabilitation. - Low intensity, early intervention services and treatment options (see priority area). 	<p>provision of culturally-responsive counselling, psycho-education to Aboriginal forensic patients, and secondary consult to their clinical treatment teams (potentially through use of telehealth). ACCHO's would require additional resourcing commensurate to their involvement.</p> <p><i>Psychogeriatric services</i></p> <ul style="list-style-type: none"> - Stakeholder consultations suggest a significant unmet need in terms of mental health treatment for older people in the region. - Data around client capacity of Northern Territory Department of Health (NT DoH) psycho-geriatric services was unavailable. Further investigation into this is needed.
<p>Priority Area: Service coordination and continuity of care</p>	
<p>Non-government providers generally report good relationships and integration with Top End Mental Health Services (Tamarind Centre). However, hospital-based mental health services are reported to operate in relative isolation from the community sector, showing limited awareness of non-government community-based services. This lack of awareness also exists between NGO providers.</p> <p>Identified causes include:</p> <ul style="list-style-type: none"> - High levels of workforce turnover resulting in loss of corporate and sectoral knowledge. This destabilises collaborative relationships between providers. Where collaborative relationships do exist, they are generally based in informal, personality-driven relationships rather than formal structures and agreements. - Services typically operate at full, or close to full, capacity, which limits the outward focus required to prioritise collaboration and integration. <p>Other identified issues:</p> <ul style="list-style-type: none"> - NGOs are often restricted from providing support inside correctional facilities, at a time when therapeutic supports are vital for rehabilitation and recovery. 	<ul style="list-style-type: none"> - Wider promotion of sector network meetings, particularly for frontline workers, may help to increase cross-service awareness, referral and coordination. - A review of mental health and suicide prevention services available to people in youth detention and prison (non-forensic) may highlight further opportunities to extend appropriate mental health care to these young people. Any review should also include investigation of continuity-of-care and client journey following release from prison/ youth detention. - Commissioning of <i>youth-severe</i> mental health services that are integrated with the youth sector may improve wrap-around care for high-risk youth.

<ul style="list-style-type: none"> - A lack of supported/transitional accommodation facilities results in routine discharge from Top End Mental Health Services (TEMHS) inpatient unit into shared accommodation where exposure to alcohol and other drugs heightens likelihood of relapse. - A lack of specialised <i>youth-severe</i> services results in the supported accommodation and youth sectors being left to support (and sit with the associated risk of supporting) young people with complex trauma and mental health problems, a role for which they are generally under-resourced and under-equipped. - Premature service discontinuation can occur when a young person turns 18 and exits the youth service system and education systems. There is a need for formal monitoring into year 13 for such young people who are identified as at-risk. - Discharge of patients experiencing homelessness from TEMHS inpatient unit into the Sub-acute Program (Papaya) and then into inadequate short-term accommodation (e.g. two nights in a hotel), significantly heightens risk of relapse. 	<ul style="list-style-type: none"> - Investment in public housing and transitional housing is necessary to reduce rates of homelessness amongst people living with mental illness. - There is a need for formal monitoring of young people who are identified as <i>at-risk</i> at the time of exit from the youth/out-of-home care sectors.
<p>Priority Area: Low Intensity Mental Health Services (LIMHS)</p>	
<p>The efficacy of digital therapies as low-intensity treatment options is seen to be impacted on by a range of factors, including:</p> <ul style="list-style-type: none"> - Degree of access to electronic devices, internet coverage and data credit - Levels of digital and English language literacy - Behaviours related to technology usage and help-seeking - Patterns of youth usage of technology in the NT - Willingness of GP's to refer patients to digital therapies - Tailoring digital therapies and education platforms to the needs of population groups is critical 	<ul style="list-style-type: none"> - Little is known about the current uptake and efficacy of digital therapies amongst the Darwin population. Investigation into this may assist in commissioning LIMHS into the future. - Linking the Digital Gateway and Health Pathways may assist in increasing GP awareness and willingness to refer to digital therapies. - Development of locally-based LIMHS' should utilise principles of co-design, include input from participants and carers and build on existing capacities of service providers. - Robust supervision and training of unqualified LIMHS practitioners, along with strong clinical governance structures, are necessary to ensure service model fidelity, and the timely elevation of high-risk participants to more intensive levels of care.

<p>Priority Area: Referral Pathways</p>	
<p>Several factors were reported to impact on efficient and appropriate referral and access to mental health services in the region, including:</p> <ul style="list-style-type: none"> - GP's appear to have limited awareness/willingness to refer patients to community-based treatment options and low-intensity digital therapies. - The lack of a 'one stop shop' access point for the general public and for GPs results in poorly targeted referral/self-referral to services. - There is a lack of effectively targeted promotional material around the range of locally available treatment options, eligibility requirements, costs to users and access pathways. - Strict eligibility criteria for service access, and a lack of formal process for onward referral and follow-up can result in people who seek treatment being shuttled between providers, becoming isolated and undermining future help-seeking behaviour. - A need for safeguards and monitoring to ensure access and continuity of care in cases of siloed service delivery and inadequate referral processes. - Carer representatives note that carers are often excluded from the referral process, resulting in inappropriate/ineffective referral and coordination of care. 	<ul style="list-style-type: none"> - There is a need to build the awareness and confidence of GP's to refer to community-based mental health services and low-intensity digital therapies. <i>Health Pathways</i> may be an avenue for this. - NT Primary Health Network (NT PHN) to ensure the inclusion of mental health and suicide prevention services in the development of health pathways. - The Darwin region is in need of a comprehensive on-line service directory that is available publicly, with long-term funding allocated to its development and ongoing maintenance.
<p>Priority Area: Public Transport</p>	
<p>Lack of public transport to some facility/office-based services is a significant barrier for people reliant on public transport. Key issues include:</p> <ul style="list-style-type: none"> - Significant transit times for people living in rural areas. - Lack of public transport availability to some service locations within the urban area. - Discrimination and harassment of Aboriginal people by transport authorities when attempting to access public transport. <p>Some youth groups are reluctant to travel outside of their home suburb due to fear of entering the territory of youth gangs.</p>	<ul style="list-style-type: none"> - There is a need to consider the public transport accessibility of facility-based services in all mental health service agreements.
<p>Priority Area: Service Funding</p>	
<ul style="list-style-type: none"> - Some service providers are reported to periodically deflect responsibility to provide treatment because of the parameters of their service funding agreements. In the absence of strong referral pathways and monitoring of referral outcomes, participants can be left highly distressed and disengaged by this. 	<ul style="list-style-type: none"> - Funding periods for mental health and suicide prevention services should move to 3-5-year periods in-line with NT Government funding. - Notification of funding renewal/cessation should be provided with maximum notice possible.

<ul style="list-style-type: none"> - To move away from funding-focussed treatment, a cultural shift is required in some organisations in order to embed client-focussed care within intake and assessment processes, as well as building capacity for appropriate referral and monitoring of referral outcomes. - Short-term funding cycles and last-minute notification of funding continuation impacts on service delivery by restricting a provider’s ability to recruit and retain program staff, develop linkages with other providers, become visible within the community and consolidate program delivery. - Block funding for services allows providers to support complex cases. Outcome-focussed funding can be a disincentive to take on more complex cases. There is an ongoing need for flexible, low barrier-to-entry services and programs to support people with mental health issues and illness who are unlikely to be eligible for an NDIS package. 	<ul style="list-style-type: none"> - Funding for program evaluation and training should be included in service agreements wherever possible.
<p>Priority Area: Workforce</p>	
<p>High levels of staff turnover and high cost of recruitment is an ongoing workforce challenge for the mental health sector. Other challenges relate to:</p> <ul style="list-style-type: none"> - The increasing need for providers to promote their services requires skill-sets distinct from client-facing work. - Data collection requirements are often complex, duplicated and take resources away from participant-facing practice. - Cultural competency - Danila Dilba Aboriginal Health Services medical model of work-based training for Aboriginal mental health workers has been effective. - Trauma training for primary health providers (including GPs) is a significant need. - Recruitment and development of Aboriginal workforce is essential to building capacity for culturally responsive mental health care for Aboriginal peoples. - Lack of cultural competence and/or confidence in one’s cultural competence periodically results in non- Aboriginal mental health professionals retreating from engagement with Aboriginal patients and reduces standards of care for Aboriginal people. 	<ul style="list-style-type: none"> - There is a well identified need to refine and simplify data collection processes to increase quality, efficiency and cost-effectiveness of mental health services. - Training in trauma practice and theory for primary health providers (including GPs) is identified as a significant need. - There is significant need to expand the Aboriginal mental health workforce in order to better engage with Aboriginal people, particularly people experiencing homelessness and those with dual diagnosis.
<p>Carer perspectives</p>	
<p><i>Carer Supports</i></p> <ul style="list-style-type: none"> - Carers are at increased risk of developing mental health issues and illness due the stress and isolation commonly experienced in caring for someone with mental illness and psycho-social disability. Access to formal and informal therapeutic supports, respite support, peer support 	<ul style="list-style-type: none"> - Establishing support pathways for carers in the development of <i>Health Pathways</i> for the Darwin region should be considered as a means of building capacity of GP’s to link carers to appropriate supports and psycho-education resources.

<p>and psycho-educational material is reported to be essential to carer wellbeing and ongoing capacity to provide care to people with mental illness.</p> <ul style="list-style-type: none"> - Carers report a range of support services available in Darwin that are effective in meeting their support needs once a linkage or referral is in place. - Pathways to carer supports are often unclear. GP’s play a critical role in linking carers to supports but are often unaware of the range of supports available to carers in the region. - Funding for respite exists in small, discrete buckets that are not coordinated or consolidated. Respite is not freely offered/linked in to carers by many services. - Navigating this funding environment is a barrier to access and requires strong self-advocacy on the part of carers. - Recent reductions in funding for respite is a key concern for carers. - Respite is not freely offered/linked in to carers by many services. - There remains stigma around accessing respite. <p><i>Marginalisation of Carers</i> Carers report experiences of marginalisation in interactions with the mental health care system, particularly in regards to:</p> <ul style="list-style-type: none"> - Being declined linkage to services when seeking help for people in prodromal state who are reluctant/lack insight to seek help themselves. - Carer perspectives being disregarded in assessment processes. - Carers being excluded from care planning meetings in Top End Mental Health Services inpatient unit is often distressing and undermines carer capacity to provide support and care for care recipients. <p><i>Associated community services</i> Carers report significant gaps in the availability of financial counselling, gambling addiction treatment, treatment for eating disorders and therapeutic support around hoarding. These gaps compound stress and anxiety in carers and care recipients.</p>	<ul style="list-style-type: none"> - Review of psycho-educational resources provided to carers following presentation, admission and discharge of care recipients to Royal Darwin Hospital, Mental Health Assessment Team and Central Australia Team is needed. Review to inform action plan to standardise provision/linkage to psycho-educational resources for carers following acute episodes of mental illness and/or suicidal ideation of care recipients. - Further research is needed into the appropriateness/uptake of existing resources for Aboriginal people in caring roles. - Investigate/map funding respite funding available to carers in Darwin, into a centralised access point may increase accessibility and equity of access for carers. - Investigation into understanding the ageing carer demographic and transition plan. - NT Primary Health Network (NT PNH) to consider inclusion of carer support services in the development of health pathways. - NT PNH to ensure that carer and participant input into service design and evaluation is sought in co-design and commissioning processes.
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Perspectives of people with mental illness	
<p>People with lived experience of mental illness in the Darwin region report a range of concerns related to accessing mental health and associated services, and report experiencing ongoing institutional and social discrimination. Key issues include:</p> <p>Prolonged homelessness and housing insecurity for many people living with mental illness in the region, due to lack of affordable housing, contributing factors include:</p> <ul style="list-style-type: none"> - Significant wait times to access Territory Housing (>6 months) and other affordable accommodation. - Extended wait times for eligibility to access the Disability Support Pension (> 2 years in some cases). - Stigma around mental illness, particularly within workplaces, is a barrier to employment. <p>Concerns raised regarding Community Management Orders include:</p> <ul style="list-style-type: none"> - Discrimination by employers and education institutions as a result of mandatory disclosure requirements around medications. - Lack of easy access to clinical information inhibits participants' preparation for review tribunal. <p>Concerns raised around function of TEMHS including:</p> <ul style="list-style-type: none"> - Lack of sunlight, and dirty, aged facilities at TEMHS inpatient unit are not conducive to recovery. - Restrictions on smoking within Top End Mental Health Services (TEMHS) inpatient unit deny patients choice and control, increasing distress and resulting in patients using visits/leave from TEMHS inpatient unit to binge on cigarettes once away from hospital grounds. - Lack of support in activities of daily living leaves patients within TEMHS inpatient unit vulnerable and deskilled upon discharge. - Discharge into temporary accommodation often results in homelessness, relapse and re-admission. - Inadequate complaints processes within TEMHS and the community sector for people who report abuse/mistreatment within TEMHS inpatient unit and within community services. - Tamarind Centre operates at full-capacity and, as a result, defers to a medical approach to treatment and is over-reliant on pharmacotherapies. This results in over-medication of people 	<ul style="list-style-type: none"> - The perspectives of people living with mental illness who access mental health services are crucial to improving the function of the mental health system. - The range of issues identified by people living with mental illness is extensive and, in some cases, point to significant breaches and violation of people's human rights and basic dignity in accessing mental health services. - Needs, concerns and opportunities for system improvement identified by participants generally fall within the remit of the NT Department of Housing, Commonwealth Department of Social Services and NT Department of Health. NT PHN is well-placed to follow-up these concerns with relevant departments and contact the Coalition for further information regarding participant consultations. - Roll-out of the basics card in different regions of Australia should be monitored, to observe any changes to exclusions.

<p>living with mental illness, which impairs functional ability, quality of life and recovery. There is a need for greater holistic, recovery-focussed, person-centred case management.</p> <ul style="list-style-type: none"> - The expense of accessing private psychiatry is beyond the reach of many people, which limits access to more holistic, person-centred care. - The function, purpose and eligibility requirements of NDIS is largely unclear. - Participant input into service planning is being gradually eroded and needs to be reinvigorated in the Darwin region. - Participants who speak English as a second language face significant barriers in accessing and navigating the mental health service system. - Referral process from Tamarind to community-based support services are generally timely and appropriate, however GP’s are often less aware of other community-based supports. <p>Quarantining of a percentage of Centrelink payments to the Basics Card is widely seen as degrading, arbitrary and financially disadvantageous. Reasons include:</p> <ul style="list-style-type: none"> - Restricting financial choice and control for people living with mental illness compounds other restrictions, stigma and marginalisation that people often experience within the community and undermines individual recovery. - The scheme is arbitrary in its definition and restriction of <i>luxury goods</i>, and the inclusion/exclusion of retailers is unpredictable. This creates confusion, frustration, disempowerment and incapacitates meaningful participation in the local economy. - Arbitrary inclusion/exclusion of retailers’ results in higher costs of living for people living with mental illness, as low-cost retailers, including fast food outlets, are not registered or are excluded from the scheme. This forces people to shop at more expensive retailers, such as service stations and supermarkets, which particularly impacts upon people who are homeless and do not have access to kitchen, food storage or refrigeration facilities. 	<p>There is a need for greater focus on recovery-focussed, person-centred case management within Tamarind Centre.</p> <ul style="list-style-type: none"> - NT PHN to ensure that participant input into service design and evaluation is sought in co-design and commissioning processes.
<p>Sector Integration – Drug and Alcohol Sector</p>	
<p>Consultation with mental health providers and the alcohol and other drug (AOD) sector highlighted a range of issues related to; cross-sector capacity for shared-care of dual diagnosis participants, increasing cross-sector skills and knowledge transfer and; increased skill sharing between mental health and AOD professionals within AOD services.</p> <p>Key issues included:</p>	<p>Mental health issues and substance use issues are often closely connected. It is essential that the mental health and AOD sectors are equipped to provide integrated service delivery in order to provide longitudinal shared care of people with dual diagnosis conditions.</p>

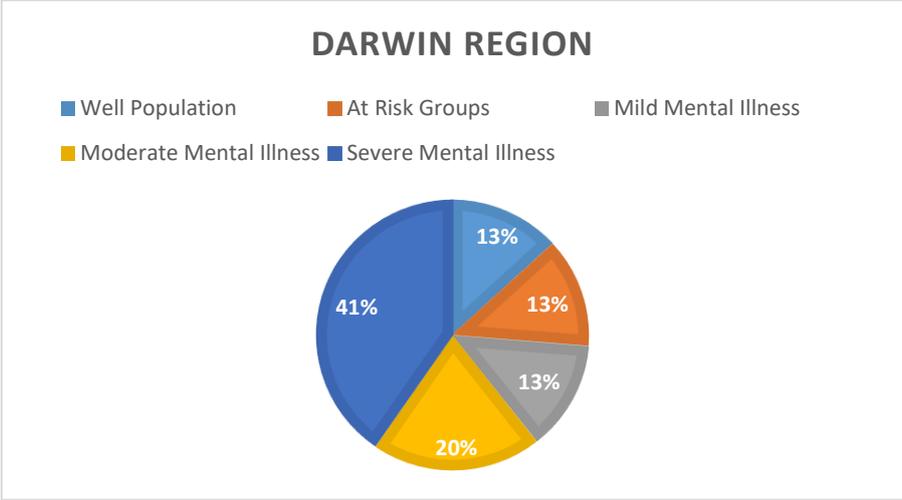
<ul style="list-style-type: none"> - Informal collaboration between mental health and AOD services is often personality and relationship-based and subject to failure upon departure of ‘champions’. - Lack of management experience, skills and capability also limits collaboration between services. - Flexibility around KPI’s and reporting on client load is necessary for both sectors to increase shared care processes for dual diagnosis participants. - NT Department of Corrections periodically fails to ensure clients are ‘referral ready’ upon release to rehabilitation services, increasing the person’s risk of relapse/failure to adhere to treatment plans. - The mental health sector shows a lack of understanding of AOD treatment frameworks, e.g. lack of understanding of recovery/harm minimisation principles. This can result in refusal of service for people whose goals don’t involve a complete cessation of AOD. - Co-location of organisations and secondment of staff can be an effective, cost-effective way to upskill and share practice knowledge between services. - Resourcing of cross-skilling between AOD and Mental health services is needed to achieve service integration and improved longitudinal care for people with dual diagnosis. <p>There is a lack of longitudinal care planning in the AOD sector. This requires:</p> <ul style="list-style-type: none"> - Funding for longitudinal supports and - AOD/dual diagnosis training for supported accommodation and mental health services. 	<p>In addition to their respective training and development needs, the NT’s AOD and mental health workforce’ require shared understanding of treatment modalities and frameworks that overlap both AOD and mental health practice.</p> <p>In developing service agreements with mental health and AOD service providers, funders should consider:</p> <ul style="list-style-type: none"> - Quality standards that include indicators of cross-sector collaboration. - Flexibility and innovation in developing KPI’s to foster longitudinal shared care of people with dual diagnosis conditions
<p>Sector Integration: Disability and Early Childhood</p>	
<p>Access to early intervention therapeutic children’s services:</p> <ul style="list-style-type: none"> - Children with significant developmental and behavioural issues (including Oppositional Defiance and Conduct Disorders) who do not meet criteria for Office of Disability funding and who are also ineligible for <i>Better Start</i> and <i>Helping Children with Autism</i> funding, are reliant on <i>Better Access Mental Care Plans</i> for access to early intervention therapeutic services. - <i>Better Access</i> provides for up to 10 therapeutic sessions per year, which does not meet the longer-term family-centred, psycho-dynamic therapeutic needs of these children and their families. - High levels of stress creates substantive levels of mental health risk in many parents of children with developmental disabilities. Psycho-dynamic, family-focussed therapeutic 	<p>The NT Department of Education has developed a new Social and Emotional Learning Curriculum, which is currently being trialled in two schools, and will soon be rolled out across the NT. The curriculum is expected to address issues around cultural inappropriateness of other Social Emotional Well Being (SEWB) frameworks and promote a uniform approach to SEWB in primary schools in the NT.</p> <p>The curriculum embeds the following principles in all areas educational activity, from the classroom to policy development:</p>

<p>support that is integrated with development of parenting skills is essential to effective mental health care for such parents.</p> <p>Service Availability</p> <ul style="list-style-type: none"> - Child and Adolescent Mental Health Services (CAMHS), Darwin tends to provide assessment rather than long-term therapeutic supports for children and families. - There is an absence of child psychiatry services in Darwin. - Paediatricians in the Darwin region is operating at full capacity, with wait times of 2-3 months. <p>Social and Emotional Wellbeing in Schools:</p> <ul style="list-style-type: none"> - Social Emotional Well Being (SEWB) and Mental Health promotion in NT schools is fragmented and inconsistent - Schools in the Darwin region rarely demonstrate a systemic orientation around safety that is child-focussed or trauma-informed. More commonly, schools tend to pathologise behaviours-of-concern in children and utilise <i>behaviour management</i> approaches that deemphasise a child’s emotional context and development of emotional resilience. - The <i>Kids Matter</i> program lacks cultural responsiveness/appropriateness for Aboriginal and Torres Strait Islander children. 	<ul style="list-style-type: none"> - Community Engaged - Strengths Based - Trauma Informed - Relationship Based - Culturally Responsive <p>Evaluation of the Social and Emotional Learning curriculum, currently being trialled by the NT Department of Education, requires evaluation within each school that it is rolled out.</p>
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1.2.2 Stepped Care in the region

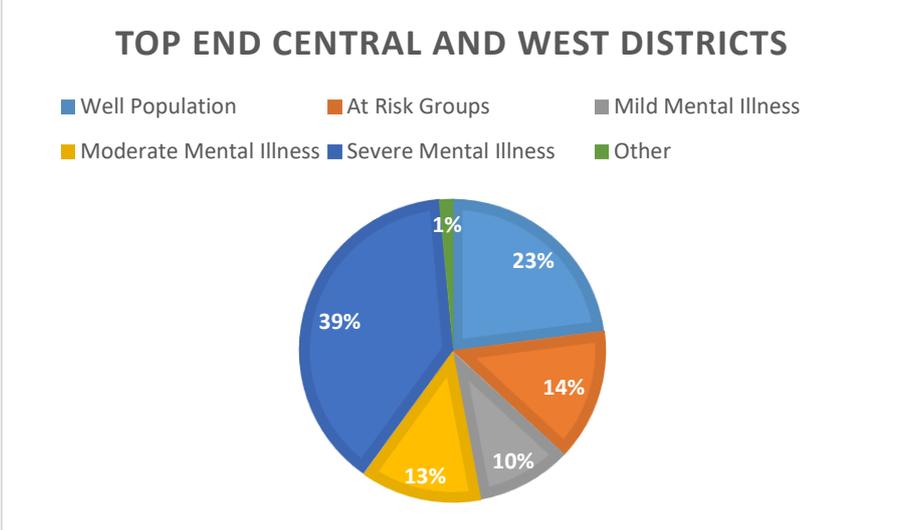
Stepped Care involves the stratification of a population into different ‘needs groups’, ranging from whole of population needs for mental health promotion and prevention, through to those with severe, persistent and complex conditions. The following tables show the percentage of total regional services that are delivered to each of these population needs groups.

Table 1: Combined NGO mental health and social and emotional welling service delivery by Stepped Care population group: Darwin Urban*



Source: Mental Health Service Profiles, NTMHC 2017

Table 2: Top End Central and West Districts*



Source: Mental Health Service Profiles, NTMHC 2017

*Excludes carer supports, referral lines, web-based support platforms, drug and alcohol services and suicide prevention programs/services.

Understanding the regional mental health system through a Stepped Care lens: Darwin Region	
Key components	Discussion of issues
Spectrum of evidence-based services from least to most intensive	<ul style="list-style-type: none"> - The relative availability of moderately well-resourced primary, secondary and tertiary mental health services across the continuum of treatment intensities, suggest that alignment of the Darwin Urban regional mental health system to a standard Stepped Care structure is largely achievable. - Gaps in the availability of specific service types, such as youth-severe, forensic, psychogeriatric and child psychiatry services exist, however these gaps are largely remedial and, in some cases are already being addressed. - The relative availability of ancillary supports, including supported housing, AOD services, carer respite and other carer supports, provides a foundation of primordial preventions that address the social determinants of health, positioning the region well for the expansion of Low Intensity Mental Health Services (LIMHS). - Developing a trained and well supervised low-intensity mental health workforce, with oversight from a strong clinical governance framework is essential to expanding LIMHS in the region. - Low intensity, digital therapies do not meet the needs of many people who prefer face-to-face interaction and support. Digital therapies should supplement practitioner/clinician-moderated services and case worker roles, not replace them.
Mechanisms for matching individual need to service level and intensity	<ul style="list-style-type: none"> - GP's are, potentially, the most effective point of access and distribution of good quality information around mental health and have a role to play in supporting and monitoring usage of digital therapies. - GP's in the region are reported to have limited awareness/willingness to refer patients to community-based treatment options and low-intensity digital therapies. - The lack of a 'one stop shop' access point for the general public and for GPs results in poorly targeted referral/self-referral to services. - Early intervention is extremely important; targeted intervention in schools needs to be developed as current screening tools/processes for school populations are inadequate. - Substance use is often a neglected issue in low-intensity service delivery. LIMHS should be equipped to recognise substance use issues, facilitate referral to AOD services and critically engage with AOD treatment frameworks throughout the course of service delivery. - Table 4 of the Service Review demonstrates the range of assessment tools utilised by mental health services across the Darwin region and shows an absence of standardisation across providers. Some degree of standardisation of assessment tools in triaging mental health participants across providers may be necessary if NT PHN seeks to develop more uniformity in how the region's mental health system matches people to services. This would also require the participation of TEMHS.
Processes for monitoring progress and adjusting level according to need	<ul style="list-style-type: none"> - Strong clinical governance is required in all mental health services to ensure that presentations of high risk (e.g. experiencing suicide ideation) results in participant being elevated to a higher service level. This should be of primary concern in the development of LIMHS and providers may require support to develop their clinical governance processes through the commissioning process.

Understanding the regional mental health system through a Stepped Care lens:

Darwin Region

Clear pathways for moving between services providers and levels	<ul style="list-style-type: none"> - Service silos persist between providers in the region. Lack of acceptance of referrals between organisations can result from overly restrictive service eligibility criteria. A lack of formal process for onward referral and follow-up can result in people who seek treatment being shuttled between providers; becoming isolated and undermining future help-seeking behaviour. Stronger oversight and follow-up of referrals by the referring organisation is necessary in some instances, to ensure that engagement following onward referral is achieved and people seeking help do not <i>fall through the gap</i>.
Capacity to monitor system as a whole	<ul style="list-style-type: none"> - Table 2. (Service Review) shows a range of disparate clinical governance structures across service providers in the region. It may be necessary for a single agency to take on the role of whole-of-system monitoring.
Key Principles of Stepped Care	<ul style="list-style-type: none"> - Cultural competency/safety in service delivery - Increased resourcing of NGO sector including AOD services - Prioritisation of trauma informed practice and engagement with dual diagnosis in all aspects of service delivery - Carers must be included in the ongoing development of the service system and service development - Community capacity-building (local people/jobs) should be imbedded in service development - Communication, accountability, transparency in service delivery - Adequately resourced affordable and supported accommodation - Robust monitoring of transient clients - Education for primary health providers; including GP's in remote areas and Darwin, around trauma informed care.

1.2.3 Regional suicide prevention

Suicide Prevention – Darwin Region Consultation Outcomes		
Intervention Area	Stakeholder perspectives	Needs and opportunities for system improvement
UNIVERSAL INTERVENTIONS Primordial prevention Gatekeeper training (“Go-to people”) Responsible media reporting around suicide	<ul style="list-style-type: none"> - High rates of homelessness, drug and alcohol use, imprisonment, youth detention and family violence in the region are all significant factors in elevating suicide risk in the local population. 	<ul style="list-style-type: none"> - Primordial prevention should be seen as the foundation of a systems-based approach to suicide prevention. In the Darwin region primordial preventions include; social policies and programs that reduce rates of homelessness, incarceration and youth-detention, domestic and family violence, problem drug and alcohol use, and those that promote community connectedness and connections to cultural identity. - Development and roll-out of <i>Health Pathways</i> for GP’s and other primary care clinicians may present an opportunity to improve referral pathways to low-intensity supports and community-based mental health, SEWB and AOD services for people who present as at-risk. - There is a limited evidence around the uptake of suicide prevention training.
	<ul style="list-style-type: none"> - There is a good level of access and uptake of suicide prevention and mental health first-aid training amongst frontline workers in the Darwin region. - The reportedly low-level of awareness amongst GPs and hospital-based mental health staff of community-based mental services is concerning. This lack of awareness is reported to result in low-rates of referral to community-based services; which has significant implications for the capacity of GP’s and other frontline staff to fully utilise the mental health service system in developing safety-plans for people who are at risk of suicide and depression. - There was very little feedback from stakeholder consultations around the approach of media on reporting suicide within the Darwin region. 	
SELECTIVE – AT RISK GROUPS School-based supports Mental health literacy	<ul style="list-style-type: none"> - Senior schools in the Darwin region are reported to be more attuned to students who are at high-risk of suicide/self-harm, and more familiar corresponding referral pathways to high intensity supports. 	<ul style="list-style-type: none"> - There is a need to increase the capacity of Darwin schools to recognise signs and symptoms of anxiety and depression and to make referrals for students to lower-intensity services and online supports.
	<ul style="list-style-type: none"> - Community awareness is severely limited around; mental health crisis supports services and pathways to accessing mental health care for people experiencing suicidal ideation and who are high risk. This is particularly so for populations that speak a first language other than English. 	

Suicide Prevention – Darwin Region Consultation Outcomes		
		- A publicly accessible on-line service directory is needed to increase the navigability of the service system.
INDICATED – AT RISK INDIVIDUALS Monitoring of youth post out-of-home-care	<ul style="list-style-type: none"> - Concerns exist around restriction of access to clinical services for people with suicidal ideation who do not present with other symptomatology. - A lack of specialised <i>youth-severe</i> services results in the supported accommodation and youth sectors being left to support (and sit with the associated risk of supporting), young people with complex trauma and mental health problems – a role for which they are generally under-resourced and under-equipped. - Premature service discontinuation occasionally occurs when a young person turns 18 and exists the youth service system and education systems. 	Funding of a youth-severe mental health service is critical to mitigating the risk of suicide amongst young people with complex trauma. There is a need for an agency to undertake formal monitoring of young people who are identified as at-risk when they exit the youth and out-of-home-care sectors.
COMMON ELEMENTS Data sharing Peer workforce Data collection – LGBTI community Workforce	<ul style="list-style-type: none"> - Data captured by police/coroner around suicide is not adequately linked into mental health service development. - There is a lack of peer-worker training and roles within mental health services. Peer support roles are invaluable in working with at-risk individuals - There is a dearth of understanding of the client journey of LGBTI people who attempt or complete suicide. - Suicide prevention and postvention assertive outreach services, such as Way Back staffing are particularly vulnerable to staff-turnover and loss of sectoral and corporate knowledge. 	Development of formal peer worker training in the Darwin region is the first step in expanding the peer workforce. All suicide prevention and postvention services and programs should be funded to implement evaluation.
SAFETY NETS Cross-agency collaboration	<ul style="list-style-type: none"> - Suicide Prevention activities in the Darwin region are somewhat fragmented. NGO mental health and suicide prevention service providers report operating in relative isolation from one and other. This inhibits referral to suicide prevention and postvention services and suggests a limited ability for cross-agency collaboration. 	<ul style="list-style-type: none"> - Suicide Prevention network meetings, potentially held quarterly, may improve coordination, referral and integration of mental health and suicide pre and postvention services.

Northern Territory Mental Health Coalition

1.2.4 Regional improvement plan

Priority Area	Regional Improvement Plan – Darwin Region	Time Frame
Service Coordination	<p><u>Improvement Area 1.</u></p> <ul style="list-style-type: none"> - NT Primary Health Network (NT PHN) to continue working in partnership with NT Mental Health Coalition to promote sector network meetings for frontline workers. 	Immediate < 12 months
Service Availability: Youth Detention	<p><u>Improvement Area 2.</u></p> <ul style="list-style-type: none"> - A review of mental health and suicide prevention services available to young people in youth detention and prison (non-forensic) in the Darwin region is needed to ensure that community-based mental health services are accessible to this vulnerable population. 	
Continuity of Care: Youth	<p><u>Improvement Area 3.</u></p> <ul style="list-style-type: none"> - NT PHN to continue working with the NT Department of Health, Top End Mental Health Services, Central Australia Mental Health Services, Territory Families and the NGO sector to review any monitoring arrangements currently in place for young people who have a diagnosed mental illness, or who are identified as <i>at-risk</i>, at the time of exit from the youth services and out-of-home care. 	
Carer Support	<p><u>Improvement Area 4.</u></p> <ul style="list-style-type: none"> - A review of the after-care resources provided to carers following presentation, admission and discharge of care recipients to RDH, MHAT and CAT is needed to better equip carers in caring for a person who is unwell. This review should inform an action plan to standardise provision/linkage to after-care resources for carers following acute episodes of mental illness and/or suicidal ideation of care recipients. - Review of avenues for 	
Suicide Prevention and afterhours services	<p><u>Improvement Area 5.</u></p> <ul style="list-style-type: none"> - NT PHN to work with NT Department of Health to explore models for a 'soft-exit' facility in Alice Springs for people experiencing a mental health crisis and suicide ideation, but who are not admitted to hospital. 	
Service Agreements	<p><u>Improvement Area 6.</u></p> <ul style="list-style-type: none"> - See NT Plan 	Medium Term 12-36 months
Referral Pathways	<p><u>Improvement Area 7.</u></p> <p>In developing <i>Health Pathways</i> in the Darwin region, NT PHN to consider inclusion of:</p> <ul style="list-style-type: none"> - Community-based mental health and suicide prevention services - Supports for carers, including respite, peer support, psycho-education and counselling services. - Linkage to the Digital Gateway to facilitate referral to digital therapies 	
Mental Health and Suicide Prevention Service Directory	<p><u>Improvement Area 8.</u></p> <ul style="list-style-type: none"> - NT PHN to continue working with NTG, the NGO sector and Darwin City Council to develop a comprehensive on-line service directory that is publicly available, with long-term funding allocated to its development and ongoing maintenance. - Explore potential to adapt health pathways 	
Transport	<p><u>Improvement Area 9.</u></p> <ul style="list-style-type: none"> - In service commissioning process, there is a need to consider whether services are accessible by public transport. 	
Peer Support	<p><u>Improvement Area 10.</u></p>	

Priority Area	Regional Improvement Plan – Darwin Region	Time Frame
	<ul style="list-style-type: none"> - A peer support workforce development strategy is needed to expand the peer support workforce and establish peer-support workers within hospital and community settings. 	
Suicide Prevention: LGBTI community	<p><u>Improvement Area 11.</u></p> <ul style="list-style-type: none"> - Undertake research into experiences of LGBTI people in accessing mental health and suicide prevention services in the Darwin region. Territory Rainbow may be well placed to undertake this work 	
SEL Curriculum	<p><u>Improvement Area 12.</u></p> <ul style="list-style-type: none"> - NT Primary Health Network (NT PHN) to seek an update from the Department of Education on the roll-out of the Social and Emotional Learning Curriculum, to ascertain the degree to which young people engaging and benefiting from the curriculum in each of the 6 regions for education in the NT. NT PHN may have a role to play in disseminating evaluation findings to community-based mental health providers. 	
Continuity of care	<p><u>Improvement Area 13.</u></p> <ul style="list-style-type: none"> - Further research may be needed to understand the ageing carer demographic in the Darwin region and the implications that the reduction in capacity to provide care will have on people receiving care from ageing parents. Continued access to public housing for people in the care of a parent with public housing tenancy is a key concern. 	Long-Term 1-5 years
Suicide Prevention: LGBTI community	<p><u>Improvement Area 14.</u></p> <ul style="list-style-type: none"> - See NT System Improvement Plan 	
GP training	<p><u>Improvement Area 15.</u></p> <ul style="list-style-type: none"> - See NT System Improvement Plan 	
Aboriginal Mental Health Workforce	<p><u>Improvement Area 16.</u></p> <ul style="list-style-type: none"> - See NT System Improvement Plan 	
NDIS/Low barrier to entry services	<p><u>Improvement Area 17.</u></p> <ul style="list-style-type: none"> - See NT System Improvement Plan 	

1.3 Alice Springs Urban, Central Australia Northern, Southern and Central Districts

1.3.1 Regional needs, priorities and opportunities

Stakeholder Perspectives	Regional needs and opportunities for system improvement
Priority Area: Service availability	
<p>Identified gaps in service availability include:</p> <ul style="list-style-type: none"> - Severe shortfalls across primary, secondary and tertiary mental health services. - A severe shortfall of GPs and gaps in Primary Health Care services, across the regions. Existing primary health providers have very little capacity to manage mental health due to the extreme incidence of chronic disease across the regions. - Only two service providers deliver services under ATAPS. - An absence of youth mental health services outside of Alice Urban (with the temporary closure of MOS Plus). - A lack of forensic mental health services. - Providers report pressure to 'be doing more with less', with a common perception that mental health funding from the NT Government Department of Health is gradually being reduced and is significantly below parity with other parts of Australia. Providers also report referrals increasing by up to 10% per year. - The mental health system has little capacity to provide low-intensity mental health services and meaningful support to people with low-level anxiety and depression disorders. 	<ul style="list-style-type: none"> - Significant gaps in service availability were described across the Central-Northern, Central-Central and Central-Southern Districts and, to a lesser degree, Alice Springs Urban. Service delivery was reported to occur in the context of significant economic and social disadvantage, including high rates of unemployment, low-incomes, homelessness and domestic and family violence. - Formal mental health care in remote communities is extremely limited, particularly LIMHS. - Primary Health Care (PHC) providers in remote areas have little capacity to provide mental health care due to workload related to the prevalence of chronic disease.
Priority Area: Triage, Assessment and Referral Pathways	
<ul style="list-style-type: none"> - An over-reliance on a small number of GPs to triage, assess and refer people on to other mental health services creates a bottleneck for many people when seeking mental health treatment for the first time. - Lack of GP training in mental health, coupled with high turnover and limitation in GP awareness of the broader sector can lead to use of pharmacotherapy as a first resort for treatment and restricts referral to the broader community sector. - Reliance on formal diagnosis of mental illness is a barrier to accessing treatment for many people with mental health issues, across the regions. 	<ul style="list-style-type: none"> - Mandatory training for GP's in mental health, trauma-informed care and dual diagnosis is essential in improving primary mental health care in central Australia

Stakeholder Perspectives	Regional needs and opportunities for system improvement
<ul style="list-style-type: none"> - Effective mental health assessment and triage for Aboriginal people relies on specific expertise in differential diagnosis, use of culturally appropriate assessment tools and establishing a culturally safe environment. - The triage system needs to be better resourced: particularly in conducting Aboriginal mental health assessments. - Reliance on English language in mental health assessment and treatment is a barrier. Interpreters and culturally appropriate assessment tools are essential for effective, equitable mental health care for Aboriginal people. 	
<p>Priority Area: Social stigma</p>	
<ul style="list-style-type: none"> - In some cases, GP’s were reported to exacerbate stigma around mental health by advising patients to avoid noting mental health issues in their records, to prevent discrimination in accessing future episodes of health care, or in requiring medical leave from their workplace. 	<ul style="list-style-type: none"> - Mandatory training for GP’s in mental health, trauma-informed care, Aboriginal mental health assessments and dual diagnosis is essential in improving primary mental health care.
<p>Priority Area: Program Funding</p>	
<ul style="list-style-type: none"> - Uncertain, short-term funding destabilises the establishment and consolidation of mental health services. This funding approach entrenches the priorities of funders in service delivery, overlooking the needs of local communities. - Complex reporting processes that often include satisfying the requirements of multiple funders (involving doubling up of client data collection), impacts on service delivery by diverting time energy away from person-centred care, to data collection and reporting. - There is a lack of funding for formal evaluation of programs/services. - A funding model that promotes integration and collaboration is essential to improving service coordination and outcomes for participants. The existing model of competitive tendering promotes competition between providers: ‘silo’ service delivery, a reluctance to share resources and approaches to practice. - Short term funding is prone to discontinuation for political reasons following the election cycle. This inhibits program development, staff retention and doesn’t allow for long term, longitudinal planning and development. 	<ul style="list-style-type: none"> - There is a need to streamline and simplify data collection processes required of mental health service providers. - Funding for evaluation of innovative mental health services and programs is essential to building an evidence base around approaches that are effective and sustainable. - Five-year funding is essential to the development and consolidation of mental health programs, staff retention and development, longitudinal organisational planning.

Stakeholder Perspectives	Regional needs and opportunities for system improvement
<ul style="list-style-type: none"> - Slow or delayed release of funding inhibits implementation of projects and back loads program spending. This puts immense pressure on service providers and interferes with program delivery. 	
<p>Priority Area: Context of service delivery</p>	
<ul style="list-style-type: none"> - The regional primary health care system and mental health care systems were reported to experience significant challenges in engaging with Aboriginal people in the region, including: <ul style="list-style-type: none"> - Geographical remoteness, extreme weather and sparse population sizes results in a preponderance of infrequent fly-in-fly-out health service delivery. - Cultural and linguistic diversity: diversity of cultural beliefs and attitudes to health/mental health care present unique challenges to the provision of culturally responsive mental health care. - Hospitals and associated processes and assessments can be alienating environments for many Aboriginal people. - There is a sense that qualitative, narrative data is under-valued and under-collected in mental health service data collection practices. 	<ul style="list-style-type: none"> - Given the demographic uniqueness of the NT, qualitative data should be highly valued and continue to be sought in future needs' assessment activities. - Community development and capacity building approaches/programs are essential to addressing the context of social disadvantage that impacts mental health issues. - The non-Aboriginal NGO sector is a major provider of mental health and SEWB services to Aboriginal people in central Australia and requires ongoing support around culturally appropriate service delivery. - Partnerships between non-Aboriginal community mental health services and the ACCHO sector may present opportunities to build the capacity of community mental health sector to provide culturally responsive services.
<p>Priority Area: Service coordination</p>	
<ul style="list-style-type: none"> - The mental health system has limited capacity for follow-up with people with mental health concerns in remote communities - Inconsistent protocols for information sharing are problematic and prevent effective communication between services. - There is need for greater coordination and collaboration between various sectors to provide wrap around support families/communities in the Alice Springs region. - Collaboration between services is critical to maximum utilisation of scarce resources. 	<ul style="list-style-type: none"> - Development of a mental health consortium and network meeting for workers in the Alice urban area may help to improve cross-service collaboration and integration.

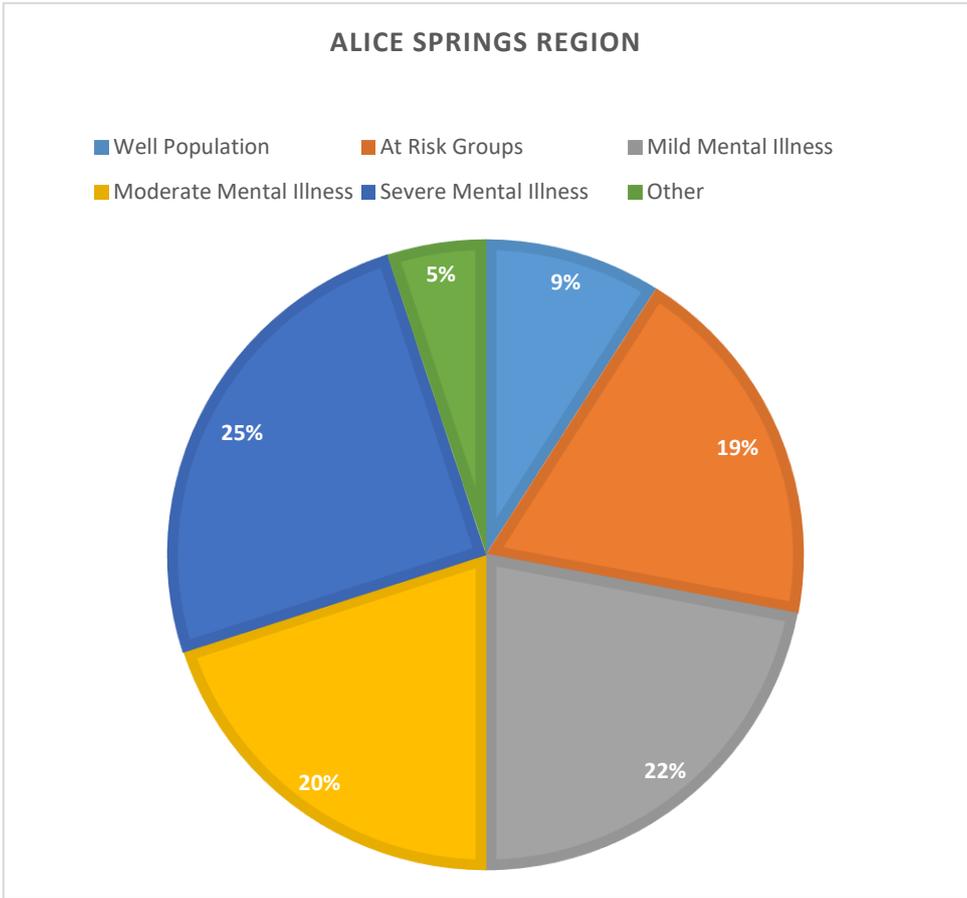
Stakeholder Perspectives	Regional needs and opportunities for system improvement
Priority Area: Digital Therapies	
<ul style="list-style-type: none"> - NT Cattlemen’s Association reports good uptake and utilisation of Mindspot amongst its members. 	
Priority Area: Workforce and Treatment Models	
<ul style="list-style-type: none"> - Recruiting, retaining and providing ongoing professional development opportunities to appropriately qualified mental health staff is an ongoing challenge in the region. Disruption of services due to high staff turnover is common. - Many primary health and mental health services do not receive enough funding to provide a safe, supported working environment for staff. Funding of services should provide for a minimum of two practitioners in all remote locations. - There has been a significant reduction in Aboriginal Health Workers over the past 17 years. The relative absence of AHW across remote communities, has resulted in a lack of status of remaining AHWs and reduction in the amount of investment that non- Aboriginal health staff put into meaningful collaboration with AHWs: this exacerbates a lack of confidence for and respect in AHW roles. - Over-reliance on mainstream qualifications restricts many local Aboriginal people from participation in the mental health workforce. 	<ul style="list-style-type: none"> - Funding agreements should provide for a minimum of two practitioners in all remote locations as a mandatory WHS requirement. - Developing a local mental health workforce in remote communities, through on-the-job training and mentoring is essential to increasing the availability of culturally engaged, low-intensity mental health services in remote communities. This workforce would greatly enhance the cultural responsiveness of higher intensity treatments and of the AOD sector. - Aboriginal communities should be empowered to inform practice standards for outside professionals. This may include establishing indicators of cultural competence, strengths-based practice and approaches to understanding Aboriginal family structures, belief systems and social support systems.
Priority Area: NDIS	
<ul style="list-style-type: none"> - Transition of funding for low-barrier-to-entry programs, such as Day-to-Day-Living and PHaMs, into NDIS will result in the closure of such programs. These are unlikely to be replicated under NDIS: as programs are often attended by early intervention/at risk groups who are ineligible for participation in NDIS, as well as people with severe mental illness. These valuable services require block funding to continue to function. 	<ul style="list-style-type: none"> - Continuation of funding for low-barrier-to-entry programs that support people with mild-moderate mental illness who are unlikely to be eligible for NDIS is essential to maintaining supports for this population group.
Priority Area: Integration of mental health and other sectors – Alice Urban	
<ul style="list-style-type: none"> - Schools are an important space for engagement and monitoring of children and families who are at-risk and/or experiencing mental health problems. However, schools performing this role effectively. - The regional education system is not always aligned to support community inclusion and participation in education. Working to include community members in the day- 	

Stakeholder Perspectives	Regional needs and opportunities for system improvement
<p>to-day operation of local schools can help to promote community wellbeing and, in turn, community mental health.</p> <ul style="list-style-type: none"> - Contact with the justice system can be a barrier to accessing ongoing mental health services and there is a lack of care planning for 18 year olds exiting youth detention and community care. - The adult and youth justice systems lack understanding/engagement with trauma theory and substance use. This entrenches superficial approaches to understanding and addressing complex causes of crime. - A lack of trauma-informed practice amongst Territory Families Child Protection Practitioners results in short-term investigations being resolved without notification or explanation being provided to relevant families. This creates instability and panic within communities and entrenches fear of ‘welfare’ and other service providers and can re-traumatise families who have experienced the removal of children. 	<p>Further investigation into formal care planning processes for young people exiting youth detention and community care is needed to ensure that these young people are adequately supported through these transitions</p>

1.3.2 Stepped Care in the region

Stepped Care involves the stratification of a population into different ‘needs groups’, ranging from whole of population needs for mental health promotion and prevention, through to those with severe, persistent and complex conditions. The following tables show the percentage of total regional services that are delivered to each of these population needs groups.

Table 3: Combined NGO mental health and social and emotional welling service delivery by Stepped Care population group – Alice Urban, Central Australia Northern, Southern and Central Districts*



Source: Mental Health Service Profiles, NTMHC 2017

*Excludes carer supports, referral lines, web-based support platforms, drug and alcohol services and suicide prevention programs/services.

Understanding the regional mental health system through a Stepped Care lens Alice Springs Urban, Central Australia Northern, Southern and Central Districts	
Key components	Discussion of issues
Spectrum of evidence-based services from least to most intensive	<ul style="list-style-type: none"> - Significant gaps in service availability were described across the Central-Northern, Central-Central and Central-Southern Districts and, to a lesser degree, Alice Springs urban. - Lack of 'pull-factors' and increased costs of housing and travel makes recruiting mental health professionals to rural and remote locations a major challenge and underlies the limited range of interventions available in remote contexts. - Providing a range of treatment types from within a single organisation – particularly Aboriginal Community Control Health Organisation's (ACCHO), is the most appropriate model for mental health service delivery in remote contexts. Within a Stepped Care model this may involve small multi-disciplinary teams, including Aboriginal Mental Health Workers, providing a <i>range</i> of tailored interventions that vary in frequency and intensity in response to client need. Such an approach requires diligent monitoring of client needs and adjustment of care based on progress. This simplifies the mechanisms required for adjusting treatment levels as the referral pathways remain internal to the ACCHO. - Providers acknowledge a very limited capacity to treat high-prevalence disorders (particularly anxiety disorders) and support greater resourcing for low-intensity treatment options, particularly for treatment of anxiety and depression. However, they are wary of being pushed to utilise digital therapies that aren't effective or don't meet the needs of local populations. Providers noted that high quality services are just as important for at-risk/mild population groups and stressed the need for comprehensive workforce training and support in the developing LIMHS.
Mechanisms for matching individual need to service level and intensity	<ul style="list-style-type: none"> - Stakeholders report that while service providers at all levels would ideally be able to assess need and refer individuals to appropriate access points, this role requires significant diagnostic expertise. - Lack of GP training in mental health, coupled with high turnover and limitation in GP awareness of the broader sector can lead to use of pharmacotherapy as a first resort for treatment and restricts referral to the broader community sector. - GPs with training and expertise in differential and dual diagnosis are very effective in assessing and matching individual need to service level intensity but are uncommon in central Australia. - Currently there is too high a threshold for access to mental health services, with the system requiring people to become significantly distressed or unwell before receiving access to treatment and an over-reliance on a small number of GPs to triage, assess and refer people on to other mental health services. This also creates an access bottleneck for many people when seeking mental health treatment for the first time. - Reliance on formal diagnosis is a barrier to accessing treatment for many people with mental health issues, across the regions. - Effective mental health assessment and triage for Aboriginal people relies on specific expertise in differential diagnosis, use of culturally appropriate assessment tools and establishing a culturally safe environment. - The triage system needs to be better resourced: particularly in conducting Aboriginal mental health assessments. - Reliance on English language in mental health assessment and treatment is a barrier. Interpreters and culturally appropriate assessment tools are essential for effective, equitable mental health care for Aboriginal people.

Understanding the regional mental health system through a Stepped Care lens Alice Springs Urban, Central Australia Northern, Southern and Central Districts	
Processes for monitoring progress and adjusting level according to need	<ul style="list-style-type: none"> - Effective mental health assessment and triage for Aboriginal people relies on specific expertise in differential diagnosis, use of culturally appropriate assessment tools and establishing a culturally safe environment. - The triage system needs to be better resourced: particularly in conducting Aboriginal mental health assessments. - Reliance on English language in mental health assessment and treatment is a barrier. Interpreters and culturally appropriate assessment tools are essential for effective, equitable mental health care for Aboriginal people.
Clear pathways for moving between services providers and levels	<ul style="list-style-type: none"> - Services need to have flexibility to support people through peaks and troughs of wellness. Eligibility guidelines that are too restrictive risks disruption of care for people with mental illness. The impact of premature referral, including inefficiencies related to additional intake and assessment processes, and building new therapeutic relationships with another service provider need to be considered when referring an individual to a different service level.
Capacity to monitor system as a whole	<ul style="list-style-type: none"> - Stakeholders raised questions around the role of a central agency in taking responsibility for monitoring client flows and outcomes. Stakeholders would benefit from more information from the NT PHN about which components of the Stepped Care model are likely to be emphasised and resourced in the NT, in order to further inform effective and appropriate application of resources.
Stepped Care Principles	<p>Given the relatively small, highly dispersed and culturally and linguistically diverse population of the NT, there are questions as to the suitability of the Stepped Care model for the NT.</p> <p>The following principles were considered to be essential in moving towards a Stepped Care model in the NT:</p> <ul style="list-style-type: none"> - Human Rights (e.g. right to housing, safety and respect) requirement to be imbedded in service delivery. - Analysis of data in ways that is meaningful in the context of the NT's unique demography. - Flexibility in providing inclusive access to support. - Strengthening local support systems by recognising, respecting and building upon local approaches. - Prevention-focussed activities need to be prioritised. - Wrap around care approaches to be prioritised. - Innovation in service delivery to meet client need rather than being exclusively fixed by funding guidelines. - Genuine empowerment of Aboriginal boards of governance to determine service delivery priorities. - Person-centred practice to be at the core of all service delivery. - Resourcing for increased cultural competency amongst non-Aboriginal mental health professionals. - Recognising traditional healers as being central to maintaining and improving mental health for Aboriginal people in Central Australia. - Long-term funding to ensure consolidation and effectiveness of mental health, SEWB and suicide prevention programs. - Funding for meaningful evaluation of mental health, SEWB and suicide prevention programs.

1.3.3 Regional suicide prevention system

Suicide Prevention – Alice Springs Urban, Central Australia Northern, Southern and Central Districts Consultation Outcomes		
Intervention Area	Stakeholder perspectives	Needs and Opportunities
UNIVERSAL INTERVENTIONS Primordial prevention Gatekeepers/Local Go to people	<ul style="list-style-type: none"> - Universal, primordial preventions within Aboriginal communities were described to include a range of activities, programs and sectors that sit alongside designated mental health and suicide prevention programs. These included; the youth sector, AOD services, family violence services, housing services, parenting and early childhood supports, schools and frontline responders. - Locally developed and driven primordial preventions, such as Suicide Story, are invaluable and require long-term, secure funding. This will increase the capacity for promotion and delivery to Aboriginal communities outside of central Australia. - Recognition of the skills and centrality of Ngangkari to SEWB/mental health care and suicide prevention for Aboriginal people in Central Australia is essential to improving mental health outcomes. Ngangkari are often the first point of contact and help-seeking for families when a family member is unwell. 	<ul style="list-style-type: none"> - Acknowledgement of the intergeneration trauma and socio-economic disadvantage experienced by many communities in Central Australia was described as an important starting point in conceptualising suicide prevention. - Improving the social determinants of health within communities, through strengths-based, community-empowerment approaches, was noted to be critical to strengthening the social, emotional and spiritual wellbeing of communities, and reducing suicide risk.
SELECTIVE – AT RISK GROUPS Mental health literacy	Key factors in effective interventions for young people at risk of suicide were described to involve: <ul style="list-style-type: none"> - Development of strengths-based resources and programs that guide people towards normative social and emotional development and strengthens cultural identity - Strength-based projects that foster mental health and suicide prevention literacy and vocabulary, and normative behaviours around help-seeking. 	

Suicide Prevention – Alice Springs Urban, Central Australia Northern, Southern and Central Districts Consultation Outcomes	
<p>INDICATED – AT RISK INDIVIDUALS</p>	<p>There is an identified need for increasing supports provided to families and carers following a person attempting suicide.</p> <ul style="list-style-type: none"> - Capacity-building of GP’s and hospital staff to provide high quality after-care resources linkages to other supports is essential to effectively supporting families following suicide attempts, including provision of basic instructions and information for parents to support a child who has recently attempted suicide. - There is a need for a facility in Alice Springs to support high risk youth who present to ED in heightened state of crisis/suicidality, who do not require admission, but who are in need of a safe, therapeutic space in which to stabilise.
<p>COMMON ELEMENTS</p> <p>Data sharing</p>	<ul style="list-style-type: none"> - Privacy and consent protocols often impact on effective communication between police, hospitals the coroner and mental health service providers following completed suicides. This restricts capacity for coordinated service responses, running the risk of service providers inadvertently re-traumatising families and carers due to being unaware of a recent death.
<p>SAFETY NETS</p> <p>Cross-agency collaboration</p>	<ul style="list-style-type: none"> - There is an identified need for a ‘soft-exit’ facility in Alice Springs for people experiencing a mental health crisis and suicide ideation, but who are not admitted to hospital. - Low-intensity service in which to stabilise and - Capacity-building of GP’s and hospital staff is needed increase provision of quality after-care resources linkage to community services essential to effectively supporting families following suicide attempts, including provision of basic instructions and information for parents to support a child who has recently attempted suicide. - Issues around protocols on information-sharing protocols follow - NT Primary Health Network (NT PHN) to take the lead in to explore reform to protocols around to increase capacity of NGO sector to work with NT Government, Deliver guidance to the NGO sector around - The development of a mental health consortium and network meeting for workers in the Alice Urban area may help to improve cross-service collaboration and integration.

1.3.4 Regional improvement plan

Priority Area	Regional Improvement Plan – Alice Springs Region	Time Frame
Service Funding and WHS	<u>Improvement Area 1.</u> - Funding agreements should provide for a minimum of two practitioners in all remote locations as a mandatory WHS requirement.	Immediate 12 months
Suicide Prevention Evaluation	<u>Improvement Area 2.</u> - See NT System Improvement Plan	
Suicide Prevention/Carer Support	<u>Improvement Area 3.</u> - A review of the psycho-educational and support resources provided to carers following admission, discharge or presentation of care recipients from Alice Springs Hospital, Mental Health Assessment Team and Central Australian Team is needed to better equip carers in caring for a loved one who is unwell. This review should inform an action plan to standardise provision/linkage to psycho-educational resources for carers following acute episodes of mental illness and/or suicidal ideation of care recipients.	
Referral Pathways	<u>Improvement Area 4.</u> In development of <i>Health Pathways</i> in the Alice Urban region, NT PHN to consider inclusion of: - Community-based mental health and suicide prevention services - Supports for carers, including respite, peer support, psycho-education and counselling services. - Linkage to the Digital Gateway to facilitate referral to digital therapies	Medium Term 12- 36 months
Suicide Prevention: 'Soft-exit' facilities	<u>Improvement Area 5.</u> NT PHN to work with NT Department of Health to explore models for a 'soft-exit' facility in Alice Springs for people experiencing a mental health crisis and suicide ideation, but who are not admitted to hospital.	
GP Training	<u>Improvement Area 6.</u> - See NT System Improvement Plan	Long Term 1-5 years
Aboriginal Mental Health Workforce	<u>Improvement Area 7.</u> - See NT System Improvement Plan	
NDIS/Low barrier to entry services	<u>Improvement Area 8.</u> - See NT System Improvement Plan	

1.4 Barkly Region

1.4.1 Regional needs, priorities and opportunities

Stakeholder Perspectives	Regional needs and opportunities for system improvement
Priority Area: Service Availability	
<ul style="list-style-type: none"> - Two mental health nurses cover the entire Barkly region, with a resultant wait time for assessment/treatment of 6-7 weeks in many remote communities. - Community awareness of services is a barrier to engagement (in places where services are available). - Gaps exists in supports for victims of crime, who are often at risk of, or presenting with symptoms of severe mental health problems. - There is a lack of specialised mental health services for children under 12 across the NT. - Significant wait times at Tennant Creek hospital result in patients leaving before receiving assessment/treatment. - GP waiting period of two weeks. - Local AOD services also working at full capacity. - Due to lack of services, practitioners are compelled to expand the scope of their role and draw on different modalities (e.g. AOD and trauma therapy counselling) in order to respond to need. - Gaps in availability of counsellors in trauma therapy, with support often focused on 'band-aid' solutions. - PHaMs is an important program but does not have capacity to respond to the basic physiological needs of the local population, which often go unmet. 	<ul style="list-style-type: none"> - Numerous remote communities in the Barkly have inadequate access to mental health treatments, from high to low intensity.
Priority Area: NDIS	
<ul style="list-style-type: none"> - PHaMs has had the flexibility to support people with complex needs. As PHaMs funding is reduced, service gaps are emerging for people with complex support needs who are ineligible for NDIS, (which is restricted to people with severe and complex mental illness). - Decreasing funding for PHaMs programs has put additional caseload pressure on fewer workers. - NDIS assessors highlights a greater understanding of physical disabilities that are visible, than of psychiatric disability. - Significant language barriers exist for Aboriginal and Torres Strait Islander population in accessing NDIS. 	<p>PHaMs or a similarly low-barrier-to-entry requires an expansion of on-going funding to support people with complex needs.</p> <p>Training for NDIA staff around psycho-social disability.</p> <p>Interpreters should be used in all support planning.</p>

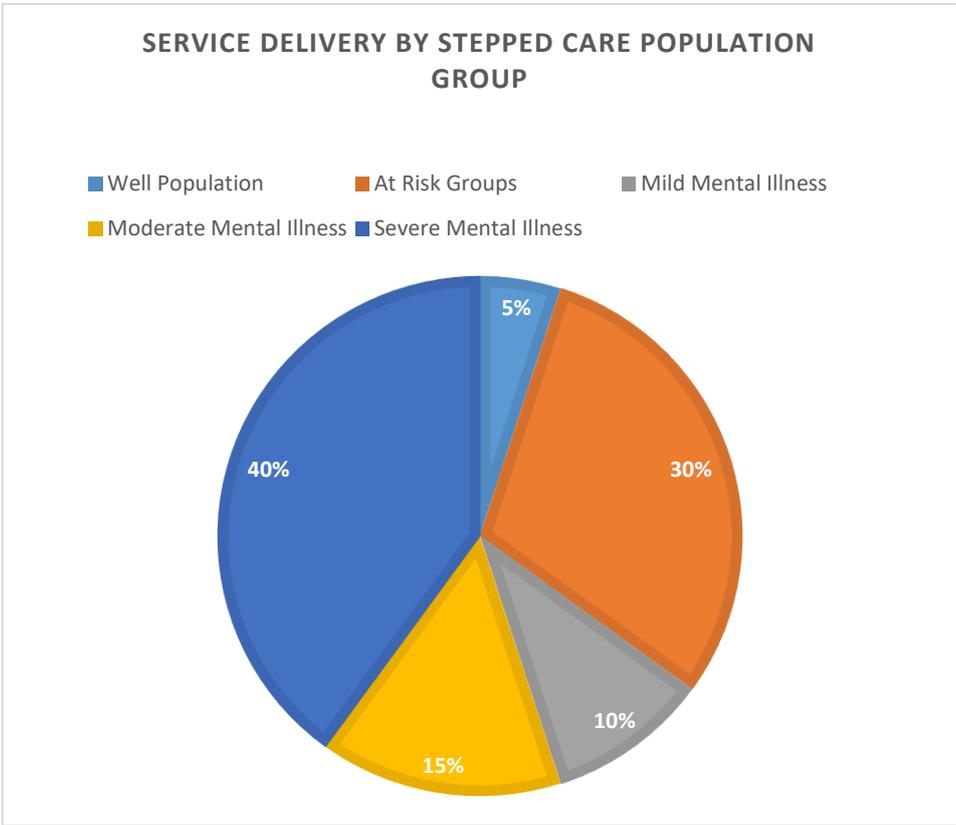
Stakeholder Perspectives	Regional needs and opportunities for system improvement
<ul style="list-style-type: none"> - Lack of availability of services and transport to services undermines choice and control for people accessing NDIS. - NDIS assessment process is inadequate; a lack of recognition of GP assessment skills and a limited access to neuropsychiatric assessment exacerbates restriction of access to NDIS for people with psychiatric disability. - Gaps in funding for advocacy within NDIS plans is alarming as many people with psychiatric disability require support to identify and articulate their needs. 	<p>NDIS to re-assess the role of advocacy in developing adequate support plans.</p> <p>Within remote areas, there need to be access to neuropsychiatric.</p>
<p>Priority Area: Program Funding</p>	
<ul style="list-style-type: none"> - Greater emphasis on performance monitoring and outcome measurement in funding agreements is necessary to ensure service providers are performing appropriately. - Redirection of funding to alternative providers can disrupt provider knowledge of referral pathways and inhibit client engagement after seeking support from a provider that has been defunded and no longer offers a service. 	<ul style="list-style-type: none"> - Funders should continue to consult at a local level around needs before commissioning of services. - Need for increased transparency in decision-making around commissioning of services.
<p>Priority Area: Continuity of Care</p>	
<ul style="list-style-type: none"> - When a person presents to Emergency Department in crisis, and is not admitted to the mental health unit, there is a lack of communication between hospital and community-based mental health providers, and the hospital social worker, (unless requested by the patient). - A youth provider network forum is now in operation in Tennant Creek, which is helping community service coordination around at-risk youth. - An ongoing tension exists between the privacy of individuals and the need for providers to share information about people who are at risk. Additional complexity of people feeling that their privacy is at risk when a family member works at the service they access. 	<ul style="list-style-type: none"> - NT PHN to emphasise information service coordination between services in contracts with providers – to facilitate better discharge planning.
<p>Priority Area: Workforce issues</p>	
<ul style="list-style-type: none"> - Staff retention a significant challenge: high turnover of medical staff results in discordant approaches to care. This inhibits client engagement due to; having to repeat personal story multiple times; being confronted by changeable patterns of cultural competence in staff and being mistrustful/unwilling to engage due to perception that the staff member's departure is imminent. - Rates of staff burnout are high due to workload and relative isolation of positions. - Support amongst professionals around vicarious trauma and stress is often informal and dependent on individuals rather than formal structures and policies. 	<ul style="list-style-type: none"> - High levels of staff turnover and high cost of recruitment is an ongoing workforce challenge for the mental health sector.

Stakeholder Perspectives	Regional needs and opportunities for system improvement
<ul style="list-style-type: none"> - Requirements for gender-specific positions are a challenge vis-à-vis recruitment. - High levels of staff turnover and high cost of recruitment is an ongoing workforce challenge for the mental health sector. 	
<p>Priority Area: Social Determinants of Health</p>	
<ul style="list-style-type: none"> - Significant number of children in the region have a history of trauma, often unrecognised and untreated. - Many children sniff petrol to stay warm, stay awake and decrease hunger. - Overcrowding in Tennant Creek is a major issue (often up to 18 people living in one house). This leads to increased exposure to family violence. - There is an extreme lack of access to affordable housing in the Barkly region, pushing many people into the regional centre, away from their home community. - A cycle of violence and fighting exists in many communities: lack of respite/spaces away from conflict are barriers to breaking the cycle. - Significant social pressure exists within over-crowded households to take part in drinking alcohol. Alcohol is also used as a way to cope with over-crowding and noise. - Groups of elderly people in Tennant Creek are regularly sleeping outdoors to avoid alcohol and violence. - Significant shortfalls in availability of holistic youth programs, drop-in centres, employment opportunities, DV reduction programs and supports. 	
<p>Priority Area: Disability and Health needs</p>	
<ul style="list-style-type: none"> - High rates of FASD are likely to increase due to heavy alcohol use amongst young parents. 	
<p>Priority Area: Community Capacity Building</p>	
<ul style="list-style-type: none"> - Investment in time and relationships between communities and service providers is key to the efficacy and sustainability of mental health literacy programs. These programs need to be developed in partnership with communities and build on strengths and knowledge base of each community. 	

1.4.2 Stepped Care in the region

Stepped Care involves the stratification of a population into different ‘needs groups’, ranging from whole of population needs for mental health promotion and prevention, through to those with severe, persistent and complex conditions. The following tables show the percentage of total regional services that are delivered to each of these population needs groups.

Table: Combined NGO mental health and social and emotional welling service delivery by Stepped Care population group – Barkly District*



Source: Mental Health Service Profiles, NTMHC 2017

*Excludes carer supports, referral lines, web-based support platforms, drug and alcohol services and suicide prevention programs/services.

Understanding the regional mental health system through a Stepped Care lens Barkly region	
Key components	Discussion of issues
Spectrum of evidence-based services from least to most intensive	<ul style="list-style-type: none"> - Numerous remote communities in the Barkly have inadequate access to mental health treatments, from high to low intensity. - Some services are overwhelmed, have reached capacity and/or are not receiving the funding necessary to develop resources to support their work. - Service providers frequently respond to needs beyond the scope of their funding: such as providing food and clothing to participants. - Low-level anxiety and depression are extremely common yet there is a significant lack of capacity in the sector to respond, which is compounded by the prevalence of people's basic physiological needs going unmet.
Mechanisms for matching individual need to service level and intensity	<ul style="list-style-type: none"> - Existing service delivery is largely crisis driven and 'scrambles' to support the basic needs of participants. Significant wait times for access to services results in a system where providing any level service provision is considered better than nothing, with tailored service delivery beyond the capacity of most services.
Processes for monitoring progress and adjusting level according to need	<ul style="list-style-type: none"> - A highly mobile population present challenges around service coordination, follow-up and continuity of care. - High levels of chronic stress and exposure to acute stressors often results in rapid deterioration in people's mental health. - Due to lack of services, practitioners are compelled to expand the scope of their role and draw on different modalities (e.g. AOD and trauma counselling) in order to respond to need.
Clear pathways for moving between services providers and levels	<ul style="list-style-type: none"> - Service mapping is valuable in increasing awareness of providers of referral pathways; however, service footprints frequently change due to funding cuts and changes. Redirection of funding from one organisation to another impacts on engagement of participants and a providers capacity to refer. Onward referral can also damage future engagement when a strong therapeutic relationship has been built.
Stepped Care Principles	<ul style="list-style-type: none"> - Stakeholders assert that the high prevalence of chronic stress; unmet physiological and safety needs, and exposure to grief, loss and trauma amongst the population means the entire region is considered at-risk of developing mental illness.

1.4.3 The regional suicide prevention system

Suicide Prevention – Barkly Consultation Outcomes	
Intervention Area	Stakeholder Perspectives
UNIVERSAL INTERVENTIONS Primordial prevention Gatekeeper training/Go to people	<ul style="list-style-type: none"> - Suicide Story has had a strong connection to the Barkly region but no longer has a permanent presence in the region. Connections with each community are essential to the delivery of the program. A train-the-trainer approach ensures those who have participated take on training roles in their communities. - Suicide Story aims to reduce the need to remove people at risk of suicide from their community by providing people with the skills, confidence and ability to deal with attempted suicides or suicide ideation. - Partnerships between MHACA (host of Suicide Story) and other organisations are needed to expand relationships with communities and promote the program - Mental health and well-being programs in school vary widely and lack coordinated implementation. - Aboriginal health workers are often first point of contact for people experiencing suicidal ideation. - There is value in teachers completing ASIST training to improve skills in identifying warning signs.
SELECTIVE – AT RISK GROUPS	<ul style="list-style-type: none"> - Providers find it almost impossible to determine who is likely to attempt suicide. People who are talking about suicidal ideation are generally looking for help. Those who do complete suicide are typically those that don't ask for help and then follow through. - Funding for the Standby program has been redirected through national channels. Referrals for Standby now needs to go through these national channels, which can be a barrier due to the lack of relationships with providers on the ground. Standby is less responsive as a result.
INDICATED – AT RISK INDIVIDUALS	<ul style="list-style-type: none"> - There is a gap in follow-up up after suicide attempts in instances where a person presents to hospital in crisis but is not admitted. - Longer term/ongoing treatment is under-funded, resulting in inadequate relapse prevention and increased suicide risk. - Reduced funding to the regional public mental health service has resulted in significant reduction of remote visits by the service. Service provision in remote communities is now approximately once every 3 months.
COMMON ELEMENTS	<ul style="list-style-type: none"> - In Aboriginal and Torres Strait Islander communities within the region, mental health, suicide prevention and crisis teams are only effective when they are invited in to the community: the public mental health service has worked hard to build rapport and relationships to facilitate such invitations and do not enter a community after a completed suicide unless they have been invited. - There is a lack of appropriate resources for teachers and family members to use following suicide. - A lack of accessible data on suicides in the NT is a barrier to developing better understanding of approaches to prevention, triggers for attempts and the role of supports and follow-up care that may have been in place prior to suicide. - Confidentiality issues are a priority but improved data collection around suicide is needed to better inform service delivery.

**Suicide Prevention – Barkly
Consultation Outcomes**

- Informal information sharing is currently the norm in cross-organisational communication around suicide and suicide prevention in lieu of formal channels.
- There is no process for relaying information to other providers when a person presents to hospital with suicidal ideation and is not admitted. This results lack of follow-up/ support for people at-risk of suicide/experiencing suicidal ideation.

1.4.4 Regional improvement plan

Priority Area	Regional Improvement Plan – Barkly Region	Time Frame
NDIS/Low barrier to entry services	Improvement Area 1. - See NT System Improvement Plan	Immediate
Suicide Prevention: Partnership	Improvement Area 2. NT PHN to facilitate partnership arrangements between MHACA (host of Suicide Story) and organisations based in areas where MHACA is not located, to expand relationships with communities and promote the Suicide Story regionally.	Medium-Term 12-36 months
Suicide Prevention	Improvement Area 3. - NT PHN to explore the development of a strategic plan for a systems-based approach to suicide prevention in the Barkly region, inclusive of a training plan for front-line community services	
GP Training	Improvement Area 4. - See NT System Improvement Plan	Long Term (1-5 years)
Aboriginal Mental Health Workforce	Improvement Area 5. - See NT System Improvement Plan	
NDIS/Low barrier to entry services	Improvement Area 6. - See NT System Improvement Plan	
Child and Adolescent Services	Improvement Area 7. - Long-term planning is needed to establish a Child and Adolescent mental health services in the Barkly region.	

1.5 Katherine Region

1.5.1 Regional needs, priorities and opportunities

Stakeholder Perspectives	Regional needs and opportunities for system Improvement
Priority Area: Service Availability	
<p>Stakeholders identified a range of gaps in service availability and capacity within the region, including:</p> <ul style="list-style-type: none"> - Little capacity to provide tertiary care and mandated treatment for people in remote communities with severe mental illness. - Lack of male counsellors for men/men’s behaviour change groups are needed to increase accessibility of services for men experiencing mental health issues or who are perpetrating family violence. - An absence of bulkbilling GP’s in Katherine township limits access for non-Aboriginal people who cannot access Wurli-Wurliinjang and cannot afford a private GP. - Need for peer-based women’s groups (e.g. GROW). - Need for supported accommodation for people living with severe and persistent mental illness. Women with mental illness are ineligible for access to the Women’s Shelter unless they are experiencing family violence. - Need for specialised services for young LGBTI people and upskilling of all existing service providers around engagement and responsiveness to LGBTI people. - Need for trauma-informed training for all providers. - Absence of youth and adolescent services. - Need for weekend, out-of-hours and on-call crisis support services. - Need for locally-based, trauma-informed mental health care for Australian Defence Force personnel affected by trauma. - People with personality disorders continue to face stigma and an absence of services with specific expertise in treating personality disorders. - Need for more rehabilitation beds for people with AOD issues. - Need for locally-based psychologists, as there is over reliance on accessing services in Darwin. - Needs around health promotion regarding the impacts of AOD use on mental health. 	<p>Significant gaps in service availability were described across a range of service types, affecting a range of population groups in the Katherine region, including:</p> <ul style="list-style-type: none"> - Bulk Billing GPs - Counselling services for men - Youth and Adolescent services - Out-of-hours services - Domestic/family violence counselling

Stakeholder Perspectives	Regional needs and opportunities for system Improvement
<ul style="list-style-type: none"> - Need for a step-up, step-down facility to minimise and prevent time spent away from home/in hospital. - Lack of domestic violence (DV) counselling has resulted in Wurli-Wurlinjang Aboriginal Health Service filling a gap in DV/FV (family violence) counselling for which it is unfunded. - Lack of full-time counsellors in schools. 	
Priority Area: Service Coordination	
<ul style="list-style-type: none"> - Regular multi-agency meetings in Katherine are well attended and foster awareness, engagement and pathways between providers. However, barriers to service coordination persist including high staff turnover and consequent shifts in organisational cultures around collaboration with other providers. - There is a lack of integration and coordination of mental health and AOD services in the region. Inflexible funding arrangements can result in misaligned aims and adversarial approaches to service provision: including restrictive intake processes that result in people being shuttled between providers while trying to access supports. - Integration of mental health and aged care services needs to be improved. - Some stakeholders observed that NTG Mental Health Services and ACCHO's often do not engage/collaborate well. This was noted to relate to the vastness of the region KMHS is required to service, and to a lack of clear process around referral and follow-up between ACCHO's and the KMHS. - Services in the Katherine region, supported by Katherine town council, have developed a service directory for the region. 	<ul style="list-style-type: none"> - Developing Key Performance Indicators around integration of service provision, and specific mental health quality improvement processes in Aboriginal Mental Services (AMS) service standards may improve intra and cross-sector integration.
Priority Area: Information exchange between service providers	
<ul style="list-style-type: none"> - My ehealth Record NT is an effective tool for tracking client journey in the region - Stigma around blood-borne viruses (BBV) can be a barrier to accessing multiple services where there is a requirement for people with a BBV virus to disclose their medical information to a new provider. Reduction of this stigma is essential to increasing the accessibility and safety of services for people with BBV. 	<ul style="list-style-type: none"> - Maintaining safeguards around sharing information is a key challenge in service coordination. Differing protocols amongst providers around obtaining consent to share information inhibit efficient information-sharing between services.
Priority Area: Funding of mental health and Primary Health Care services	
<ul style="list-style-type: none"> - Stakeholders reported that competitive tendering processes pit Aboriginal Community Control Health Organisations (ACCHO) against national NGOs, which are better resourced to 	<ul style="list-style-type: none"> - Competitive tendering can obscure the realities of on-the-ground needs, skills and resources. Collaborative

Stakeholder Perspectives	Regional needs and opportunities for system Improvement
<p>pursue tenders. This has resulted in ACCHOs losing out on funding and staff and undermines the ACCHO sector. Cross-cultural engagement skills and the value of existing relationships between providers and communities are difficult to assess through grant application processes.</p> <ul style="list-style-type: none"> - Territory and Commonwealth Governments are more inclined to fund programs than infrastructure, meaning that services are often lacking appropriate facilities. - High staff turnover within funding bodies make relationships and agreements around use of funding difficult to maintain over time. 	<p>approaches between funders and services to understand need and the effective mobilisation of local resources and capacity is preferable.</p> <ul style="list-style-type: none"> - Co-design of services that closely involves remote providers is essential to the development of programs and services that are; responsive to local culture and need, build local capacity for service provision, utilise local resources, are cost-effective, sustainable and can be utilised in a timely manner. - Local providers are well placed to understand challenges around recruitment and retention. - The Aboriginal Peak Organisation NT (APONT) Partnership Principles provide an important framework through which Aboriginal Community Control Health Organisations (ACCHO) and community mental health services can work together to build the capacity of the ACCHO sector and delivery high quality services to Aboriginal people.
<p>Priority Area: Referral Pathways</p>	
<ul style="list-style-type: none"> - Entry point to mental health services often occurs through community services rather than through GPs. Good work is being done to ensure that community groups are aware of mental health and suicide prevention services available in the region. - The absence of a bulk billing GP in Katherine limits access to a GP for non-Aboriginal people. GP's are a vital screening and entry point to treatment for people experiencing mental health issues/mental illness. 	<ul style="list-style-type: none"> - Better integration of the district's three Aboriginal Medical Services (AMS) is a key challenge in improving continuity of care in the district. - The absence of a bulk-billing GP presents a major need for the Katherine population. - The Digital Gateway will be an essential filter for directing users to appropriate digital mental health services.
<p>Priority Area: Population needs & social determinants of health</p>	
<ul style="list-style-type: none"> - Overcrowding in housing is common and has extremely negative impacts on people's mental health and wellbeing - Family violence affects many Aboriginal women and families across the district and has significant impact on the mental health and suicide risk of the population. 	<ul style="list-style-type: none"> - Strengths-based, community-empowerment policies and approaches are central to improving the social determinants of health within regional communities. All

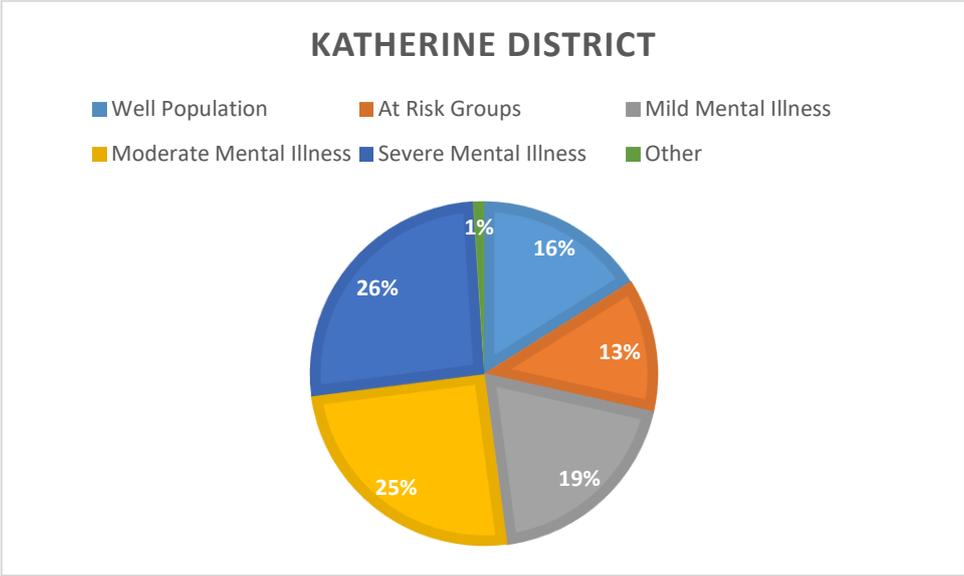
Stakeholder Perspectives	Regional needs and opportunities for system Improvement
<ul style="list-style-type: none"> - There is a lack of public housing available for people with severe, complex and persistent mental illness. - Katherine’s migrant population has risen from 5% to 30% but the service system has little expertise in the provision of CALD mental health services. - Centrelink/CDP requirements of 25 hours work per week causes significant stress and financial hardship for Aboriginal people who have cultural obligations which must be prioritised ahead of Centrelink requirements. This has resulted in numerous people being cut-off from Centrelink, adding the burden of financial stress experienced by families. This unintended social impact reverberates throughout the mental health and AOD sector. 	<p>levels of government and all the community sector have a role to play in this.</p> <ul style="list-style-type: none"> - Little is known about the mental health needs of this population and further consultation may be required to identify opportunities for local service providers to engage with this population.
<p>Priority Area: Workforce development</p>	
<ul style="list-style-type: none"> - Recruiting mental health professionals with the broad experience, skillset and level of cultural competence required to work effectively in relatively autonomous and isolated roles is a constant challenge for providers. - Disparity exists around funding for the remuneration of specialist mental health professionals to remote and very remote areas. Sharing of specialised roles (such as mental health nurses) between health boards may present an opportunity to ‘level the playing field’ in recruitment – as there is little incentive for mental health professionals to live and work in very remote communities and when they do, they are at higher risk of burnout. Recruitment and deployment of specialist health workforce should be considered a systemic issue requiring a coordinated strategy, i.e. a pool of mental health nursing staff that rotate between remote clinics and the regional centre. This would help to prevent burnout of remote staff and promote greater retention, ensuring greater overall continuity of care in remote communities. - A workforce strategy for non-Aboriginal practitioners with a focus on applied skills in engaging with Aboriginal communities: developing cultural intelligence and capacity to deeply value Aboriginal cultures and communities is required to improve the quality of the regional system. - Aboriginal Community and Mental Health Worker roles requires stable team environments including access to a professional peer support network. - Numeracy and literacy are often limited as potential employees, school-based education is often only year 10 and English is a second, third or fourth language. 	<ul style="list-style-type: none"> - Developing a whole-of-region approach to recruitment, retention and deployment of specialist mental health professionals is an opportunity that could be explored by the region’s three AMS’. - Co-design, involving participants, carers and service providers, and flexibility in use of funding is seen as essential to fostering innovative and efficient use of local and outside resources - A lack of Registered Training Organisations providing high education and training in mental health in the NT is a significant impediment in the development of the remote Aboriginal mental health workforce.

Stakeholder Perspectives	Regional needs and opportunities for system Improvement
<ul style="list-style-type: none"> - The entire service system requires additional training in engaging with young LGBTI people in order to deliver wrap-around care and more effectively mitigate suicide risk for these young people. - The only child and adolescent mental health services available are based in Darwin: there is need for specialist services for children and adolescents in Katherine. - More education and support are required for parents to reduce stigma around mental health and increase parental capacity to support children who are at risk of suicide or who have mental health issues - More mental health promotion, prevention and early intervention is required in early years. - There's a lack access to paediatricians and diagnostic skills for ADHD and Foetal Alcohol Spectrum Disorder (FASD). - FASD is an ongoing issue and concerns exist around accessing funding to support children with FASD. Autism and ADHD appear to be more readily diagnosed and supported with funding than FASD. - Lack of specialist services for under 12s means that mental health problems often go untreated and deteriorate in the teenage years. 	<ul style="list-style-type: none"> - Further exploration into the development of youth services that are responsive to LGBTI young people is needed. - All mental health and suicide prevention providers in the region would benefit from professional development resources that support the implementation of the National Practice Standards for the Mental Health Workforce that relate to LGBTI populations.

1.5.2 Stepped Care in the region

Stepped Care involves the stratification of a population into different ‘needs groups’, ranging from whole of population needs for mental health promotion and prevention, through to those with severe, persistent and complex conditions. The following tables show the percentage of total regional services that are delivered to each of these population needs groups.

Table: Combined NGO mental health and social and emotional welling service delivery by Stepped Care population group – Alice Urban, Central Australia Northern, Southern and Central Districts*



Source: Mental Health Service Profiles, NTMHC 2017

*Excludes carer supports, referral lines, web-based support platforms, drug and alcohol services and suicide prevention programs/services.

Understanding the regional mental health system through a Stepped Care lens Katherine Region	
Key components	Discussion of issues
Spectrum of evidence-based services from least to most intensive	<ul style="list-style-type: none"> - Development of the Aboriginal mental health workforce is fundamental to expanding the breadth of culturally responsive services available to Aboriginal people in the district. - Cultural competence should be considered a central element of evidence-informed approaches at levels of mental health service delivery for Aboriginal people. - Development of Child and Adolescent services are a necessity in the region - An over-reliance on digital mental health technologies risks diverting funding away from face-to-face mental health and Social Emotional Well Being (SEWB) provision at the local level and reducing the range of low-intensity options available to people who may not be engaged or face other barriers to digital mental health technologies.
Mechanisms for matching individual need to service level and intensity	<ul style="list-style-type: none"> - The absence of a bulk billing GP in Katherine limits access to a GP for non-Aboriginal people. GP's are a vital screening point and entry point to treatment for people experiencing mental health issues/mental illness. - Aboriginal Health Practitioners should be upskilled to work more effectively as the first line of early identification of mental illness in remote communities.
Processes for monitoring progress and adjusting level according to need	<ul style="list-style-type: none"> - Risk assessment process need to be strengthened and greater emphasis put on standardisation of risk assessment protocols within the regions. - Greater emphasis on monitoring and ensuring continuity of care for people who move between remote locations is also required.
Clear pathways for moving between services providers and levels	<ul style="list-style-type: none"> - The region's three Aboriginal Medical Services have a tendency to operate in isolation from one another. This has the potential to disrupt continuity-of-care for patients. Integrating the regions three AMS is a challenge to improving continuity of care in the region for people who are highly mobile.
Stepped Care Principles	<p>Stakeholders noted that;</p> <ul style="list-style-type: none"> - Stepped Care's advantages include a greater focus on low-intensity, preventative and mental health promotion activities, which aligns with Aboriginal approaches to mental health care. - Stepped Care and Comprehensive Primary Health Care (Aboriginal Community Control) are very similar models and largely compatible in their emphasis on prevention and providing a spectrum of treatment modalities based on need.

1.5.3 The regional suicide prevention system

Suicide Prevention – Katherine District Consultation Outcomes		
Intervention Area	Stakeholder Perspectives	Needs and Opportunities
UNIVERSAL INTERVENTIONS	<p>‘Mental Mates’ is a community-driven suicide prevention initiative, which has been instrumental in expanding delivery of mental health first aid training to the Katherine community: training over 100 community members in 2016 – 2017. Supported by Red Cross Australia, this initiative has made a valuable impact on the mental health literacy of the local community and equipped the community to respond to, and support people experiencing suicidal ideation. The initiative is an important example community-driven suicide prevention.</p> <p>Expansion of community-based suicide prevention activities and training packages for Aboriginal communities need to include the perspectives of local Aboriginal peoples. Differing expectations around privacy and information-sharing in mainstream and local Aboriginal cultures means that mainstream crisis intervention approaches are not always appropriate.</p> <p>Designated mental health training for Aboriginal health practitioners is needed to build the capacity of the workforce in early identification of mental illness in remote communities.</p> <p>Mental health first aid training and ASIST training need to include components around:</p> <ul style="list-style-type: none"> ○ Awareness of local services may be available to someone at risk ○ Understanding referral pathways into services 	<ul style="list-style-type: none"> - Mental Mates requires support around governance, administration and strategic planning to maximise reach and positive impact within the community. - A need has been identified for a designated suicide prevention training coordinator position, to be auspiced and supported by an existing service provider or community organisation. This role would focus on developing a strategic plan to understand the training needs of communities and community service workforce within the Katherine district to; organise the logistics around training; apply for and report on funding; monitor training needs/scheduling refresher training. The strategic planning would also look at de-stigmatising mental illness and discussing suicide. This role would take the load off community volunteers and ensure that all training opportunities available in the NT are fully maximised in the district.
SELECTIVE – AT RISK GROUPS	Young LGBTI people have been identified as an at-risk population in the Katherine region	<ul style="list-style-type: none"> - All mental health and suicide prevention providers would benefit from professional development resources that support the implementation of the National Practice

Suicide Prevention – Katherine District Consultation Outcomes		
		<p>Standards for the Mental Health Workforce that relate to LGBTI populations</p> <ul style="list-style-type: none"> - Further consultation is required to better understand the mental health needs Katherine’s growing migrant population. - Provision of
INDICATED – AT RISK INDIVIDUALS		
COMMON ELEMENTS	<ul style="list-style-type: none"> - Suicide prevention initiatives based in outside jurisdictions should be encouraged to contact local Aboriginal Medical Services prior to engaging in service delivery or community development initiatives, in order to ensure that their suicide prevention activities are aligned and building upon local capacity, needs and priorities. 	<p>Capturing a base-line set of data around incidence of suicide; completed and attempted, is needed to inform service development and delivery, inclusive of</p>
<p>Approach of mainstream initiatives</p> <p>Data collection</p>	<ul style="list-style-type: none"> - Capturing a base-line set of data around incidence of suicide; completed and attempted, is needed to inform service development and delivery. 	
SAFETY NETS	<ul style="list-style-type: none"> - The Katherine Suicide intervention and prevention group (SIP) is a valuable reference group for suicide prevention in the region and supports service coordination 	<ul style="list-style-type: none"> - All mental health, AOD, Domestic Violence and suicide prevention service providers should be encouraged to coordinate via SIP

1.5.4 Regional improvement plan

Priority Area	Regional Improvement Plan – Katherine Region	Time Frame
Migrant Population	Improvement Area 1. - NT Primary Health Network (NT PHN) to be aware of the significant growth of Katherine’s migrant population. Little is known about the mental health needs of this population and further consultation may be required to identify opportunities for local service providers to engage with this population.	Immediate < 12 months
GP Training	Improvement Area 2. - The absence of a bulk-billing GP presents a major need for the Katherine population. NT PHN to explore resourcing a bulk-billing GP in Katherine town.	Medium-Term 12-36 months
Suicide Prevention	Improvement Area 3. - NT PHN to explore the development of a strategic plan for a systems-based approach to suicide prevention in the Katherine region, inclusive of a suicide intervention training plan for front-line community services.	
Suicide Prevention	Improvement Area 4. - NT PHN to invest in supporting locally-based, community-driven models for suicide prevention.	
Workforce Development	Improvement Area 5. - All mental health and suicide prevention providers in the region would benefit from professional development resources that support the implementation of the National Practice Standards for the Mental Health Workforce that relate to LGBTI populations.	
Service Coordination and regional capacity-building	Improvement Area 6. - Developing a whole-of-region approach to recruitment, retention and deployment of specialist mental health professionals is an opportunity that could be explored by the region’s three AMS’.	
GP Training	Improvement Area 7. - See NT System Improvement Plan	Long Term 1-5 years
Aboriginal Mental Health Workforce	Improvement Area 8. - See NT System Improvement Plan	
NDIS/Low barrier to entry services	Improvement Area 9. - See NT System Improvement Plan	
Child and Adolescent Services	Improvement Area 10. - Long-term planning is needed to establish a Child and Adolescent mental health services in Katherine.	

1.6 East Arnhem

1.6.1 Regional needs, priorities and opportunities

Stakeholder Perspectives	Regional needs and opportunities for system Improvement
Priority Area: Service Availability	
<p>Miwatj Health Aboriginal mental health services in Galiwin'ku and Nhulunbuy provide an example of best practice in community-controlled mental health care. However, the geographic coverage of these services is limited, and stakeholders report a range of gaps in service availability across East Arnhem North and South districts, including:</p> <ul style="list-style-type: none"> - Counselling and psychological therapies largely unavailable to people living on homelands and outstations. Limited clinical monitoring and support around medication is the extent of remote service delivery for people with moderate-severe mental illness. - A lack of trauma-informed counselling and support services for people who have suffered sexual, assault as sexual assault referral centre (SARC) does not have funding to travel to remote areas. - Absence of local psychiatry. - Short-fall of allied health workers, particularly occupational therapists and psychologists. - Inadequate mental health focussed on aged-care. - 3-4 week wait times to see a small and highly transient GP workforce. - There is a need for a Step-up Step-Down service in the region, to minimise duration of hospital admissions in Darwin and to support people in times of mental health decline, preventing the need for transport to Darwin. Aboriginal Mental Health Workers would have a pivotal role to play in such a facility. - There is an absence of targeted Child and Adolescent Mental Health Services (CAMHS) in the East Arnhem region. 	<p>A consortium of Aboriginal Community Control Health Organisations and NGO services may be best placed to deliver Child and Adolescent Mental Health services in the region. Embedding cultural competence, local ownership and a recovery focus into service delivery is seen as a priority. To foster this, a multidisciplinary team structure has been canvassed by some stakeholders and involves:</p> <ul style="list-style-type: none"> o Aboriginal Mental Health Practitioner o Aboriginal Mental Health Worker o Primary Health Care Child Nurse and o Mental Health Nurse o Care planning and coordination with family support services, i.e. Raypirri Rom o Secondary consult with volatile substance abuse, AOD services as required o Clinical oversight provided by a Paediatrician
Priority Area: Service Coordination	
<ul style="list-style-type: none"> - Nhulunbuy has a range of services, but these tend to operate in silos. This is attributed to: the 'silo' funding that services receive, poor relationships between providers and a lack of understanding/agreement around the roles and responsibilities of providers. - Client information is recorded over two different systems: NT Government and Community Controlled systems, inhibiting efficient information sharing between providers. There is a need for greater uniformity in procedures around sharing client information between providers 	<ul style="list-style-type: none"> - Development of a regular mental health network meeting for providers in East Arnhem (Nhulunbuy) may help to increase service coordination, strengthen referral pathways and develop a shared understanding of the roles and responsibilities of each provider.

Stakeholder Perspectives	Regional needs and opportunities for system Improvement
<ul style="list-style-type: none"> - There is a need for greater crisis support for remote health workers, as well as increased assistance in transporting a person who is unwell to hospital in either Gove or Darwin. Currently, some remote services rely on police to assist with this work. - Gove Crisis Accommodation Centre reports receiving referrals from Gove District Hospital for people who are highly distressed and at-risk of self-harm/suicide, in the absence of discharge summaries, risk-assessments or adequate handover. - Top End Mental Health Services inpatient unit commonly discharges patients who have only partially stabilised from an acute phase of mental illness. Upon return to their home community, patients often quickly relapse and are re-admitted. - Fly-in-fly out clinical service delivery is problematic due to the high costs of charter flights and difficulty in building rapport with communities and clients. - NT Government services to the homelands are infrequent. Issues exist around lack of effective follow-up following specialist health and mental health treatment in Nhulunbuy and Darwin. 	
<p>Priority Area: Best practice treatment approaches</p>	
<ul style="list-style-type: none"> - Aboriginal Mental Health Practitioners (AMHPs) should have meaningful participation in all aspects of mental health care for Aboriginal people experiencing mental illness, particularly in assessment, follow-up and monitoring. Without this participation assessments can lack validity. 	<ul style="list-style-type: none"> - The expansion of a well-trained and appropriately supported Aboriginal mental health workforce is essential to the provision of culturally safe, effective and equitable mental health care for Aboriginal people in the East Arnhem region.
<p>Priority Area: Sector Integration</p>	
<ul style="list-style-type: none"> - Concerns raised around release planning and care coordination for people with cognitive impairment and/or mental illness exiting the corrections system: release planning is dominated by the Department of Corrections to the exclusion of AMS’s and community-based frontline services. This prevents meaningful coordination of release planning with the community/family to which the person is returning, undermining the capacity of the community and local service providers to effectively support the re-integration of a person into their home community. - Abrupt summons to court and a lack of return to country programs can leave people stuck in Darwin, at high risk of homelessness and exposed to AOD use. - Collaboration of AOD and health treatment teams on Groote Eylandt has improved service integration for people with dual-diagnosis on Groote Eylandt 	<ul style="list-style-type: none"> - Processes around release-planning are inadequate and need to be improved in order to ensure continuity-of-care for people with mental illness who are exiting the corrections system.

Stakeholder Perspectives	Regional needs and opportunities for system Improvement
<ul style="list-style-type: none"> - Local Aboriginal mental health workers (AMHWs) are often put at risk of harm in supporting people in crisis. Good working relationships with police are reported to be essential to mitigating risk. 	
<p>Priority Area: Funding models</p>	
<ul style="list-style-type: none"> - Inadequate funding results in deferring to/prioritising approaches based in medical model (and associated clinical roles) rather than recovery-focussed, holistic approaches that include the development of the Aboriginal Mental Health Workforce. - In remote areas, funding of services should be planned strategically to build on the strengths and capacities of communities and service providers. - Co-design between funders and remote providers is essential to the development of programs and services that are; responsive to local culture and need, build local capacity for service provision, utilise local resources, are cost-effective and sustainable. - Opportunity to explore: Realignment of funding for professional roles. Professional roles that are difficult/costly to recruit to remote areas could be located in Darwin where there are higher rates of staff retention and lower risk of burnout. The focus of this role would be to build capacity of regional/remote services rather than provide client-facing services. The position would utilise tele-conferencing and periodic travel to provide secondary consult, mentoring, training and advice to locally based mental health practitioners 	<ul style="list-style-type: none"> - Co-design of services that closely involves remote providers is essential to the development of programs and services that are; responsive to local culture and need, build local capacity for service provision, utilise local resources, are cost-effective, sustainable and can be utilised in a timely manner. - Flexibility in using funding innovatively, such as through engaging professional mental health consultants (with clinical competence) to provide short-term, or periodic, program support to build the capacity of local staff and providers, is an important reform in building the capacity of remote services. This might involve a mental health professional with clinical competence providing clinical oversight and supervision to a locally-based mental health team.
<ul style="list-style-type: none"> - Ongoing, peer-driven professional development is an important component of workforce development for Aboriginal Mental Health Workforce (AMHWs). - There is a lack of appropriate training for AMHWs in the NT. - External mental health training for AMHW's should be aligned with ongoing supervision from local clinic staff with mental health skills and qualifications. - Experience in a range of service settings is invaluable to skill and knowledge development of workers: AMHW's are often restricted to working within their home community and a single service context. Facilitation of cross-service experience should form a central component of ongoing personal development for Aboriginal mental health workers (e.g. rotation into Top End Mental Health Services inpatient units). - Mental health skills and training of nurses in Gove District hospital is insufficient: nurses often lack confidence in assessment and the cultural competence to understand presentations of 	<ul style="list-style-type: none"> - Funding for more AMHW positions is essential to improving mental health service delivery. These positions need to be planned strategically to ensure roles are appropriately supported i.e. team-based and resourced for ongoing professional development. - Experience in a range of service settings is invaluable to skill and knowledge development of workers: AMHW's are often restricted to working within their home community and a single service context. Facilitation of cross-service experience should form a central component of ongoing PD for AMHW's (e.g.

Stakeholder Perspectives	Regional needs and opportunities for system Improvement
<p>psychological distress. This results in frequent deferment to East Arnhem Mental Health team for issues that should be addressed by hospital-based staff. High turnover of hospital staff exacerbates these skill deficits.</p> <ul style="list-style-type: none"> - Numeracy and literacy is a significant barrier to Yolngu accessing mental health training and professional development opportunities. - Professional development training mental health that doesn't require high-level English-language literacy/numeracy for existing Aboriginal Health Workers would build local capacity and improve local mental health care – particularly lower intensity supports and the capacity of Aboriginal Health Workers to work under supervision from a clinical psychologist based in Darwin. - 'Pop-up' training in AOD – provided by NT PHN - has been highly valuable and should continue. 	<p>rotation into Top End Mental Health Services (TEMHS) inpatient unit).</p>
<p>Priority Area: Community Control & Ownership of Services</p>	
<ul style="list-style-type: none"> - Principles of community control should be embedded in each step of service planning and development. The FIFO model undermines community control and ownership of service delivery - Laynhapuy Aboriginal Health is developing a community empowerment program with a focus on supporting Yolngu choice and control in their interactions with mainstream systems and agencies regarding works that take place on their country, such as housing, education, and utilities. This is addressing social determinants of health and addressing basic psychological needs to have agency in one's life and community. This program could be considered a low intensity mental health promotion/prevention aimed at a community wide level. The community empowerment program also functions as an opportunity for early intervention/mental health screening by building engagement between local people and service providers. 	<ul style="list-style-type: none"> - The Aboriginal Peak Organisation NT Partnership Principles provide an important framework through which Aboriginal Community Control Health Organisations (ACCHO) and community mental health services can work together to build the capacity of the ACCHO sector and delivery high quality services to Aboriginal people.

1.6.2 Stepped Care in the region

Understanding the regional mental health system through a Stepped Care lens East Arnhem Region	
Key Components	Discussion of issues
Spectrum of evidence-based services from least to most intensive	<p>There is a significant lack of mental health services available to people living in many remote communities in the East Arnhem region. Periodic visits from the East Arnhem Mental Health team provide pharmacotherapy support to people with moderate and severe mental illness, but there is an absence of on-going therapeutic interventions for this population and an absence of preventative and early intervention treatments for people with mild mental illness or who are at-risk.</p> <p>Miwatj Aboriginal Health’s mental health and social and emotional wellbeing programs in Galiwin’ku, Nhulunbuy and Yurrwi are an exception to this. Miwatj’ Comprehensive Primary Mental Health Care model reflects many of the components of Stepped Care, offering a range of closely integrated, evidence-based primary and secondary services from within a single organisation, and collaborates closely with tertiary services to deliver wrap-around, culturally appropriate mental health care.</p>
Mechanisms for matching individual need to service level and intensity	<p>Whole-of -community mental health screening and promotion programs have been effective in increasing early identification of at-risk or unwell individuals in Aboriginal communities such as Galiwin’ku and across Groote Eylandt. However, screening and promotion also results in increased referral to, and demand on services that are often already working at full capacity. Due to the lack of treatment options available in some remote areas, people who are unwell deteriorate significantly before being evacuated to Darwin for treatment. Innovation in service design – such as Laynhapuy’s Community Capacity-building program – is important in developing opportunity for early intervention/mental health screening by building engagement between local people and service providers.</p>
Processes for monitoring progress and adjusting level according to need	<p>Training is needed for frontline staff in Gove District Hospital (GDH) in order increase GDH’s role in assessment and referral to the NGO sector for people showing symptoms of mild, moderate and severe mental illness.</p> <p>A current lack of capacity for this results in premature and unnecessary referral directly to Northern Territory Mental Health Services and admission to Top End Mental Health Services (TEMHS) inpatient unit</p>
Clear pathways for moving between services providers and levels	<p>Issues have been identified around discharge processes from TEMHS inpatient unit, where patients have been sent back to their home community without having fully stabilised – resulting in relapse and readmission.</p> <p>There is a reported lack of mental health assessment skills within the Emergency Department of Gove District Hospital (GDH), which results in unnecessary and/or premature referral and medivac of patients to TEMHS inpatient unit. This practice may also be linked to a lack of awareness amongst hospital staff of community-based treatment option.</p> <p>Discharge and referral of patients from GDH to the Crisis Accommodation Centre (CAM) in Nhulunbuy is said to occasionally occur in the absence of discharge summaries, risk assessments or formal handover, leaving the CAM exposed and struggling to support people who are highly distressed, potentially suicidal and with complex support needs.</p>

Understanding the regional mental health system through a Stepped Care lens East Arnhem Region	
Capacity to monitor system as a whole	There is a need for improvement of data collection around service outcomes and continuity of care processes. Currently, there is a lack of analysis of the effectiveness of service delivery and an over reliance on anecdotal evidence.
Stepped Care Principles	Mental Health planning frameworks such as Stepped Care should be informed and driven by communities and value their cultural standpoints. Questions remain around the compatibility of community control and the stepped care model, though the Miwatj model provides an example Stepped Care being successfully implemented from within an Aboriginal Community Control Health Organisation.

Note: Insufficient data was available to analyse *combined service delivery by population group* in the East Arnhem region.

1.6.3 The regional suicide prevention system

Suicide Prevention – East Arnhem District Consultation Outcomes		
Intervention Area	Stakeholder Perspectives	Needs and Opportunities
UNIVERSAL INTERVENTIONS Gatekeeper training	<ul style="list-style-type: none"> - Suicide postvention programs need to be place-based and staffed by practitioners who have connections to the communities affected. - Impact of suicide prevention activities can be measured by increased vocabulary and capacity for discussion around suicide, and help-seeking behaviours. - Schools, educators and other front-line staff (police, paramedics etc) need training and support in understanding suicide ideation and crisis intervention. - Early intervention/postvention programs and workshops with families around finding safe ways to discuss suicide and the subsequent loss and grief following suicide is critical to community resilience. - AMHWs have an important role to play in working with families to build capacity to identify high risk people. - A coordinated, whole-of-community approach to suicide prevention is effective in increasing community awareness, confidence and skills in crisis counselling and identification of people at-risk. - Suicide prevention activities should be driven by locally identified needs. - Train-the-trainer/capacity-building approaches with specific focus on grief/loss/trauma commonly experienced in remote communities are important approaches. 	Schools, educators and other front-line community services (including police and paramedics) require training and support in understanding suicide ideation and crisis intervention. Training should include; <ul style="list-style-type: none"> - Safetalk - Mental Health First Aid
INDICATED – AT RISK INDIVIDUALS	<ul style="list-style-type: none"> - Nhulunbuy’s crisis accommodation centre struggles to meet the demand and intensity of support required by people who access it. Resourcing for staff training does not sufficiently provide staff with the skills to support at-risk individuals who are in crisis. - Gove District Hospital (GDH) to improve mental health and suicide prevention to limit admissions to RDH and keep people on country. 	
COMMON ELEMENTS	<ul style="list-style-type: none"> - Coordinated training for providers can build trust and strengthen referral process between service providers. 	

Suicide Prevention – East Arnhem District

Consultation Outcomes

	<ul style="list-style-type: none">- Suicide prevention training should be tailored to cultural and mental health needs of communities: where trauma, grief and loss are high, focus on counselling skills around these as part of training.- Anglicare have engaged Yolngu facilitators to deliver ASIST using cultural appropriate resources with great success.	
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1.6.4 Regional improvement plan

Priority Area	Regional Improvement Plan – East Arnhem Region	Time Frame
Service Coordination	<p><u>Improvement Area 1.</u></p> <ul style="list-style-type: none"> - NT Primary Health Network (NT PHN) to explore indicators of engagement in local network meetings within service agreements (including youth, family violence, homelessness sectors). - NT PHN to explore development of a mental health network meeting for providers in East Arnhem (Nhulunbuy) in order to increase service coordination, strengthen referral pathways and develop a shared understanding of the roles and responsibilities of providers. 	Immediate < 12 months
Release planning	<p><u>Improvement Area 2.</u></p> <ul style="list-style-type: none"> - NT PHN to liaise with the NT Department of Corrections and NT Department of Health around reviewing release-planning processes, to ensure continuity-of-care for people with mental illness who are exiting the corrections system. 	
Service Coordination	<p><u>Improvement Area 3.</u></p> <ul style="list-style-type: none"> - NT PHN to liaise with NT Department of Health and the East Arnhem ACCHO sector around reviewing and improving discharge planning processes and procedures at RDH. 	
Flexible Funding	<p><u>Improvement Area 4.</u></p> <ul style="list-style-type: none"> - NT PHN to engage in co-design with providers around the flexible use of funding in order to foster innovation and efficient use of local and outside resources. This could potentially involve engagement of professional mental health consultants (with clinical competence) to provide short-term, or periodic, program support to build the capacity of local staff and providers. 	Medium-Term 12-36 months
Referral Pathways	<p><u>Improvement Area 5.</u></p> <ul style="list-style-type: none"> - NT PHN to liaise with NT Department of Health around expanding training for frontline staff in GDH in mental health assessment (including suicide alertness, assessment and treatment) and local referral pathways. 	
GP Training	<p><u>Improvement Area 6.</u></p> <ul style="list-style-type: none"> - See NT System Improvement Plan 	Long Term 1-5 years
Aboriginal Mental Health Workforce	<p><u>Improvement Area 7.</u></p> <ul style="list-style-type: none"> - See NT System Improvement Plan 	
Child and Adolescent Mental Health Services	<p><u>Improvement Area 8.</u></p> <ul style="list-style-type: none"> - Long-term planning is needed to establish a Child and Adolescent mental health team in the region. 	
NDIS/Low barrier to entry services	<p><u>Improvement Area 9.</u></p> <ul style="list-style-type: none"> - See NT System Improvement Plan 	
Regional sub-acute service	<p><u>Improvement Area 10.</u></p> <ul style="list-style-type: none"> - There is a need for a Step-up Step-Down service in the region, to minimise duration of hospital admissions in Darwin and to support people in times of mental health decline, preventing the need for transport to Darwin. Aboriginal Mental Health Workers would have a pivotal role to play in such a facility 	