



Northern Territory Mental Health Coalition

Submission to the Draft Report for the Productivity Commission Inquiry:

The Social and Economic Benefits of Improving Mental Health

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

NT Mental Health Coalition

The Northern Territory Mental Health Coalition is the peak body for community mental health and wellbeing.

We represent NT community managed mental health organisations.

We work in collaboration with a wide network of organisations, people with lived experience, their families and supporters across the Northern Territory.

We work at both a national and local level to improve the mental health and wellbeing of Territorians.

Background to this submission

The Coalition welcomes the opportunity to provide feedback on the Draft Report for the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health.

As the peak body for the Northern Territory (NT) mental health sector, the Coalition made a detailed submission to the Productivity Commission Inquiry focussing on the Northern Territory, its diverse population, vast distances, thin economy and the complexities inherent in delivering adequate and appropriate services in such an environment.

Our earlier submission covered the areas of:

- prevention and early intervention, suicide and self-harm and co-morbidities
- workforce needs
- social determinants including housing, employment and income support and justice
- coordination and integration of services
- adequacy and duration of funding.

Our feedback again highlights these issues and provides additional evidence which has been collected since our submission was made. Reforming the mental health system is a very important endeavour and we welcome the Productivity Commission's analysis and proposals. However, it is essential that reform works for everyone. The Coalition is concerned that the direction of reforms set out in the Draft Report will not adequately address mental health needs in rural and remote areas of the Northern Territory, and in some cases may make services even more difficult to access. This submission identifies issues that will need to be addressed in order to ensure that the Northern Territory benefits from proposed changes.

It is important to recognise the characteristics of the Northern Territory that impact on service delivery:

- remoteness, which adds time and cost to delivering services, especially where these need to be co-designed with local communities for tailoring to individual needs
- thirty percent of the population are Aboriginal and/or Torres Strait Islander people; 77 percent of the Aboriginal population lives in remote or very remote areas of the NT¹

¹ Department of Treasury and Finance 2019 Population, Northern Territory Economy <https://nteconomy.nt.gov.au/population>

- the economy is relatively small, and the NT Government has very few streams of own-source revenue. The Territory Government remains in considerable debt, and is predicting operating deficits for the duration of the budget out years²
- Commonwealth arrangements that allocate funding on the basis of jurisdictional populations rather than need inevitably result in under investment in services in the NT where the population is small but relative disadvantage is high
- there is a historical underinvestment in mental health services compared to need, across the government, private and community sectors.

Our experience of major reforms such as the National Disability Insurance Scheme (NDIS) and the aged care system is that centralised program design, planning and implementation fails to take into account the on-ground realities of remote and rural communities operating in a resource-poor jurisdiction. In these situations – where market failure is not addressed by alternative government action – we have observed disadvantaged people becoming even more disadvantaged.

This submission briefly revisits the Northern Territory (NT) statistics and provides commentary on issues of particular concern to the NT non-government community-based mental health sector raised in the Draft Report.

Disproportionate burden of mental health

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 (NT). The accessibility and quality of mental health services must be considered in conjunction with the significant socio-economic disadvantage and intergenerational trauma experienced by many Aboriginal and Torres Strait Islander communities across the NT.

Our earlier submission identified the extent to which the mental health burden of disease in the Northern Territory is higher than the national average³ and that the number of Aboriginal Territorians experiencing high or very high psychological distress is on average 2.7 times that for non-indigenous people.⁴ Almost one third (30%) of Aboriginal people experience high/very high psychological distress, compared with 11.8% for non-Aboriginal and Torres Strait Islander people.⁵ In the NT, mental health conditions contribute to 16.3% of the burden of disease, compared to 7.4% in Australia as a whole.⁶ 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.⁷

² Northern Territory Government 2019 Budget 2019-20 Budget overview

https://budget.nt.gov.au/_data/assets/pdf_file/0005/690134/Budget-Overview-book.pdf

³ 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>

⁴ 4727.0.55.001 - Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13

<https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/9F3C9BDE98B3C5F1CA257C2F00145721>

⁵ 4727.0.55.001 - Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13

<https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/9F3C9BDE98B3C5F1CA257C2F00145721>

⁶ 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>

⁷ 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>

In the Northern Territory (NT) in 2017, 51 people died by suicide, the highest NT level over the last 10 years, except 2014.⁸ 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). 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.⁹ Despite this, the NT has extremely limited clinical suicide intervention and prevention services.

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. For example, 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 hub towns.

Issues raised by the draft Productivity Commission report

This section provides comments and suggestions about issues and recommendations identified in the Draft Report that are of particular relevance to the Northern Territory.

1. Access to mental health care

The Coalition supports the Draft Report's commentary and recommendations (reform objective: healthcare access) about the need for all Australians to have access to mental health care at the level of care that most suits their needs and which is timely and culturally appropriate.

a) Culturally appropriate services

The Coalition supports the Draft Report's commentary about the need for culturally appropriate. Services need to be co-produced and co-designed with local communities so that they are culturally safe, respectful and inclusive of participants, families, carers and communities.

This is particularly important in the Northern Territory (NT) given the rates of high and very high psychological distress experienced by Aboriginal people and the pervasive history of

⁸ABS 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>

⁹ 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/prodispui/bitstream/10137/7055/1/Northern%20Territory%20Suicide%20Prevention%20Strategic%20Framework%202018-2023.pdf>

having policy and programs implemented without appropriate engagement of the people they are intended to benefit.

The NT PHN is investing in social and emotional wellbeing programs which are aimed at improving services for Aboriginal people. However, these are not yet at a scale which enables the needs of people living in remote and very remote areas to be adequately addressed.

It is important that the funding arrangements in place for delivering services in remote communities are sufficiently flexible to support service providers who are familiar with the communities they are serving.

b) Prevention and early intervention

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 health.

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 makes implementing a stepped care service model difficult, if not impossible.

The Darwin region is best placed in relation to available services. However, even in Darwin inadequate or inappropriate referrals by GPs and the Clinical Mental Health Service¹⁰ make it difficult for families to navigate the system. There is no comprehensive online or printed directory providing an overview to services and referral pathways that families can access independently. Nor is there an up-to-date map of the mental health service landscape, with the most recent mapping exercise undertaken in 2017.

c) Access to psychiatry, psychology and assisted travel for specialist care

The NT has limited access to psychiatry, psychology and specialist acute mental health services.

Most of the psychological services available in the NT are by private providers. The NT Primary Health Network (NT PHN) funds the Access to Allied Psychological Services (ATAPs) program for priority groups of people experiencing moderate to complex mental illness. The NT Government mental health services primarily provide pharmacotherapy under the guidance of psychiatrists and case management. Programs such as the Child and Adolescent services are significantly under-resourced and very difficult for families to access.

The current hourly rate for clinical and non-clinical psychologists ranges between \$180 and \$250 per hour. Most private psychologists in the NT apply the Australian Psychological Society recommended rate of \$251 per hour. Medicare rebates vary from \$84.80 to \$124.50 leaving a gap payment of up to \$160 per session which many Territorians cannot afford. Indications from our sector suggests bulk billing may be made available to pension cardholders or upon negotiation between private psychologists and existing clients. However, there is no source of information that enables private psychologists who would work under this arrangement could be located.

¹⁰ https://justice.nt.gov.au/_data/assets/pdf_file/0006/614994/D01362017-Di-Lembo.pdf

Better Access to Mental Health Care allows for Medicare rebates to telehealth psychological services in all areas of the Northern Territory (NT) outside of urban and rural Darwin with appropriate referral by a GP. It would be useful to make this service available in Darwin where there are limited options or expertise, for example, for treating eating disorders.

There are very few private psychiatrists and no known bulk billing psychiatric services available for face to face consultations in the NT outside of NT Government services. Neither Medicare funded telehealth psychiatry nor psychology appear to be widely used for referral by NT GPs which would open the door to bulk billing practitioners interstate.

There is only one private hospital in the Northern Territory which is located in Darwin. An inpatient mental health unit is being constructed and expected to be operational in 2021. Unlike other types of inpatient care, there is currently no ability to overflow patients from the public hospital to the private hospital. The new private mental health unit will not admit people presenting with high risk/suicidality, and will depend on psychiatrists from the public and private systems to admit and oversee patients.

There has also been no known use of Patient Assisted Travel to transport mental health patients interstate where local services are overcapacity or not available due to a lack of local expertise. For example, one of the authors of this submission worked with two families of adolescent girls in the Darwin region who had severe eating disorders. Clinical mental health services recommended that the families take their daughters interstate to access appropriate care. Neither family could afford to do so, nor were they offered patient assisted travel to take their child interstate for appropriate care and support.

d) Suicide prevention

The Coalition supports the development of a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and implementation plan (draft recommendation 21.2). Developing and implementing the strategy must be led by Aboriginal and Torres Strait Islander people and organisations.

2. Social determinants of mental health

The Coalition supports the implication of draft finding 20.2, that addressing the social determinants of health, including housing, justice and employment and income support are critical to improving social and emotional wellbeing. In the NT, the need for holistic investment in order to achieve mental health gains is very apparent.

a) Housing

The Coalition welcomes the acknowledgment of the importance of non-health services, organisations and adequately trained and resourced (social housing) sector workers in both preventing mental illness from developing and in facilitating a person's recovery. The effectiveness of mental health service delivery can be compromised when provided to people residing in unstable living environments or experiencing homelessness. When people with mental ill-health are housed and supported, their recovery improves.

We support the reform objectives on service delivery integration and housing supply, and the intent of draft recommendations 15.1 (housing security for people with mental illness), 15.2 (support for people to find and maintain housing) and 24.3 (the National Housing and

Homelessness Agreement). More detail can be found in the NT Shelter submission. The following elements should be strengthened:

- mental health training and resources for social housing workers *must* be offered and encouraged, with mental health services or care coordinators working *with* housing workers through culturally appropriate integrated and collaborative partnerships to stabilise existing tenancies¹¹
- state and territory social housing authorities should review their policies to reduce the risk of eviction¹² *as part of the nationally consistent formal policy proposed in draft recommendation 15.2* to ensure no exits into homelessness for people with mental illness
- the NDIA should review its Specialist Disability Accommodation strategy and policies with a view to encouraging development of long-term supported accommodation for NDIS recipients with severe and persistent mental illness, and *with a specific focus on NDIS participants residing in areas of thin markets*¹³
- governments should work towards meeting the gap in the number of ‘supported housing’ places for those individuals with severe mental illness who are in need of integrated housing and mental health supports,¹⁴ with long-term housing solutions *for people residing in both urban and rural/remote locations* incorporated into assessments of both current need and forward planning
- as part of the next negotiation of the National Housing and Homelessness Agreement, State and Territory funding allocations must be increased, and determined *with regard to actual need rather than population size alone*.

The NT currently receives \$18.9 million or 1.3% of total Commonwealth funding for affordable housing and homelessness, despite a capita rate of demand for services at three times that of other states and territories and a rate of 42.3 clients per 10,000 population presenting to specialist homelessness services in 2018-19 with a current mental health issue (compared to the national average of 34.6).¹⁵

b) Justice

The NT has the highest rates of imprisonment and youth justice supervision in the nation. At 30 June 2018, 84 percent of adult prisoners were Aboriginal, as were 96 percent of the youth detention population. Aboriginal young people (aged 10-17 years) made up 97 percent of young people in detention or under community-based supervision.¹⁶ There is limited or no access to mental health care services in correctional facilities and no government-provided, youth forensic mental health service despite the recommendations

¹¹ Regarding Point 1, Draft Recommendation 15.1: *Housing security for people with mental illness*

¹² Regarding Point 2, Draft Recommendation 15.1: *Housing security for people with mental illness*

¹³ Regarding Point 3, Draft Recommendation 15.2: *Support people to find and maintain housing*.

¹⁴ Regarding Point 4, Draft Recommendation 15.2: *Support people to find and maintain housing*.

¹⁵ Australian Institute of Health and Welfare, *Specialist Homelessness Services Annual Report 2017-18*. (demand in the NT is 390 clients per 10,000 population compared to the national average of 116 per 10,000, with an average of 15 requests for assistance unmet each day.)

¹⁶ NT Department of the Attorney General and Justice 2019 NT Aboriginal Justice Agreement Aim One Reduce reoffending and imprisonment rates of Aboriginal Territorians https://justice.nt.gov.au/_data/assets/pdf_file/0010/728164/aim1-Reduce-reoffending-and-imprisonment.pdf

of the Royal Commission into the Protection and Detention of Children in the Northern Territory.¹⁷

Holistic approaches to dealing with complex and compound disadvantage are demonstrated by the health justice partnership between the Central Australian Women’s Legal Service and Anyinginyi Aboriginal Health Service in Tennant Creek, and Disability Justice Partnership operated by the Darwin Community Legal Service linking disability and aged advocacy, housing and legal services.

There is no specialist mental health tribunal in the NT. Current guardianship legislation operates on a substitute decision making model and engenders no right to legal representation or even participation.

c) Income support

The Australian Government’s Community Development Program has onerous eligibility requirements including minimum weekly hours for participating. People who are caring for others may have limited availability for work, and therefore find themselves ineligible for income support. Culturally, caring responsibilities may be shared amongst a number of community and family members. Families are often expected to fill gaps arising from the lack of formal support services in remote communities. The role of community and family members in providing support where no services exist should be recognised through a review of the availability of carers allowance (as envisaged in draft recommendation 13.1) and an investment in capacity building and provision of resources, remuneration and respite.

The Australian Government’s Community Development Program has onerous eligibility requirements including minimum weekly hours for participating. People who are caring for others may have limited availability for work, and therefore find themselves ineligible for income support. Culturally, caring responsibilities may be shared amongst a number of community and family members. Families are often expected to fill gaps arising from the lack of formal support services in remote communities. The role of community and family members in providing support where no mental health services exist should be recognised through a review of the availability of carers allowance (as envisaged in draft recommendation 13.1) and an investment in capacity building and provision of resources, remuneration and respite. This investment is also needed for addressing the high rates of physical disability experienced by residents in remote communities.

3. Workforce

The Coalition agrees “that governments should strengthen the peer workforce” (draft recommendation 11.4). There needs to be additional investments in an expanded, skilled, peer support workforce, that goes beyond the recommendations for investing in peer worker qualifications and a professional organisation. We note the recent National Mental Health Commission recommendation¹⁸ that the Australian Government produces a clear

¹⁷ Royal Commission into the Protection and Detention of Children in the NT 2017 Recommendation 15.1 2(b) Findings and Recommendations. <https://www.royalcommission.gov.au/sites/default/files/2019-01/rcnt-royal-commission-nt-findings-and-recommendations.pdf>

¹⁸ National Mental Health Commission 2019 Monitoring mental health and suicide prevention reform National Report 2019 Summary <https://www.mentalhealthcommission.gov.au/getmedia/c84bc89a-ae1c-489f-afef-296f0207da96/2019-National-Report-Summary>

implementation plan to accompany the development and release of the National Mental Health Workforce Strategy.

Accredited training opportunities for peer workers are currently more limited in the NT than in other jurisdictions. The NT is the only jurisdiction that does not have a local pathway for the Certificate IV in Peer Support, nor are there any clearly defined, informal peer support pathways. The lack of peers working in the NT mental health sector has impacted the quality of recovery orientated services and the readiness of organisations in the mental health sector to appropriately support a peer workforce, should a vocational pathway be established.

A variety of factors influence supply and demand for the NT peer workforce:¹⁹

- the legacy of under-developed understanding and application of the recovery model in the NT mental health sector means that demand for peer workers is not yet universal across the sector, and limited opportunities for people with lived experience to contribute their expertise in voluntary or paid capacities. This limits the supply of people interested and ready to take on peer worker roles.
- conversely the emerging experience and commitment to person-centred, recovery-focused care within the sector is strengthening demand for peer workers.
- funding stream size and uncertainty are barriers to demand. Funding for peer worker positions may be found from an organisation's establishment, for example by redesigning positions. However, funding is generally not available for investing in the organisational capacity building and support arrangements required to underpin an effective peer workforce. Productivity improvements from employing lived experience workers will accrue as additional and/or high quality services for clients rather than as savings that can be reinvested. Commissioning/funding bodies could prioritise employing peer workers and building organisational capacity, similar to investments in culturally appropriate service and practice. NDIS providers will have limited opportunities to employ peer workers until foreshadowed psychosocial reforms are implemented, including the introduction of recovery coaches.
- peer workers identify lack of confidence in their experience, and fear of stigma arising from disclosing their lived experience in small communities as barriers to applying for positions as peer workers. Upskilling organisations to value peer workers and to be ready for the peer workforce is considered critical.

In addition to strengthening the peer support workforce, the Coalition supports efforts to develop and expand the Aboriginal Health Practitioner workforce (p28). The Aboriginal mental health workforce in the NT has dissipated over time. Individual organisations are investing in training for Aboriginal health practitioners, for example for Aboriginal wellbeing workers to work with young people and families using social and emotional wellbeing principles. However, efforts need to be formalised and expanded across the sector.

The Coalition also supports improving mental health training for GPs (draft recommendation 11.5). Coroners reports of NT suicides²⁰ have made specific recommendations to improve

¹⁹ NT Mental Health Coalition 2019 Needs Assessment for the NT Mental Health Peer Support Workforce. Report to the NT Primary Health Care Network <https://www.ntmhc.org.au/2018-2019-mental-health-peer-support-workforce-needs-assessment/>

²⁰ https://justice.nt.gov.au/_data/assets/pdf_file/0006/614994/D01362017-Di-Lembo.pdf

the mental health awareness and training for NT GPs, which includes facilitating better integration between local GPs and acute mental health services.

The Productivity Commission has overlooked the need for a robust, non-clinical recovery support workforce and its skill development. These psychosocial support workers are essential, with further workforce development required, especially for workers providing care to people with lived experience and cultural connections.

4. Recognising the role of the non-government, community-based mental health sector

The Draft Report appears to not understand or value the role of the non-government, community-based mental health sector and seems to consider delivery of mental health in community settings as provided by government services. It does not appropriately reflect the extent and importance of the community-based, non-government mental health sector which provides a range of services within the stepped care model (e.g. psychosocial support, care coordination, peer support). Some of this apparent confusion may arise from the AIHW database which only holds information about expenditure on government-provided services in community settings. We note that in the NT such government services are largely clinical outpatient services. We would like the Productivity Commission to acknowledge the non-government, community-based mental health sector as critically important, in addition to the services provided in community directly by government.

The partnership between government-provided services and non-government, community-based mental health services is an essential component of the stepped care model which underpins the mental health system across Australia. Submissions from Coalition members (for example TeamHEALTH) provide examples of how these partnerships operate in practice, and support the case for greater investment in service coordination and integration. Person-centred care relies on these partnerships for the smooth delivery of care that meets the changing needs of individuals.

In the NT the non-government, community-based mental health sector plays vital roles in:

- the provision of all psychosocial support services, advocacy, rehabilitation, step-up step down care, supported accommodation, tenancy support, carer support services, mental health promotion and awareness, counselling, care navigation and referral, and the vast majority of mental health education.
- coordination and integration across the mental health system and in providing wraparound services for people with lived experience.

In a small jurisdiction like the NT, this integration and coordination is essential to maximise scarce resources, tap into networks and to bridge service gaps wherever feasible. The not-for-profit community mental health sector coordinates local mental health networks in regions of the NT. Draft finding 10.2 recognises the importance of collaboration but is not followed up by a recognition/recommendation of the value of funding the transactional costs (particularly in time) associated with effective collaboration.

- bringing forward the views of people with lived experience of mental health.

The NT is the only Australian jurisdiction that has not invested in supporting consumer and carer participation in the mental health system, and as result does not have a formal lived experience network providing advice to government and service providers. The result is a lack of meaningful engagement with people with lived experience, their families and supporters. Consultation is ad hoc and the views of carers and consumers are often overlooked. Where engagement does occur, it is frequently with the same subset of people with lived experience who have the confidence and skills to engage, but potentially not to the extent recommended by the Productivity Commission. This means that a limited perspective is contributed to these processes, and the broader views and needs of the greater lived experience community are not appropriately represented. Aboriginal people and those from non-English speaking backgrounds are among the most marginalised in current approaches.

Meaningful engagement of people with lived experience is essential to achieving better mental health and wellbeing outcomes for all Australians. The National Mental Health Commission states²¹ that “engagement and participation with people with lived experience in mental health and suicide prevention that actively supports co-design, coproduction, and co-delivery of systems and services leads to better health and wellbeing outcomes, aids recovery, and achieves better experiences for service users and service providers”. Furthermore, to achieve this “requires strong policy commitment to partnering with people with lived experience in monitoring and reviewing system and service performance, and decision-making about what is deemed to be a desired outcome”.

In the Northern Territory (NT), the community sector is leading the development of a peer-worker workforce which will benefit mental health services across the Territory.

- supporting people needing mental health services in regional and remote areas where clinical services may be unaffordable or non-existent. There is limited access to fully-funded psychological services in the NT through the ATAP (Access to Allied Psychological Services) program funded by the NT PHN provides psychological services to priority groups.²² ATAP is a triaged service by referral from GPs and is only available to people have been diagnosed with mild to moderate illness; it will not accept clients that are deemed to high risk. The suicide prevention stream will accept complex risk, but not acute presentations. In the NT, beyond the Aboriginal medical services, there are no bulk-billing GPs in Katherine or Tennant Creek; and there are very few bulk-billing private psychologists and available GPs may not have mental health training.
- NT community-based mental health services also assist schools with counselling services. The availability of counselling services in government run schools is ad hoc with school counselling services only accessible to less than half of student numbers.

²¹ National Mental Health Commission 2020 Consumer and carer engagement <https://www.mentalhealthcommission.gov.au/Mental-health-Reform/Consumer-and-carer-engagement>

²² <https://www.ntphn.org.au/access-to-allied-psychological-services>

Many schools, large and small, urban and remote, have no access to service except for critical incident response.²³ In order to address this gap, some schools have formed relationships with not-for profit community mental health counselling services.

5. Increasing reliance on technology

The Productivity Commission is proposing a heavier reliance on digital technology for providing mental health services, particularly for early intervention and low intensity services (draft recommendation 6.1). The Coalition recognises that there is a place for technology but urges caution against a major shift at the expense of investing in services.

The provision of culturally safe services across the mainstream health sector is key to improving the availability and quality of services available to First Australians, and the application of a “one size fits all” model for centralised and digitalised services makes it far less probably to provide culturally safe services.

In relation to the request for information (6.1) about supported online treatment for CALD communities, we can advise that telephone support services and 1800 services are not accessed by people living in remote Aboriginal communities. Evaluations of 1800RESPECT, Centrelink services and other phone services, such as SUPPORTLINK in the NT have demonstrated the problems of these phone lines for remote, and particularly Aboriginal communities. Issues have also been encountered by people needing access to the MyAgedCare portal. This stems from a number of factors:

- there is often no connection available to the person needing support for example, there may be limited phone or internet coverage in their location; they may not have a phone or an internet account, or available credit. In 2016-17, 22.9% of households and 20.2% of people living in remote and very remote locations did not use the internet²⁴
- the phone or internet may be in a public place and they have no privacy to make the call
- the person responding to the call doesn't speak their language, doesn't understand the cultural context and usually has no real idea of their location, and so there are delays, wrong or inappropriate referrals
- it is not a culturally appropriate way to engage in personal conversations (person on the other end of the line is not known to client, therefore lack of trust, inability to communicate).

The most important issue is that these connections are generally referral services and in remote communities there are no services that can be usefully referred to.

The Department of Social Services is introducing a new Integrated Carer Support Service, a major reform to the funding of carer services. A single Regional Delivery Partner will replace multiple carer service providers across the NT. A series of centralised programs are being commissioned including Online Peer Support Service Provider, Education Provider (for

²³ https://education.nt.gov.au/__data/assets/pdf_file/0011/707861/Final-Report-Study-of-the-School-Counselling-Service-in-the-NT-Government-Schools-February-2018.pdf

²⁴ Australian Bureau of Statistics 2018 8146.0 - Household Use of Information Technology, Australia, 2016-17 <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/8146.0Main+Features12016-17?OpenDocument>

online programs), Carer Coaching Service Provider (including online coaching and a peer model to be implemented by Regional Delivery Partners) and Digital Counselling Service Provider.²⁵ In the NT, carers are concerned that this move to centralise and digitise a large portion of the Integrated Carer Support Service will further disadvantage Aboriginal Territorians, especially those living in remote and rural areas.

6. Recognising the role of carers

The Coalition welcomes the Productivity Commission's acknowledgement that it is critical to ensure consumers and carers participate fully in the design of policies and programs that affect their lives (reform objective: governance, responsibilities and consumer participation) and that government support for carers needs to be flexible to reflect individual circumstances (p41).

7. Children and Youth Mental Health

The Coalition supports the commentary around the potential for early identification of risks in children offers a great potential for improving health, social and economic outcomes, and the idea that schools need to be effective gateways for students and their families to access help (p10-11). Significantly more investment will be needed to establish and maintain such services in the NT.

Similar to the situation nationally, the NT does not currently have dedicated mental health services for early intervention for children under 12 years experiencing mild to moderate mental health difficulties.

In the NT there are very limited services and supports available for young people outside the main centres of Darwin, Alice Springs and Katherine (where there is a single position). In addition, other than the government services in Darwin and Alice Springs, fully-funded youth mental health services, such as the Child Youth and Family team in Katherine, only support young people with mild to moderate illness.

The only youth inpatient facility is located at the Royal Darwin Hospital. During late 2019, there were media reports that the youth ward had been used for an overflow of adult patients raising concerns for the suitability of care for young people and adequacy of services in general.²⁶

headspace has only 3 locations in the NT (Darwin, Alice Springs and Katherine) providing a combination of clinical and psychosocial support to 12 to 25 year olds experiencing mild to moderate illness.²⁷ Its only early psychosis unit is located in Darwin. This unit also provides a limited Enhanced Care Service for young people experiencing complex mental health issues.

a) Addressing youth mental health in NT school settings

The Coalition notes draft recommendations 17.3 and 17.4 which aim to improve educational support for children with mental illness. Additional investment will be needed to ensure that such initiatives are implemented equitably and in ways that are culturally appropriate

²⁵ https://www.dss.gov.au/sites/default/files/documents/12_2018/icss-service-blueprint-version-13.pdf

²⁶

https://www.ntnews.com.au/subscribe/news/1/?sourceCode=NTWEB_WRE170_a&dest=https%3A%2F%2Fwww.ntnews.com.au%2Fnews%2Fleaked-emails-reveal-depth-of-mental-health-crisis-at-royal-darwin-hospital%2Fnews-story%2F4ce4981fcb809f0b9521ee4c88c005de&memtype=anonymous&mode=premium

²⁷ <https://www.ntphn.org.au/youth-mental-health-services-2>

and address the needs of young people in the NT. Setting a minimum enrolment number for a school before it is required to have mental health support (information request 17.1) will inevitably result in many young Aboriginal people missing out on the help they may need.

The NT has the highest proportion nationally of students with additional needs, with 27% of students receiving education adjustments.²⁸ The NT Council of Government Schools Organisation (COGSO) estimates that less than a quarter of these have a formal diagnosis.²⁹ COGSO suggests that the barriers to obtaining a diagnosis and accessing therapeutic supports include low levels of health/disability literacy, high levels of socio-economic disadvantage, fragmented pathways between health and education, long waitlists, lack of affordable private pathways, and an overrepresentation of complex family issues, chronic disease and psychological distress, particularly among Aboriginal populations. These issues are exacerbated in remote locations.

More investment in coordinating care for young people is warranted, given the multiple barriers they face. Multiple agencies are funded to provide services to a single individual, leading to poor service integration, disparate approaches to care, and confusion and poor engagement for the young person.

Sixty-eight percent of NT Government schools are in remote and very remote areas and 46% of students are enrolled at remote and very remote schools.³⁰ Of 33,000 students in the NT, 44% are Aboriginal or Torres Strait Islander and more than three quarters live in remote and very remote locations. Remote and very remote schools are numerous, but very small. NT Government operated schools are funded based on attendance, rather than enrolment.³¹ For 2019, the average attendance rate for Aboriginal and Torres Strait Islander students was 61.7%, (compared with 87.2% for non-Indigenous students). In remote regions, attendance was 63.9% and in very remote regions was 48.9%. The result is that schools, particularly in remote and very remote areas, have inadequate funding to address the needs of students who experience the lowest wellbeing and highest psychological distress. These are also the areas with the least access to mental health services and which are most disadvantaged in relation to all social determinants of health.

Eighty to ninety percent of Aboriginal children in remote schools' experience middle ear infection which causes fluctuating conductive hearing loss, as do 50% of Aboriginal children in urban schools.³² Children and adults with hearing loss have been found to have more behavioural problems and social problems, and Aboriginal adults with listening problems describe higher levels of psychological distress. Aboriginal children with hearing impairment in the NT struggle to attend school, are at increased risk of child maltreatment and boys with hearing problems are at higher risk of youth offending.³³

²⁸ https://education.nt.gov.au/__data/assets/pdf_file/0008/662786/Review-of-Policy-and-Practice-for-Students-with-Additional-Needs.pdf

²⁹ <https://www.ntcogso.org.au/practical-help/children-additional-needs>

³⁰ https://education.nt.gov.au/__data/assets/pdf_file/0008/662786/Review-of-Policy-and-Practice-for-Students-with-Additional-Needs.pdf

³¹ <https://education.nt.gov.au/statistics-research-and-strategies/enrolment-and-attendance>

³² https://education.nt.gov.au/__data/assets/pdf_file/0008/662786/Review-of-Policy-and-Practice-for-Students-with-Additional-Needs.pdf

³³ He, V.Y., Su, J., Guthridge, S. *et al.* Hearing and justice: The link between hearing impairment in early childhood and youth offending in Aboriginal children living in remote communities of the Northern Territory, Australia. *Health Justice* 7, 16 (2019) doi:10.1186/s40352-019-0097-6

<https://healthandjusticejournal.biomedcentral.com/articles/10.1186/s40352-019-0097-6>

8. Provision of psychosocial supports and impacts of the NDIS reforms in the NT

The Coalition notes the commentary in the Draft Report about the NDIS and the need to provide ongoing funding for psychosocial supports for people who cannot access the NDIS (p31).

Major Commonwealth reforms including the aged care and NDIS reform have been designed without considering the realities of remote and very remote regions causing significant consequences to vulnerable people living across the NT.

The Coalition has developed a detailed understanding of pathways into the NDIS and provision of other psychosocial supports across regions of the NT in order to assess the potential impact on people affected by severe and complex mental illness and the community mental health sector more broadly. This information is presented in Appendix 1.

Our findings indicate that of the estimated 7,700 Territorians with severe and complex mental illness, as few as 800 people (approximately 10%) have access to a NT Government- or Commonwealth-funded psychosocial support service to support their recovery. Of these, approximately 600 participated in Commonwealth-funded PIR, PHAMs and D2DL programs, and about 200 access NT Government-funded services in Darwin, Katherine and Alice Springs.³⁴

NDIA data shows that 147 people experiencing psychosocial disability in the NT had been approved access to the NDIS by 30 June 2019.³⁵ The NT Mental Health Coalition survey data is taken into account, it appears that the people accessing the NDIS in the NT were supported by Commonwealth-funded psychosocial support services. NT Government services do not appear to be assisting people to test eligibility and transition to the NDIS, nor are family members likely to be sufficiently skilled to support people to access the NDIS.

Progress remains slow: at 30 September 2019, the number of NDIS participants with psychosocial disability in the NT had increased to 173. Assuming all remaining Commonwealth-funded participants test eligibility and a transition rate of 50%, 300 Territorians with psychosocial disability may be successfully supported to access the NDIS by 30 June 2020. This compares poorly with the 1,000 Territorians who are expected to be eligible.

The Commonwealth National Psychosocial Support Measure allocated \$800,000 to the NT for the period from 1 July 2018 to 30 June 2021.³⁶ This equates to approximately \$240,000 per annum to support all new or re-emerging clients requiring psychosocial support after 30 June 2019 (other than the 200 estimated to be accommodated by NT Government-funded programs). This is grossly inadequate for supporting the estimated 6,900 other people experiencing severe and complex mental illness.

Unless commissioning bodies act swiftly to expand services to support eligible people who are not connected with a service which is skilled and provisioned to support their access to the NDIS, there will be a significant reduction in funding flowing into the NT community mental health sector. This will occur when Commonwealth Transition funding ceases on

³⁴ https://www.ntphn.org.au/web_images/2018%20Program%20Needs%20Assessment.pdf

³⁵ <https://data.ndis.gov.au/data-and-insights/data/participant-data>

³⁶ <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-n-national-psychosocial-support-measure>

30 June 2020, at which time potentially only 30% of the originally forecast NDIS participant plan funding will be circulating within the sector across the NT. The likely result will be the collapse of long-time psychosocial support service providers in multiple regions of the NT.

The NDIA policy to address this is to fund a “provider of last resort”, but this will be hard to establish if regional service providers have already collapsed or withdrawn services in remote and very remote regions of the NT.

We support the National Mental Health Commission recommendations³⁷ that the Australian Government considers whether funding available under the National Psychosocial Support and Continuity of Support measures matches the needs of people who are ineligible for the NDIS; and together with state and territory governments ensures that people who are ineligible for the NDIS have access to adequate psychosocial support services.

9. Monitoring and evaluation

The Coalition supports continually driving systems improvement (reform objective – monitoring, reporting and evaluation) and the intent of draft recommendation 22.5 – building a stronger evaluation culture. Programs and investment need to be informed by better quality data and evaluation to identify, adapt and apply what works in particular circumstances. This in turn requires investments in building the capacity of service providers to collect, analyse and interpret data at a service level. The Coalition also supports establishing national program and population level analyses and evaluations.

We note that the National Mental Health Commission recommends³⁸ the routine collection of comprehensive, publicly reported data across all systems that affect mental health in order to inform service planning and facilitate improved outcomes for consumers and carers.

It is critical that people with lived experience lead research and program co-design. The Coalition supports the overarching recommendation (22.3) that consumers and carers should have the opportunity to participate in the design of government policies and programs that affect their lives.

It is also important that consumers and carers inform the design of data collection methods to accurately measure improvements in the mental health care system, reduction in restrictive practices which contravene their human rights, improvements in their quality of life and related outcomes. The Coalition notes that there is no national or NT level routine collection of data relating to the use of chemical restraint.

10. Funding arrangements

The Draft Report indicates that the Productivity Commission prefers a new funding (‘rebuild’) model which will disburse all funding related to mental health through new state-level commissioning bodies (Regional Commissioning Authority). The rationale appears to be that responsibility for the other social determinants of mental health such as housing,

³⁷ National Mental Health Commission 2019 Monitoring mental health and suicide prevention reform National Report 2019 Summary <https://www.mentalhealthcommission.gov.au/getmedia/c84bc89a-ae1c-489f-afef-296f0207da96/2019-National-Report-Summary>

³⁸ National Mental Health Commission 2019 Monitoring mental health and suicide prevention reform National Report 2019 Summary <https://www.mentalhealthcommission.gov.au/getmedia/c84bc89a-ae1c-489f-afef-296f0207da96/2019-National-Report-Summary>

education and justice are provided at state/territory level, and therefore can be more readily engaged in mental health policy and programs.

The Productivity Commission also proposes to extend activity based funding to mental health services, rather than block-funding.

The Coalition acknowledges that the Productivity Commission is seeking ways to improve investment in mental health. We see considerable merit in a more integrated approach to planning and commissioning mental health services. We note that the National Mental Health Commission³⁹ recently identified that there is considerable variability in how PHNs plan and evaluate commissioned services to address the needs of their region and that they require further support and capacity building to help them with their expanding role.

However, in the NT a shift to the 'rebuild' model would need to be carefully managed in order to avoid unintended consequences.

- The 'rebuild' model could result in duplication of infrastructure/administrative systems established to service the local NT PHN at both the operational and advisory levels. The small size of the NT means that many of the same people and organisations hold advisory and leadership roles across the health sector, as well as being commissioned/contracted as service providers. Providers in the NT often deliver holistic services, and would need to be engaged with the new regional commissioning authority as well as with the local NT PHN, the NT Government and directly with Commonwealth agencies including the NIAA, Attorney-General, Department of Social Services as well as the Department of Health.
- A 'rebuild' model could undermine efforts to take an integrated and holistic approach to mental health, social and emotional wellbeing reflecting person-centred care. The Draft Report acknowledges the potential for fragmentation when it asks if alcohol and other drugs programs should also be transferred to a new regional commissioning authority in recognition of the co-morbidity of alcohol and other drugs dependence and mental health.
- The 'rebuild' model may also lead to further fragmentation and underinvestment in the Territory mental health system due to the likelihood that both the Commonwealth and the Territory Governments vacate the field. This has already occurred in the transition to the NDIS, where greater clarity of roles between the Commonwealth and the NT Government has resulted in less people accessing support services than was previously the case (see Appendix 1). Commonwealth block-funded psychosocial support programs have been phased out with the expectation that eligible people have transitioned to the scheme. Where inadequate investment has been made to transition people into the system the net result is a reduction or decommissioning of services.

³⁹ National Mental Health Commission 2019 Monitoring mental health and suicide prevention reform National Report 2019 Summary <https://www.mentalhealthcommission.gov.au/getmedia/c84bc89a-ae1c-489f-afef-296f0207da96/2019-National-Report-Summary>

- In the areas of both disability and aged care, the shift from block funding to activity funding has widened rather than closed gaps in services (see Appendix 1). In thin markets, servicing sparse and relatively disadvantaged populations results in diminished services – in less choice rather than more. This market failure is not confined to the NT and is apparent across regional and remote Australia. For example, local service providers in remote areas have difficulty registering due to strict quality and safety guidelines, despite their familiarity with remote communities; and we have yet to see the NDIA step in as the provider of last resort in servicing remote communities under the NDIS. As a result, access to services continues to decline.

By defining the activities to be funded and the rate at which they will be funded, activity-based funding has the potential to undermine the person-centred care, where services need to be available when they are required and in the form that they are required.

- There is a need to ‘top-up’ investment from the Commonwealth. The ‘rebuild’ model links the size of each regional commissioning authority’s funding pool to the volume of Medicare Benefits Scheme (MBS) rebates for allied mental healthcare in their region with each RCA permitted to contract with MBS-subsidised allied mental health professionals to create a single regional mental healthcare budget (p47). In the NT, linking the funding pool to the volume of MBS rebates would require a funding adjustment for Commonwealth investment, as the reliance on the Medicare Benefit Scheme (MBS) as the benchmark will short-change the NT. This disadvantage is well documented and arises from lack of access to MBS payments for services delivered by remote health practitioners (such as nurse practitioners); the extent of services delivered by Aboriginal community controlled health organisations which received block-funded rather than MBS-funded; and the paucity of available MBS-subsidised mental health professionals.

Relying on the MBS as a baseline for funding levels also risks penalising prevention efforts; as treatment rebates decline as a result of prevention programs, funding for the region would also decline. Less funds would then be available for prevention programs, and prevalence would rise.

Conclusion

The Coalition welcomes the Productivity Commission Draft Report and in particular its recognition of the need for access to culturally appropriate, person-centred within a stepped care model; the critical roles for consumers and carers; a focus on prevention and early intervention; and improved data collection, monitoring and evaluation.

However, the Coalition is concerned that draft recommendations may inadvertently exacerbate already difficult situations, such as those that exist in the Northern Territory. The Productivity Commission needs to give further consideration to the implications of the draft recommendations for providing services in disadvantaged rural, remote and very remote areas across the Northern Territory.

The Coalition is also concerned that there is insufficient understanding of the role and value of the non-government, community-based mental health sector within the mental health system. The final report should include clear recommendations that address:

- the need to expand community-based support
- provision of appropriate funding to enable this expansion to occur
- the role of community-managed mental health organisations in addressing the current service gaps through the provision of person-centred, psychosocial rehabilitation and support services.

The Coalition supports developing a Community Mental Health Care Model based on the following service principles:

Accessibility

- Services are easily located, available and perceived as safe, welcoming and appropriate for all types of Australian communities
- Initial entry is open with multiple access points and “no wrong door” approach
- Proactively connecting and reaching out to [isolated] people in need
- No access or service disadvantages due to age, gender, location, race/ethnicity, sexuality, gender identity, etc.

Person-centred delivery

- people with lived experience, their families and support people are central to the process and involved in all decisions
- strengths based and recovery-oriented
- focused on prevention and early intervention
- wrapped around the needs of the Individual and integrated with the wider health, welfare and justice systems, covering the continuum of mental health care for whole-of-life needs

Mental health workforce

- an enhanced role for peer workers
- all workers are qualified to provide high-quality treatment that is strengths-based, culturally appropriate and trauma competent
- team-based and interdisciplinary

Quality and Accountability

- quality and accountability is assured through audited compliance with agreed standards and targets.
- human rights are embedded into all aspects of the system
- services provide evidence-based treatments which are outcomes-focused to achieve value for money and for individuals and society
- consistent approaches to data collection and analysis facilitate the effective undertaking of monitoring, review, quality improvement, evaluation and research.

Appendix 1: Provision of psychosocial supports and impacts of the NDIS reforms in the NT

Major Commonwealth reforms including the aged care and NDIS reform have been designed without considering the realities of remote and very remote regions causing significant consequences to vulnerable people living across the Northern Territory.

In the case of the NDIS, the former Commonwealth-funded psychosocial support programs were phased out with the expectation that all eligible people would be transitioned to the scheme by 30 June 2019. Lack of progress resulted in the Commonwealth making a late investment to extend the transition period to June 2020.

The Coalition has developed a detailed understanding of pathways into the NDIS and provision of other psychosocial supports across regions of the NT in order to assess the potential impact on people affected by severe and complex mental illness and the community mental health sector more broadly.

Northern Territory Government-funded psychosocial support services for adults presently exist in Darwin, Katherine and Alice Springs. Commonwealth-funded psychosocial supports extend beyond these three areas to include East Arnhem, Tennant Creek, Yuendumu, Gunbalunya, Ngkurr, Kintore, Papunya Communities and the Tiwi Islands.

Based on epidemiological data the prevalence of the adult population experiencing severe and complex mental illness is approximately 3.1%.⁴⁰ This is equivalent to approximately 7,700 people across the NT, the total population of people who may require and may be eligible for referral to psychosocial support services (this figure is not adjusted for the additional mental health burden experienced by Aboriginal people who constitute 30% of the NT population). Of the population experiencing severe and complex mental illness, the NDIS targets a relatively small group of people with severe and persistent illness with complex multi-agency needs, whose symptoms are the most severe and who are likely to experience significant functional disability as a result of their illness. In the Northern Territory this cohort is estimated to be approximately 1,000 people.

The Coalition contacted psychosocial support providers across the NT to estimate the numbers of people receiving support in each region (NDIS, Commonwealth and NT Government funded services). From the data collected to date, we estimate that 600 unique clients were participating in Commonwealth-funded programs affected by the psychosocial funding reforms at 30 June 2019, when the former program arrangements and new referrals ceased. The former Personal Helpers and Mentors (PHaMs), Partners in Recovery (PIR) and Day to Day Living (D2DL) programs were replaced by ongoing Continuity of Support (CoS) funding for clients denied access to the NDIS and 12-month transition funding for clients who were yet to test access to the NDIS.

In 2018 the NT PHN estimated that the collective capacity of the Commonwealth programs was approximately 1,000 unique clients across the NT, which allowed for some cross over of

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[https://www1.health.gov.au/internet/main/publishing.nsf/Content/2126B045A8DA90FDCA257F6500018260/\\$File/4.%20PHN%20Guidance%20-%20Primary%20Mental%20Health%20Care%20Services%20for%20People%20with%20Severe%20Mental%20Illness%20-%202019.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/2126B045A8DA90FDCA257F6500018260/$File/4.%20PHN%20Guidance%20-%20Primary%20Mental%20Health%20Care%20Services%20for%20People%20with%20Severe%20Mental%20Illness%20-%202019.pdf)

clients between programs where more than one type of program was available.⁴¹ The large variance between the original estimates (1,000) and actual number (600) of unique clients was due to program vacancy and a significant number of clients shared between programs in the regions of Darwin and Alice Springs where there were multiple programs on offer.

Only 600 people will have the opportunity to test access to the NDIS with the support of Commonwealth-funded programs, formerly known PHaMs, PIR and D2DL.

The Coalition estimates that at 30 June 2019, approximately half the 600 people participating in the Commonwealth-funded programs had tested access to the NDIS and approximately half of those had gained access to the NDIS. Therefore, less than a quarter of former Commonwealth-funded program participants had been supported to access the NDIS by the time PIR, PHaMs and D2DL programs ceased. In contrast, funding agreements nominated that all program participants should have been supported to test eligibility in the three years prior to this date, with transition rates anticipated between 70 and 90%.

Although the Coalition has yet to determine the current number of participants in NT Government funded psychosocial support services, based on previous service mapping exercises, its estimate that there are 200 people accessing NT Government-funded services in Darwin, Katherine and Alice Springs.⁴² This means that of the estimated 7,700 Territorians with severe and complex mental illness, as few as 800 people (approximately 10%) have access to a NT Government or Commonwealth-funded psychosocial support service to support their recovery.

The NDIA release of participant data, shows that 147 people experiencing psychosocial disability in the NT had been approved access to the NDIS by 30 June 2019.⁴³ When our data is taken into account, this suggests that potentially all the people accessing the NDIS in the NT were supported to transition to the NDIS by Commonwealth-funded psychosocial support services. Our survey indicates:

- NT Government-funded psychosocial support programs and NT Government mental health services do not appear to be assuming responsibility for the preparation and submission of NDIS access requests.
- A skilled worker available through a psychosocial support program is required to access the NDIS in the NT. The NDIA shared data at the 2018 Transition Support Conference indicating that 29% of psychosocial participants had accessed the scheme without the support of a psychosocial support provider. The data for the NT indicates that this is far from the case, which corroborates feedback from Coalition members in relation to the challenges of preparing comprehensive NDIS Access Requests in the NT.
- Family members are unlikely to be sufficiently skilled to support people to access the NDIS in the NT given the challenges experienced by Commonwealth-funded psychosocial support workers who have been trained by the Flinders University Transition Support Project.

⁴¹ https://www.ntphn.org.au/web_images/2018%20Program%20Needs%20Assessment.pdf

⁴² https://www.ntphn.org.au/web_images/2018%20Program%20Needs%20Assessment.pdf

⁴³ <https://data.ndis.gov.au/data-and-insights/data/participant-data>

Progress remains slow: at 30 September 2019, the number of NDIS participants with psychosocial disability in the NT had increased to 173. Assuming all remaining Commonwealth-funded participants test eligibility and a transition rate of 50%, 300 Territorians with psychosocial disability may be successfully supported to access the NDIS by 30 June 2020. This compares poorly with the 1,000 Territorians who are expected to be eligible.

Commonwealth funding to support any new or re-emerging clients is provided under the National Psychosocial Support Measure (NPSM). The NPSM was allocated based on population only, which meant that the Northern Territory attracted a total of \$800,000 in Commonwealth funding for the period from 1 July 2018 to 30 June 2021.⁴⁴ This equates to approximately \$240,000 per annum to support all new or re-emerging clients requiring psychosocial support after 30 June 2019 (other than the 200 estimated to be accommodated by NT Government funded programs). This is grossly inadequate for the NT, equating to the equivalent of two full time positions across the entire jurisdiction, to support 2.8% of the population who may require psychosocial support and cannot access other services (i.e. 90% of the severe and complex population, is approximately 6,900 people).

The Coalition’s survey has revealed investment in psychosocial support services across individual regions of the Northern Territory to be ad hoc and uncoordinated. Complete data is available for Darwin and East Arnhem regions (but is not yet available for other regions).⁴⁵

	Darwin Urban	East Arnhem
Total population in region ⁴⁶	122683	13585
Estimated population with severe and complex mental illness (3.1%) ⁴⁷	3803	421
Estimated population eligible for the NDIS due to psychosocial disability (0.4%)	491	54
Actual number of NDIS participants with psychosocial disability (at 30 September 2019) ⁴⁸	58	49
Approximate transition rate achieved by regional providers for NDIS Access Requests	60%	90%
Actual NDIS participants as a proportion of the NDIS eligible population (at 30 September 2019)	12%	90%
Actual number of Commonwealth-funded Continuity of Support and Transition clients (circa 30 September 2019)	119	42
Projected number of NDIS participants with psychosocial disability (at 30 June 2020) ⁴⁹	105	80
Projected NDIS participants as a proportion of the NDIS eligible people (at 30 June 2020)	21%	146%

⁴⁴ <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-n-national-psychosocial-support-measure>

⁴⁵ Commonwealth funded psychosocial support providers Miwatj Health Aboriginal Corporation, TeamHEALTH and Mission Australia have contributed participant data.

⁴⁶ Australian Bureau of Statistics, Data by Region (NT) and Local Government Area. Unincorporated area of Nhulunbuy included in East Arnhem population estimate. <https://itt.abs.gov.au/itt/r.jsp?databyregion#/>

⁴⁷ Noting that this percentage does not account for the additional mental health burden experienced by the Aboriginal and Torres Strait Islander population

⁴⁸ NDIS Participant Data <https://data.ndis.gov.au/data-and-insights/data/data-downloads>

⁴⁹ Calculated by applying a transition rate of 50% to the estimated number of transition clients in the NT and adding the number of people who are already in the NDIS.

The data indicates significant historic under investment in Commonwealth-funded psychosocial supports in the Darwin region. Under present circumstances as few as 21% of people with psychosocial disability who are eligible for the NDIS in the Darwin region are likely to receive the support necessary to gain entry to the NDIS by 30 June 2020. By comparison, it is likely that the entire population of people in East Arnhem with psychosocial disability are likely to have support necessary to gain access to the NDIS. There are also high proportions of Continuity of Support (CoS) places available in East Arnhem compared to the Darwin region.

Unless commissioning bodies act swiftly to expand services to support the estimated 700 eligible people who are not connected with a service which is skilled and funded provisioned to support their access to the NDIS, there will be a significant reduction in funding flowing into the Northern Territory community mental health sector. This will occur when Commonwealth Transition funding ceases on 30 June 2020, at which time potentially only 30% of the originally forecast NDIS participant plan funding will be circulating within the sector across the Northern Territory. The likely result will be the collapse of long-time psychosocial support service providers in multiple regions across the Northern Territory.

The NDIA policy to address this is to fund a “provider of last resort”, but this will be hard to establish if regional service providers have already collapsed or withdrawn services in remote and very remote regions of the Northern Territory.

Thank you on behalf our members for this opportunity to respond to the Draft Report.

OUR MEMBER ORGANISATIONS

CatholicCare NT



MHACA
Mental Health
Association of
Central Australia

TEMHCO



Top End Mental Health
Consumers Organisation



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power of
humanity

