Northern Territory Government

SUBMISSION TO THE SENATE SELECT COMMITTEE ON MENTAL HEALTH

MAY 2005

SUBMISSION FROM THE NORTHERN TERRITORY GOVERNMENT

TO THE

SENATE SELECT COMMITTEE ON MENTAL HEALTH

INTRODUCTION

The Northern Territory (NT) Government is committed to a better mental health service system to achieve improved outcomes for consumers, their carers, families and communities.

New funding invested by the NT Government ($12.7M) has been allocated to Mental Health Services in the Territory over the three years 2003/04-2005/06. The final instalment of $1.5M will be added to the Mental Health Budget in 2005/06. Additional funding of $5.5M from 2005/06 to 2007/08 was also announced in the 2005/06 NT budget. Funding for Mental Health Services in the NT represents approximately 4% of the total NT health budget.

This funding has been invested in a program of reform to modernise the approach to client care in the Northern Territory and build a more comprehensive Mental Health Service system with the capacity to provide an appropriate range of service options for all Territorians.

The Mental Health Program funds the Top End Mental Health Service (TEMHS) and Central Australian Mental Health Service(s) (CAMHS) and non-Government organisations (NGO's) to provide:

- program management, policy and service development;
- mental health promotion and prevention and early intervention initiatives;
- specialist mental health assessment, treatment and case management services;
- primary mental health care initiatives;
- consumer rehabilitation and support; and
- support for carers and families.

SERVICES & STAFF

Comprehensive specialist mental health services have been located in the NT only since the 1980s. Funding for mental health support services in the non-Government sector commenced in 1989.

Mental Health Unit (Policy & Program Management)

A small policy and program management unit is located in Darwin. This unit has a small permanent staffing compliment of 7 FTE that work to the Director of the Program and across a range of local and national priority areas. The unit has primary responsibility for implementing, monitoring and reporting progress on all National Mental Health Strategy initiatives in addition to substantial local responsibilities, including:

- funding and direct responsibility for public mental health service delivery;

- funding and service agreements for non-Government mental health support services;
- policy development and implementation;
- service development;
- information management; and
- legislative reform.

Three additional staff are currently employed utilising Australian Government 'Quality Through Outcomes' funding to train mental health clinicians in the use of a standardised suite of outcome measures and to integrate outcome measurement into routine clinical practice in the NT.

Specialist Services

Specialist integrated Mental Health Services are delivered by the TEMHS and CAMHS and include community based adult, child, youth, forensic services and inpatient services.

Inpatient and community based services are provided in Darwin and Alice Springs. Rural and Remote community mental health services are also located in Darwin Rural, Katherine, East Arnhem, Alice Springs Remote and the Barkly Regions.

The NT has paralleled the rest of Australia in that an increasing proportion of the budget is allocated to community-based services.

Non-Government Services

Nine NGO's are funded by the NT Mental Health Program to provide a range of services, including:

- Consumer support services including sub-acute, outreach, rehabilitation and disability support services;
- Carer support services;
- Aboriginal Social and Emotional Wellbeing services; and
- Mental health promotion.

CONTEXTUAL ISSUES AND KEY DRIVERS OF EXPENDITURE IN THE NT

The Territory has a range of unique characteristics that make it difficult to provide the full spectrum of mental health services across the Territory, particularly in rural and remote communities. These characteristics include a unique socio-demographic composition, dispersion of a small population over a large landmass, climate and infrastructure.

Key features of the Northern Territory environment and population that impact directly on service provision in terms of the demand for services, models of service delivery and the cost of providing services are outlined below.

Environment and Population Characteristics

Population Dispersal

The NT covers approximately one sixth of the landmass of Australia, but constitutes only one percent of the population. There are only five urban centres, all of which are remote from the rest of Australia. The estimated NT population for 2003 was 198,358 NT Department of Health and Community Services (DHCS) of which 68% of people reside in either the Alice Springs or Darwin Urban areas. The remaining 32% of the population live in smaller, dispersed communities, only two of which have populations of greater than 10,000 people.

The Top End, which covers an area of 614,000 square kilometres, has a population of approximately 153,000 people (NT DHCS). The Top End region comprises Darwin Urban, Darwin Rural, Katherine and East Arnhem Regions.

The Darwin Rural Region includes rural areas surrounding Darwin, and a number of remote locations such as, Oenpelli, Wadeye and Maningrida. The population of the region is approximately 12,667. The major town in the region is Jabiru. The region also includes the Tiwi Islands to Darwin's north.

The Katherine region covers an area of approximately 340,000 square kilometres between the borders of Western Australia and Queensland, extending as far as Dunmarra to the south and Pine Creek to the North. The Katherine region has a population of approximately 18,325 people.

The East Arnhem Region covers an area of 64,000 square kilometres extending west as far as Ramingining, south to Numbulwar and includes Groote Eylandt. The population of 13,975, predominantly Aboriginal, live in twelve main communities and numerous smaller Aboriginal homelands located on the mainland and adjacent islands. The major town is Nhulunbuy.

The Central Australia Region comprises an area of over 830,000 square kilometres. It shares borders with South Australia, Queensland and Western Australia. The region has a population of about 44,700 people, of whom approximately 16,200 are Aboriginal. While approximately 26,000 people live in Alice Springs and Tennant Creek, the remainder of the population is scattered throughout the 45 remote communities and out-stations of the region.

A large proportion of the service to Central Australia is provided over significant distances where populations in remote pastoral concessions and Aboriginal communities may vary between 50 and 1000 people.

A unique feature of providing services in this region is the need for flexible cross border, or tri-partite service delivery agreements. Mental Health Services are also provided to residents in the Anangu Pitjantjatjara Yankunytjatjara Lands across the border in South Australia.

In addition to the NT resident population, approximately 1.8 million tourists visit the NT each year, some of whom may require mental health services.

Indigenous Population

The primary characteristic of the NT is that 28.5% of the Territory's population is Indigenous, compared to 2.2% in Australia's total population. A very high proportion of the Indigenous people, 70%, live in remote areas (ABS, 2002) and English is often a second or third language.

Significant long-term primary health and environmental problems pose challenges to the delivery of mental health services to this population. Issues such as poverty, alcohol and drug misuse, domestic violence, sexual and other forms of abuse, high morbidity rates as well as a pervasive sense of grief and loss amongst the Aboriginal population increase the incidence of mental health problems whilst at the same time reducing individual and community capacity to respond to them. A natural consequence of this phenomenon is a much higher demand for services, however, the complexity of many Indigenous issues, the need for services to be culturally appropriate and the general dispersion of the Indigenous population in the Territory, mean that it is also much more difficult to provide these services.

Youth Population

The NT has the youngest population in Australia. Territorians under the age of 18 constitute 30% of the population, a greater percentage than anywhere else in the country. Of the 57,000 plus children in the Territory, more than 21,000, or 37%, are Aboriginal. This creates both challenges for service delivery and opportunities for early intervention.

A range of studies have reported that young adults (18-24 years of age) have a greater likelihood of a mental disorder than older age groups. This group represents over 10% of the NT population.

Climate

The tropical climate of the Top End means that access to many of the smaller communities is very limited during the wet season as unsealed (dirt) roads become impassable and heavy periods of rain and thunderstorm activity restrict air access to some communities. Central Australia's desert climate also frequently hampers or prevents travel to remote communities.

Infrastructure

In many rural and remote areas of the NT 4-wheel drive vehicles are required to gain access and the time spent travelling to and from communities and outstations is considerable and resource intensive in that the cost of travel is considerable and clinician 'down time' spent in transit is substantial.

Outside of the metropolitan areas there is no public transport system. For those living in many communities outside of Alice Springs or Darwin, access to inpatient services requires expensive air evacuation.

Many communities have limited access to telecommunications (telephones, video-conferencing, computers including e-mail and internet access), and the communities, that do have access to new technologies experience slow network response times. In some remote areas, conditions (i.e. dust) interfere with the functioning of electronic equipment.

Prevalence of Mental Disorder, Suicide and Co-morbidity

Mental disorders are responsible for an estimated 11% of disease burden worldwide and account for five of the ten leading causes of disability.

Almost one in five (18%) Australians experience a mental disorder at some time in their lives. Of these, only 38% seek assistance. The non-Aboriginal prevalence rate in the NT is higher (22 %), and Territorians appear to have a greater tendency to seek help (49%) (NT CATI Survey Findings 2003).

Accurate prevalence rates for Aboriginal Territorians are not currently available however it is generally accepted that the incidence of mental health problems is higher in Aboriginal communities. Service provision data collected since 2000 indicates:

- 38% of all consumers assisted by the community based (non-inpatient) mental health services are Aboriginal (10% above population proportion of 28%); and
- 42% of admissions to mental health inpatient facilities are Aboriginal (14% above population proportion of 28%).

The following information taken from NT DHCS service activity data provide some indication of the diagnostic pattern of consumers admitted to inpatient services in the NT between 2002/03 and 2004/05 (estimated).

Figure 1: NT MH Inpatient Major Diagnostic categories (ICD-10-AM)

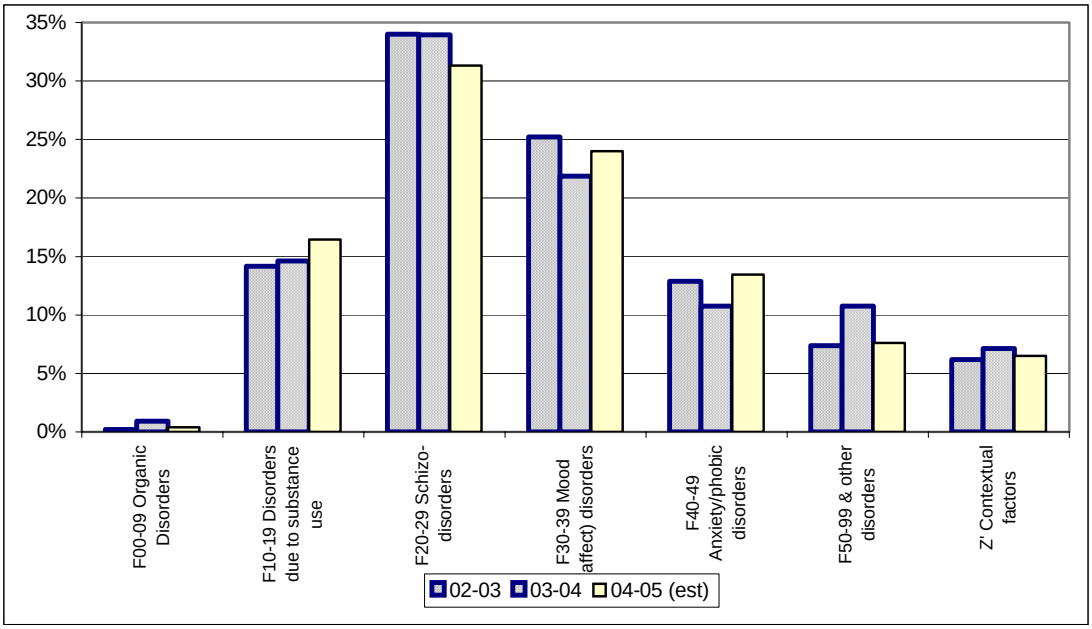


Figure 1 indicates categories F10-19 (Mental and behavioral disorders due to psychoactive substance use), F20-29 (Schizophrenia, schizotypal and delusional disorders) & F30-39 (Mood [affective] disorders) are high-needs categories of care in the NT context and account for 72% of all mental health inpatient admissions.

Figure 2: Mental Health inpatient episode diagnostic category by Indigenous status (percentile terms) 2003-2004.

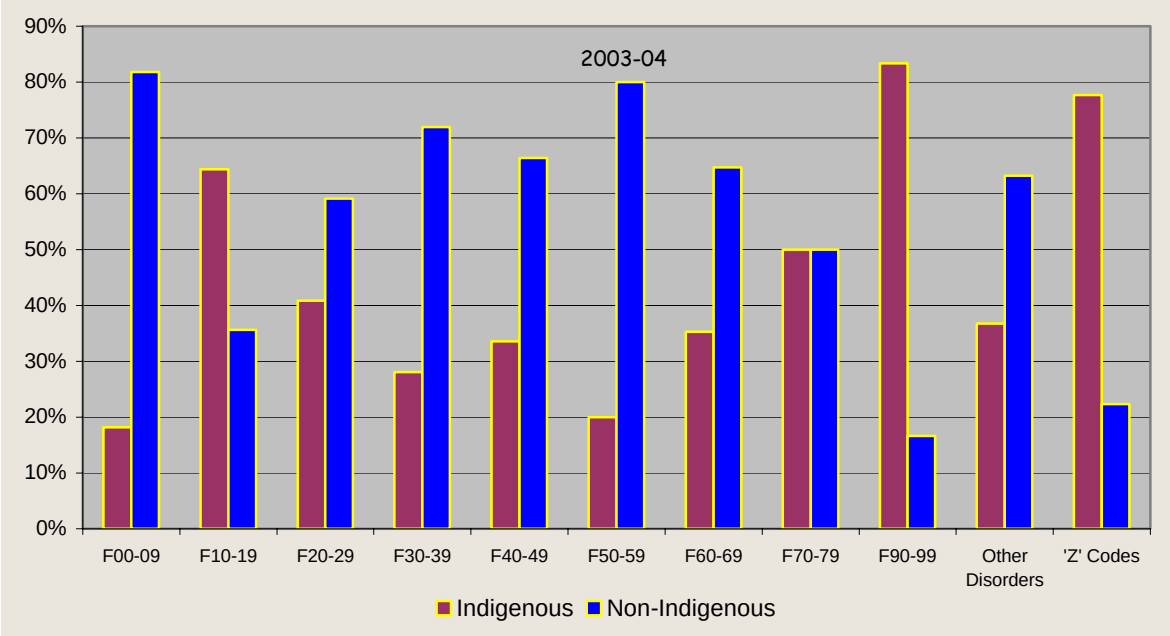


Figure 2 provides a 12-month snapshot, which indicates that Indigenous consumers are more likely to be admitted with disorders linked to drug/alcohol use compared to the non-Indigenous population. The high prevalence of the 'F90 - F99' Unspecified mental disorder and 'Z' (Contextual factors - Persons encountering health services) category coding also highlights the potential difficulties encountered when attempting to apply Western diagnostic concepts and categories to Indigenous consumers.

Figure 3: NT inpatient episode by age group and diagnostic category (2002-2005).

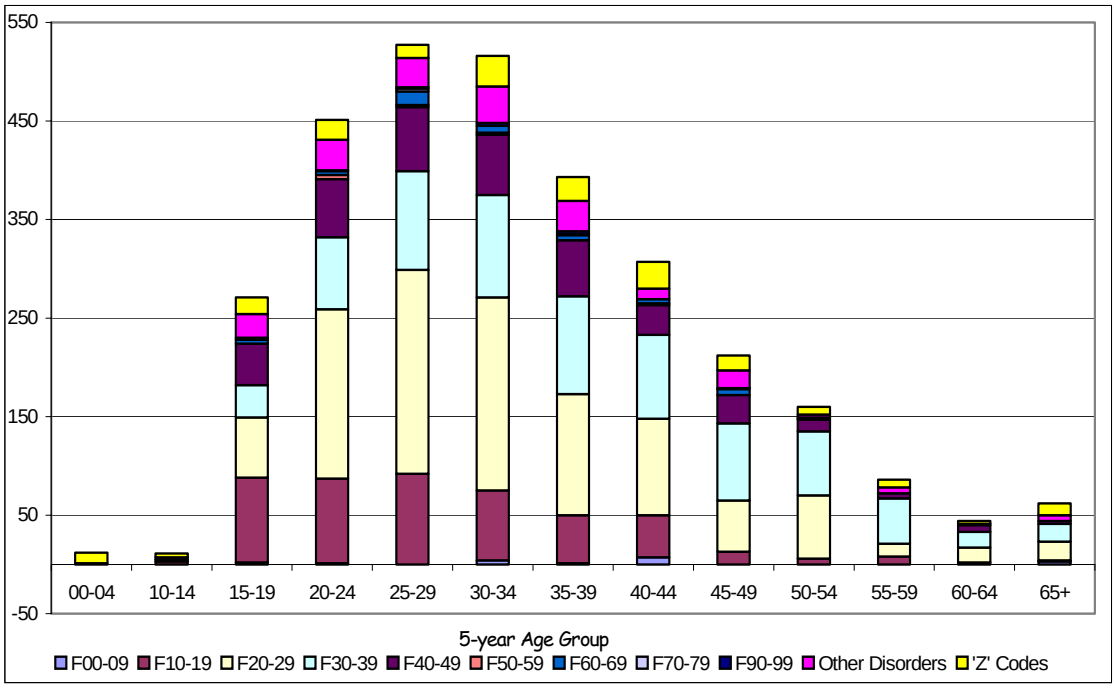


Figure 3 indicates that between 2002 and 2005 (estimated), 80% of all inpatient admissions in the NT occurred within the 15 to 44 year age group. Forty percent of all inpatient admissions are in the 15 to 29 year age group. This group also has significant prevalence of drug induced disorder and/or psychoses.

Prevalence of these disorders appears to be increasing in this age group.

Figure 4: NT MH consumer participation by Gender

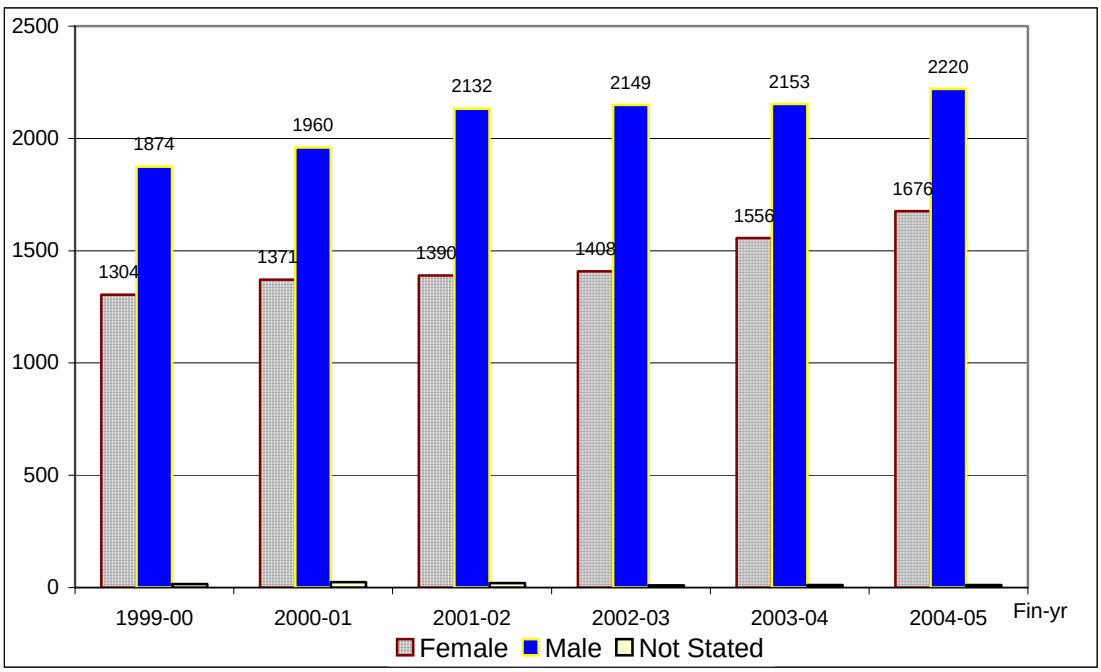


Figure 4 indicates that over a six-year period (1999-2005) males have consistently represented approximately 60% of all mental health consumers in the NT.

Figure 5: NT Mental Health consumers by Aboriginality (absolute numbers)

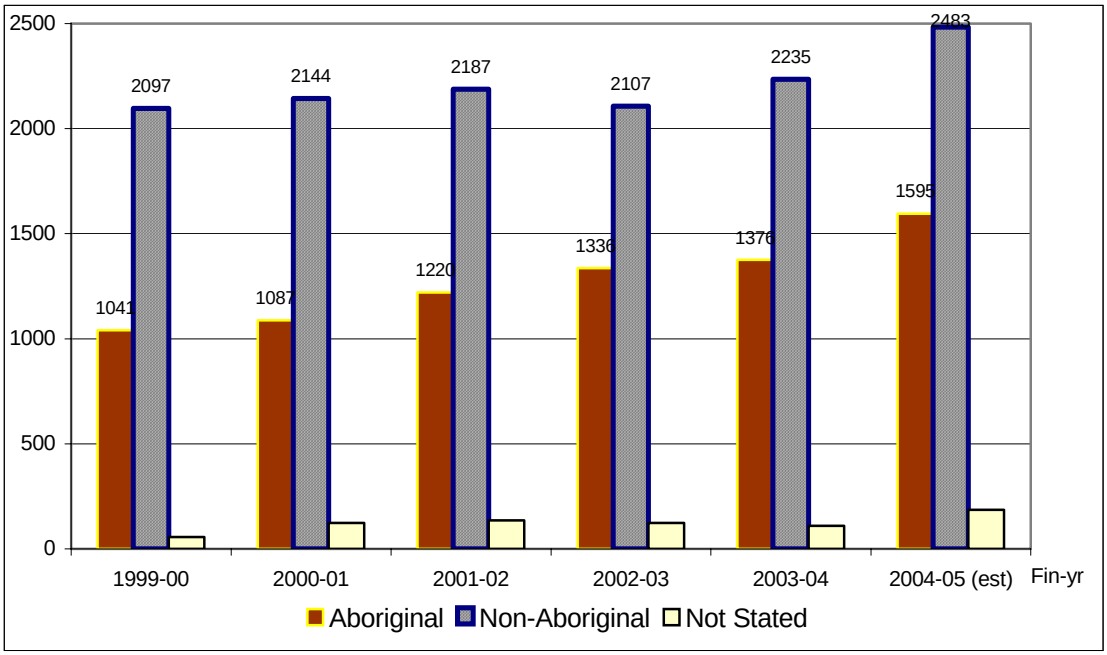


Figure 5 indicates Aboriginal representation in the NT mental health services consumer population has increased from 33% in 1999-2000 to an estimated 37% by June 2005. The current trend indicates the number of Aboriginal mental health consumers is increasing at a greater rate than for the rest of the NT population.

Figure 6: Relative participation of MH consumers by Aboriginality standardised per 100,000 population.

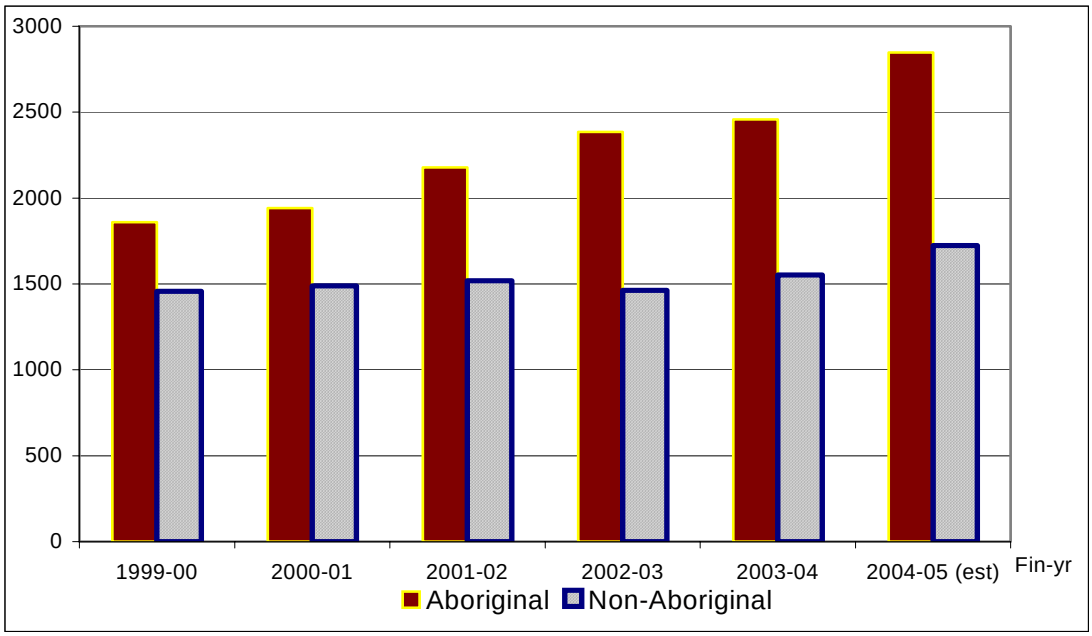


Figure 6 demonstrates the level of over-representation of Aboriginal consumers of public mental health services compared to the rest of the NT population. NT Aboriginal consumer growth was 53% between 2002/03 – 2004/05 (estimated), whilst non-Aboriginal consumer growth rate was only 18% for the period. Aboriginal

consumers have increased their participation by three times the rate of the rest of the NT community over this period.

Figure 7: Mental Health inpatient separations by Indigenous status per 100,000 pop.

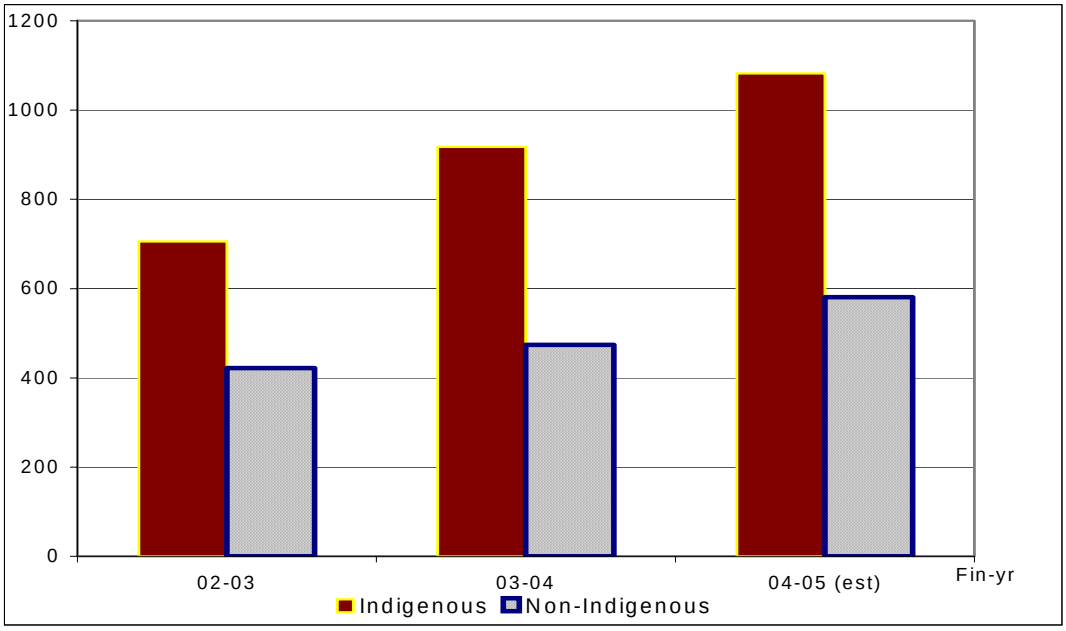


Figure 7 indicates that when data is standardised (per 100,000 residents), and Indigenous status is factored into the equation, Aboriginal people are significantly over-represented in the mental health inpatient population. This over-representation has increased since 2002-03 from 67% to an estimated 86% by the end of June 2005.

Figure 8: NT ambulatory (community) service contact events by Aboriginality

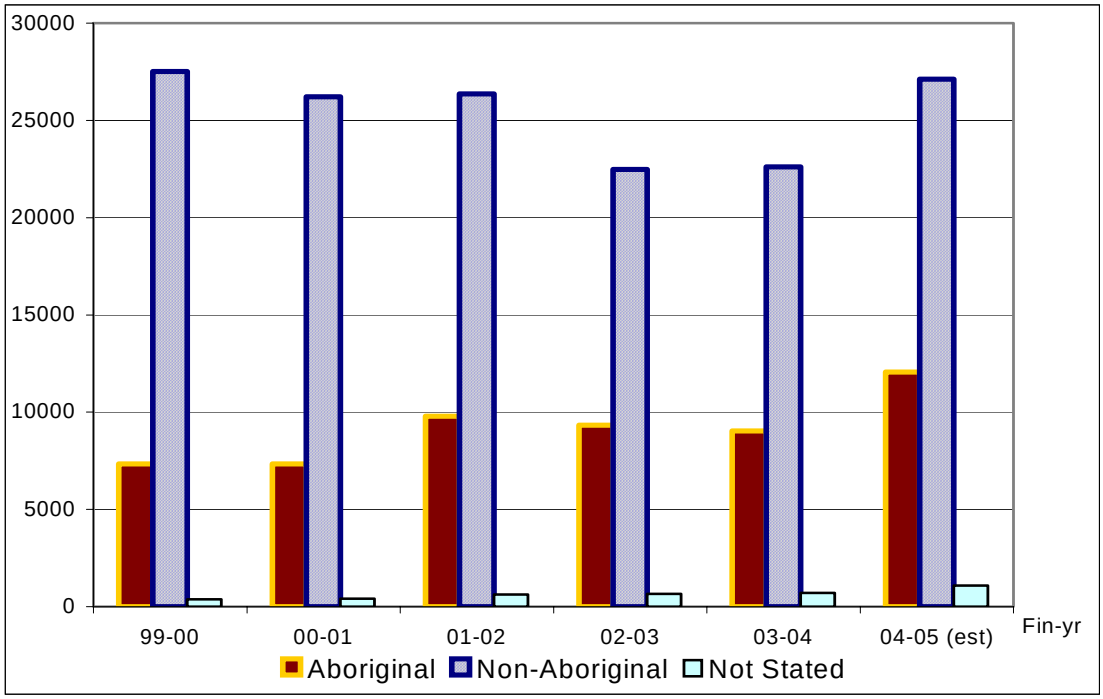


Figure 8 indicates a steady increase in contacts with Aboriginal consumers over the reporting period. Contacts with non-Aboriginal consumers declined between 2002/03 and 2003/04, however rose in 2004-2005 to a level equivalent to 1999/2000.

There has been a 6-year growth of 64% in Aboriginal consumer contact whilst non-Aboriginal contacts declined by 1% over the same period. The combined growth rate for ambulatory service contacts is 14% over 6 years. Growth rates over the last 12 months are as follows: Aboriginal 34%; Non-Aboriginal 20% – Total increase 24%.

Figure 9: NT MH community service contacts by age group

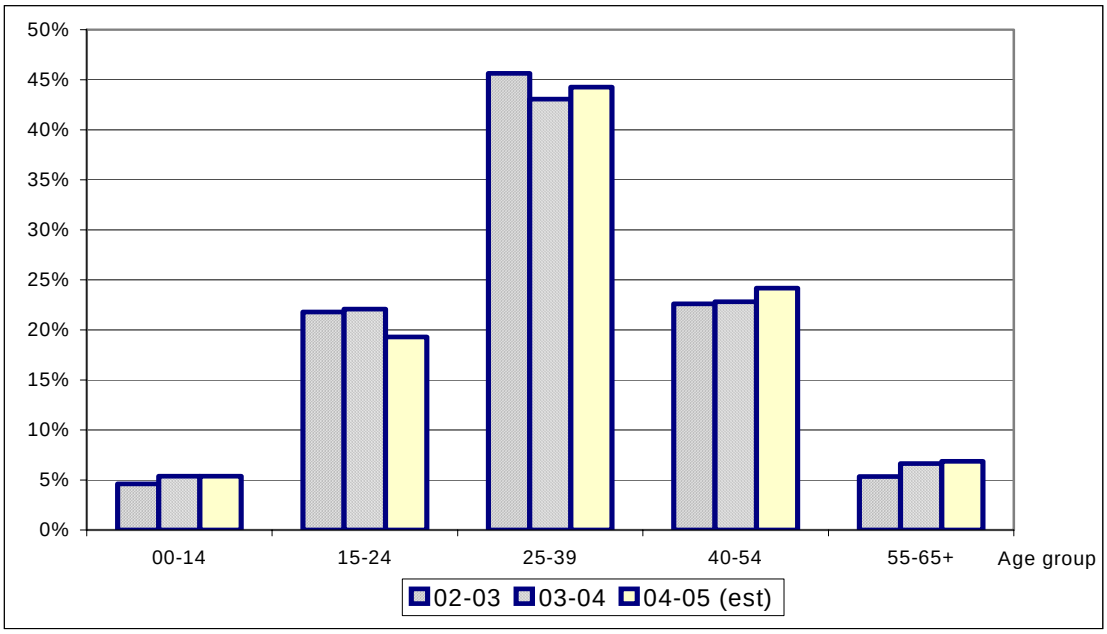


Figure 9 indicates the age profile of service contacts provided to consumers over the last three years. Approximately 20% of all contacts were provided to consumers in the 15 to 24 year age group. This age group represents 15% of the general NT population. Approximately 5% of all contacts were provided to consumers in the 0-14 age group which represents 25% of the general NT population. New funding has been allocated to increase Child and Adolescent mental health services throughout the Territory.

The total Community Service contacts have risen from 32,467 in 2002/03 to 44,662 in 2004/05 (estimated) representing a 37% increase.

NT Suicide Rates

On 15 December 2004, the Australian Bureau of Statistics (ABS) published *Suicides: Recent Trends, Australia* (Cat. 3309.0.55.001). The publication summarises suicide mortality data over the period 1993-2003 for each State and Territory.

The publication reports the NT's 1999-2003 suicide rate was the highest of all jurisdictions (21.7 deaths per 100,000 population) and 77% above the national average.

All jurisdictions show an increased rate of suicide in rural areas at approximately two times the rate in capital cities. This pattern is also common in the NT at commensurately higher rates. (2005 Report on Government Services).

Rates of suicide in Aboriginal populations have climbed from baselines of close to zero, and now occur in conjunction with an escalating incidence of depression, self-mutilation, parasuicide, anxiety, interpersonal violence, alcoholism, drug mis-use and low self-esteem.

In the 1980's non-Indigenous suicide rates were approximately twice those reported for Indigenous people. However between 1992 and 2002 the Indigenous suicide rate doubled and in 2001-2002 the rate of suicide amongst NT Indigenous males was approximately three and a half times the corresponding Australian rate. Indigenous

males aged 25-44 years had the highest suicide rate among all age groups in the Territory.

The ABS publication advises caution when comparing annual State and Territory suicide data as administrative issues may influence the recording process. The Northern Territory's small population and comparatively small number of suicides registered annually contribute to large fluctuations in the suicide mortality rate.

Co-Morbidity

Hospital inpatient figures indicate that Aboriginal people in the NT have more than twice the rates of admission for psychoses than non-Aboriginal people. Data also indicates that of mental health patients with a principal diagnosis of alcohol or drug induced psychoses, 46% are Aboriginal males.

People who have both a mental illness and a substance misuse disorder use more health services than people with a mental illness alone (National Mental Health and Wellbeing Survey). With the high level of alcohol and other substance misuse in the NT, the use of services by those with both a substance misuse disorder and mental illness can be expected to be particularly high. Approximately 15% of all admissions to mental health facilities in the NT have a primary diagnosis associated with substance misuse and anecdotal evidence suggests that up to 70% of mental health service clients in the NT have co-occurring alcohol or drug problems.

The high rates of substance misuse and injury in the Territory also result in higher rates of Acquired Brain Injury (ABI), which require intensive, and expensive specialist services and a high support response. The average cost of caring for an individual in this category is approximately $100,000 per annum, however costs are dependent on a range of factors including level of support required, specific accommodation needs and capacity to adapt to a congregate living arrangement versus a more individualised approach.

There are currently many individuals receiving this level of care across the NT though the prevalence appears higher in Central Australia where a higher rate of volatile substance misuse (i.e. petrol and other inhalants) occurs. Many of these individuals have a co-occurring mental disorder requiring both mental health and disability services.

Homelessness

National estimates suggest that between 40 and 60% of homeless people may experience mental health problems.

An analysis of 2001 census data jointly funded by the Salvation Army and the Australian and State and Territory Governments found that the NT has the highest rate of homelessness in Australia. In part this reflects the high number of people in remote areas living in substandard, impoverished dwellings but even in urban areas, the rate of homelessness is significantly higher than other jurisdictions.

At the time of the 2001 census, it was estimated that 5,423 people were homeless in NT. Of these, 17% were in boarding houses, 39% were staying with friends or relatives, 40% were sleeping rough and 4% were engaged with services funded through the Supported Accommodation Assistance Program (SAAP). There are currently 38 SAAP funded services throughout the NT.

Indigenous people were over-represented in the SAAP client population (55.7%) relative to their proportion in the general population (28.5%) in 2002/03.

Source: National Report for 2002-03 published by the Australian Institute of Health and Welfare, and the 2001 census report, Counting the Homeless 2001.

The NT Government has initiated work on an NT Homeless Strategy to address the high rates of homelessness especially amongst the Indigenous population, which includes the Community Harmony Project. As part of this project, the Larrakia Nation (traditional owners of the Darwin and Palmerston area) has worked with elders from across the Territory on the Larrakia Host Program to develop protocols on respect for Larrakia country. The plan also includes assistance for itinerants to return to their homelands; locating suitable housing and providing an information and referral service to itinerant groups.

ADDITIONAL COST OF SERVICE PROVISION

The high cost of providing services to a small, widely dispersed and culturally diverse population in remote areas is a substantial challenge in the NT. Some of the factors that increase the cost of service delivery are outlined below.

Culturally Appropriate Services

Cultural and language differences compound the geographical gap between NT Aboriginal people and access to mental health services. The marked differences between the traditional Western model of health and illness and traditional Aboriginal perspectives, which regard all social, spiritual and physical aspects of life as interrelated, adds to the difficulty of diagnosis. Language also presents a significant barrier as many NT Aboriginal people speak English as a second or third language, for example, in 1996, 97% of Aboriginal people over five years of age in Central Australia spoke an Aboriginal language (ABS 1998b).

To maximise the health benefit for the Indigenous population the provision of culturally appropriate community mental health services as close to an individual's community as possible is essential. Features and initiatives that impact on the cost of providing culturally appropriate services include:

- A highly mobile and transient population resulting in increased resources required to physically locate an individual to provide services;
- Language barriers which necessitate use of interpreters and the difficulty accessing an interpreter with a particular Aboriginal language or dialect;
- Development of specific resources to appropriately communicate mental health concepts in a culturally consistent way;
- Employment of Indigenous mental health staff (male and female) to work with mental health teams and to provide services in rural and remote communities.

Despite these initiatives there remains a substantial challenge in providing appropriate services in the Territory where the health workforce is overwhelmingly non-Indigenous.

Remote Population

The need to provide health services to a widely dispersed and remote population is a substantial cost driver in the NT. There are approximately 90 health centres in Territory remote communities.

The diseconomies of scale associated with providing health services over a large number of small communities are clearly evident. However, matters are made even more difficult for service providers in remote communities through the need to provide services to even more widely scattered outstations.

A prime example is the community of Maningrida where, subject to resource availability, health staff at the Maningrida health centre provide visiting services to about 30 outstations in its catchment area. A similar pattern of service delivery occurs across the Territory, thereby swelling the number of health service delivery outlets to several hundred.

Additional costs are incurred by the mental health program in establishing and supporting small teams in rural centres to provide outreach services to these communities and remote communities and outstations in the region.

Some key resourcing issues include the high cost of travel and the need to travel extensively to remote areas. This activity may involve a combination of 4-wheel drive vehicles (which need to be purchased and maintained), commercial airfares, expensive charter flights, evacuation of a patient from remote areas to inpatient facilities and the provision of boarding facilities for accompanying family members. Travel time for clinical staff visiting rural and remote communities also increases costs significantly.

Difficulties attracting appropriately qualified and experienced staff able to work relatively independently in a cross-cultural context, recruitment, retention, relocation and accommodation costs, access to education, training, supervision and peer support are all substantial challenges in the NT context.

High Bed Day Cost

The NT has two relatively small inpatient units situated in Darwin and Alice Springs. The Darwin facility services Top End communities including Katherine, East Arnhem, Darwin Rural and the Tiwi Islands and has the only secure unit in the NT which admits individuals from across the Territory and provides brief stay acute beds for prisoners where required.

Australian Institute of Health and Welfare Annual Reports of general public hospital bed day costs and National Survey of Mental Health Services data comparisons reveal that NT mental health bed day costs are historically on par with NT general hospital bed day costs. Nationally, this mirrors the evidence that general hospital costs are generally of the same magnitude as their respective jurisdiction's mental health acute care costs. In comparative terms, NT bed day costs (general or mental health) are approximately twice the national average.

The average cost per mental health acute inpatient bed day in the two NT facilities in 2003/04 and NT aggregate cost in the same period is compared with the national average for 2001/02 (the most recent validated national comparative data) in the table below and clearly highlights this issue. The substantially higher bed day cost in Central Australia in particular reflects the high use of Agency personnel to staff the facility.

Bed Day Cost

Top End	Central	NT Aggregate (2003-04)	National Average (2001-02)
$818	$1,301	$922	$501

Lack of Access to Private Providers

Limited access to private providers, such as general practitioners (GPs) and specialists (Psychiatrists), adds considerably to the cost of public mental health services in the Territory. In general, private practitioners provide the majority of clinical services for Australians with funding for these services coming from the Australian Government through Medicare and PBS. However, this is not the case in the Territory where the majority of mental health clinical services are provided by the public health system, and are funded by the NT Government. This also means that for Territorians there is minimal choice.

Private psychiatrists funded under the Medicare Benefits Schedule provide a relatively small proportion of mental health services in the NT. Service levels have increased since the National Strategy commenced in 1993 but the Territory continues to receive by far the lowest level of services of this type. Number of attendances by private Consultant Psychiatrists and MBS benefits paid in 1999/2000 were both approximately 80% less, or 1/5 of the national per capita average.

Figures reported in the National Mental Health Report 2002 indicate in 1999/2000 there were 2.6 attendances per 100,000 with MBS funded Consultant Psychiatrist Services in the NT (National Average 11.0). The % of population seen by the private sector was 0.5% (National Average 1.5%) and benefits paid per capita were $1.88 (National Average $10.08).

Due to its vastly different nature, practice in remote clinics is not adequately compensated by the current fee-for-service payment system (that is, Medicare). Research into relative values suggests that due to the medical complexity and language/cultural differences of Indigenous patients in remote areas, it would not be possible for a GP in such an area to see even 50% of the patients seen in a day by an urban practitioner. This severely disadvantages and discourages fee-for-service practice. Many communities in the NT do not have a resident GP/medical officer. Clinic services are supplemented by District Medical Officers (DMOs) who visit on one or more days per fortnight depending on the health needs of the community.

While the Australian Government's 'Better Outcomes in Mental Health Care' (BOiMHC) initiative attempts to increase the capacity of GPs to provide mental health care, the success of this initiative in rural and remote areas of the NT has been marginal. Although a number of GP practices and Aboriginal controlled health services in the NT were initially accredited and accessed BOiMHC training, fewer practices are now making that commitment due to the costs associated with achieving the expected standards and the relative benefits for individual practices. The uptake rate in the NT has been confined to a small group of Darwin based GPs.

The Top End Division of General Practice has been innovative in utilising funds available under the More Allied Health Services initiative to employ Aboriginal Mental Health Workers (AMHWs) to work with medical officers and clinic staff in a number of rural and remote communities. This is assisting to provide more effective primary mental health services.

The NT has no private mental health inpatient beds.

NATIONAL COMPARATIVE DATA

Comparative information contained in the most recent National Mental Health Report 2004 refers to 2001/02 data and places the NT as follows on a number of key indicators:

	Northern Territory 1992-93	**National 1992-93**	**Northern Territory 2003-04**[1]	**National 2001-02**[2]
Per capita expenditure on mental health services	$58.63	$75.16	$109.00	$92.00
Full Time Equivalent staff (FTE) clinical service delivery staff per 100,000 residents	70.6	80.1	72.6	85.1
Full Time Equivalent staff (FTE) clinical service delivery staff per 100,000 residents in community based services.	25.8	20	40.3[3] (2001/02)	36
Ratio of percentage of inpatient and community expenditure (inpatient: community)	57.6:42.4	73:27	49:51	49:51
Percentage of total service expenditure allocated to the non-government sector	1%	2%	10%	5.4%

[1] Unpublished data currently being validated.

[2] Data provided was for 2001-02 as 2003-04 comparative data was not available nationally

[3] 2001/2002 NT figure

Per capita expenditure on MHS

In 2001/02, the highest spending jurisdiction with $110.82 per capita was Western Australia (WA). The NT was the 5th ranked jurisdiction in 2001/02 with a figure of $85.56 per capita. The National Average in 2001/02 was $92.03 per capita.

The most recent published comparative information refers to 2002/03 and is contained in the Report on Government Services (ROGS) 2005 by the Productivity Commission. This information is invalidated and caution should therefore be exercised when referring to this information. Nevertheless, the figures indicate that in 2002/03 WA maintained its number one ranking, spending $119 per person on mental health services. In 2002/03 the NT spent the least ($89 per person). The national average was approximately $100 per capita.

Figure 10 NT Mental Health per capita expenditure (current prices)

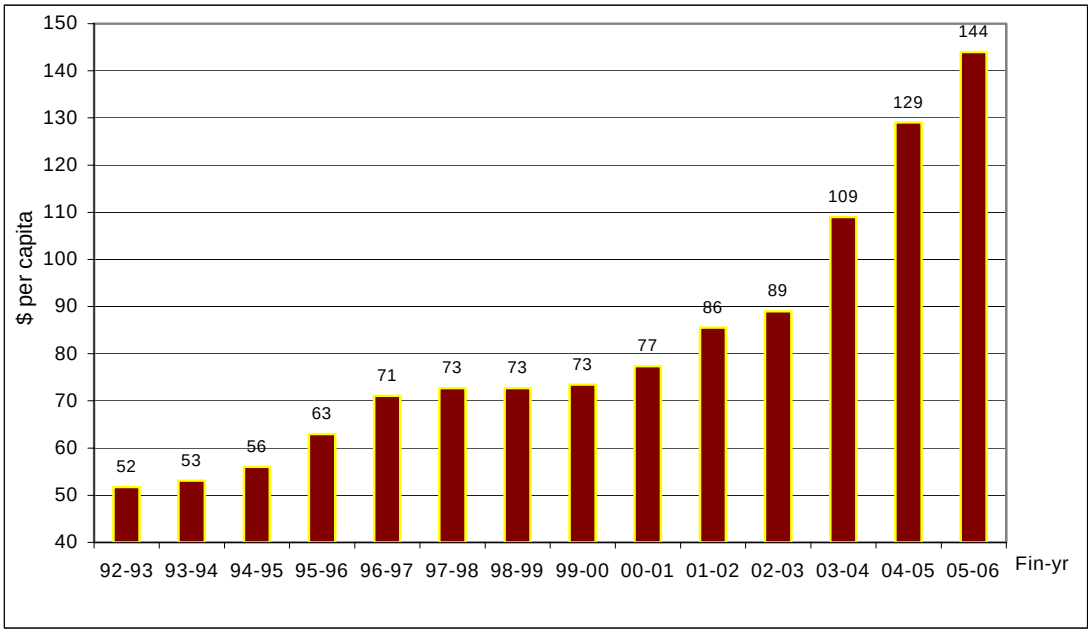


Figure 10 indicates per capita expenditure on mental health services in the NT has increased by $92.3, or 179% since 1992/93. A sharp upward trend since the NT Government's substantial funding injection in 2003/04 is clearly evident.

In the absence of more recent comparative data the NT's position relative to other jurisdictions since 2003/04 is unknown.

Full – time equivalent (FTE) clinical service delivery staff per 100,000

The NT has often experienced substantial fluctuation on this indicator for a number of reasons including recruitment and retention difficulties and employment of staff utilising time limited National Mental Health Strategy funds.

In 2001/02 the jurisdiction with the highest average FTE staff per 100,000 was Tasmania (104.0 per 100,000). The NT was ranked 8th with a figure of 78.1 per 100,000. The national average was 90.0 FTE per 100,000.

The most recent (invalidated) comparative information contained in the ROGS 2005 Report indicates that in 2002/03, WA had the highest number of FTE direct care staff per 100 000 people in specialist mental health services (104.2) and the NT had the lowest (63.7).

The NT's poor ranking on this indicator can be attributed to the small inpatient service component in this jurisdiction. If the clinical FTE staffing numbers in community based services are considered, the NT figure has been consistently above the National Average since 1992/93. In 2001/02 the NT was the 3rd ranked jurisdiction in FTE clinical staff employed in ambulatory care services with 40.3 FTE per 100,000.

New NT Government funding since 2003/04 has allowed for the creation of a number of additional clinical positions across the NT increasing the estimated average FTE per 100,000 figure in 2004/05 to 83 FTE per 100,000 (128 in Top End and 39 in Central Australia in absolute terms) with further growth expected in subsequent years.

Figure 11: NT Inpatient direct care staff FTE per 100,000

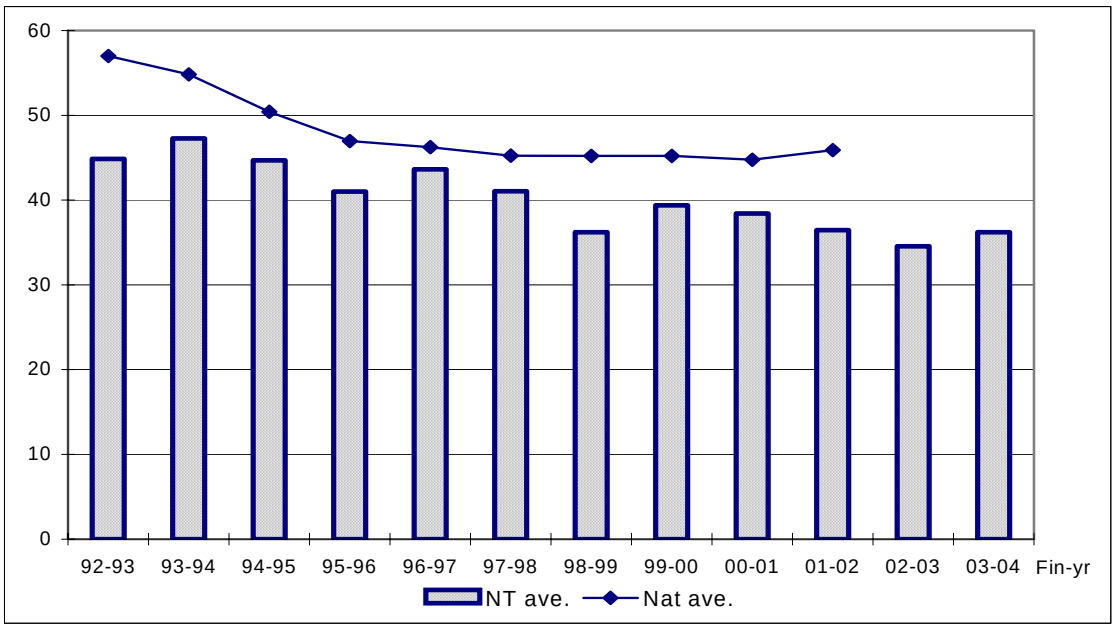
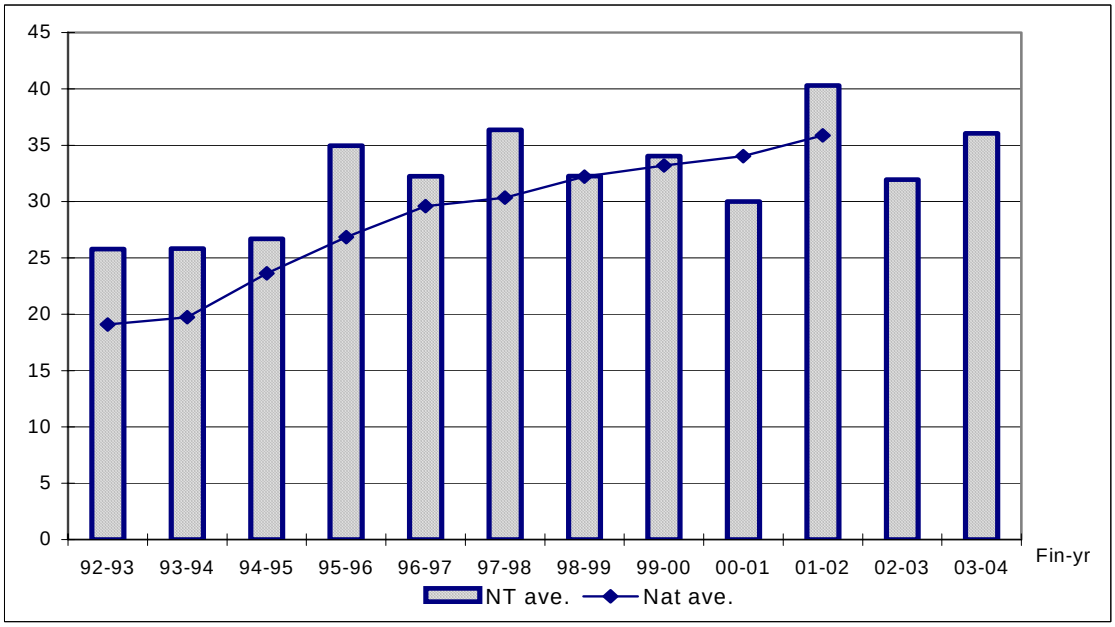


Figure 11 indicates that NT inpatient direct care staffing per 100,000 is approximately 10 FTE below the National Average. The reflects the comparatively small number of beds in the Territory.

Note: National published data is only available to 2001-02.

Figure 12: NT Ambulatory direct care staff FTE per 100,000



Note: National published data is only available to 2001-02.

Figure 12 indicates that over the period 1992 to 2001, average ambulatory direct care staff per 100,000 in the NT equalled or exceeded the national average. Since 2000/01, the NT FTE average fluctuated, however these figures do not include agency staff FTE, which increased over that period.

Percentage of total services expenditure allocated to the NGO sector

In 2001/02 the jurisdiction with the highest proportional allocation to the non-government sector was Victoria with 9.3% of the total service expenditure allocated to NGO services. The NT was the 5th ranked jurisdiction on this indicator with an allocation of 5.4%. The national average in 2001/02 was 5.5%.

New Government funding invested in the NGO sector in the NT since 2003/04 has increased the NGO proportional allocation to 9% (as at March 2005). It is anticipated that by the end of the 2004/05 financial year this figure will be approximately 10% and this is forecast to increase once again to approximately 11.5% by 2006/07 when new funding announced in the 2005/06 Budget is allocated.

The NT Government has made a commitment through its 'Building Healthier Communities' Framework to continue to build capacity within mental health non-Government services to deliver carer and consumer support in the NT. The Mental Health Program is currently creating better ways of working together with a focus on collaboration between the government and non-government sectors to meet the mental health needs of Territorians.

Total Inpatient and 24 hour staffed residential beds per 100,000 at June 2002

In June 2002 the jurisdiction with the highest number of inpatient and 24 hour staffed beds was Tasmania with 51.0 beds per 100,000. The national average for inpatient and 24 hour staffed beds was 37.4 per 100,000. The NT figure at this time was 16.2 per 100,000. It should be noted all beds reported by the NT were acute inpatient beds, as the NT had no extended care or 24 hour staffed residential beds. The NT does not have any large public psychiatric hospitals. Two relatively small inpatient units with a combined total of 32 beds provide inpatient care to the NT population. These units are co-located with general hospitals.

In the 2005/06 NT Budget $1.8M has been allocated to establish 24 hour staffed 'sub-acute' residential beds in Darwin and Alice Springs. This new service will create an additional 14 beds (eight in Darwin and six in Alice Springs) to provide a residential 'step-up or step-down option' for people who cannot be intensively supported in their own home. Services of this nature will complement planned 'sub acute' individual care package trials in Darwin and Alice Springs.

Two high dependency beds were also recently established in the new Alice Springs Inpatient Unit bringing the total bed increase to 16 (or 8 per 100,000), which means in 2005/06 it is anticipated the NT will have 24.2 beds per 100,000. Whilst this figure remains below the National Average (37.4 per 100,000) it should be noted reforms in the NT are aiming to strengthen community based care and support and reduce reliance on the small number of inpatient beds available in Darwin and Alice Springs.

SERVICE ACTIVITY

Inpatient Service Activity

Figure 13 NT Inpatient Bed days and Separations

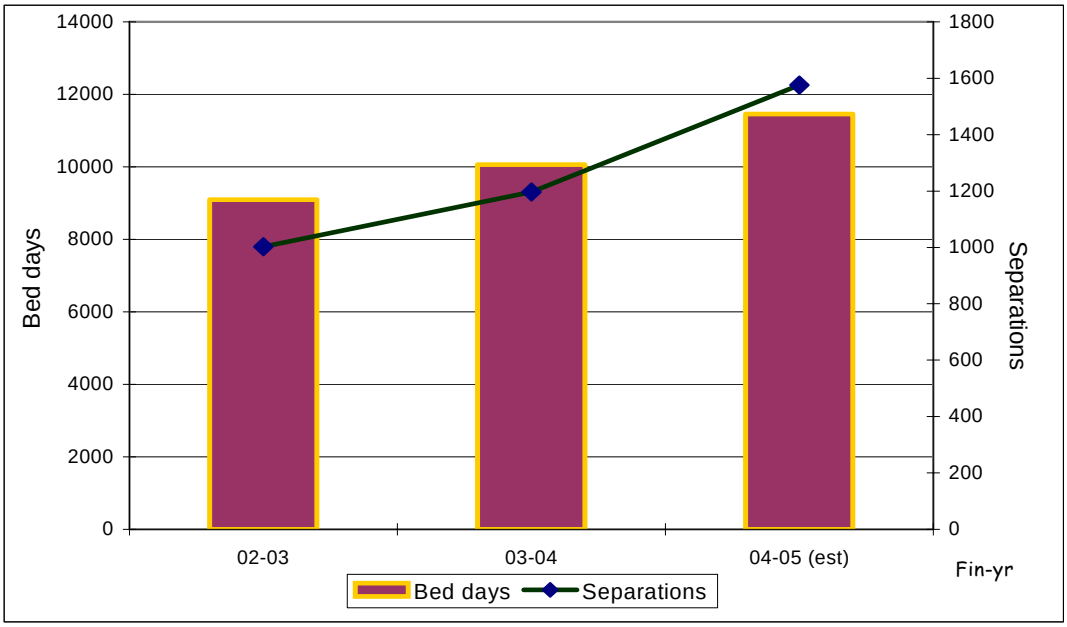
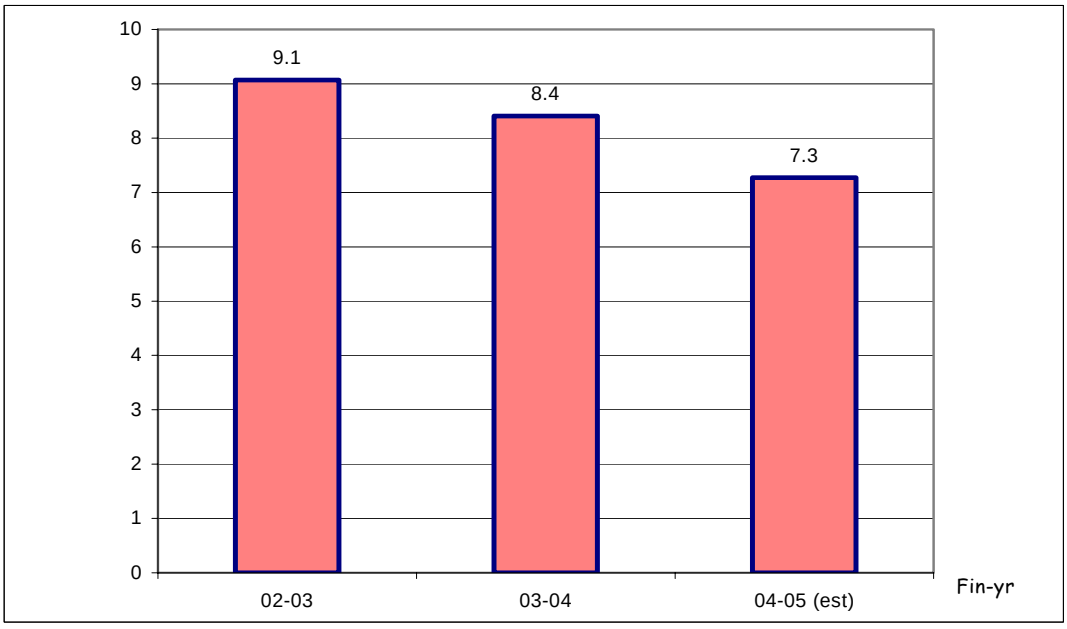


Figure 14: NT Average length of stay (ALOS)



Figures 13 and 14 illustrate the relationship between Bed days and Separation activity on average length of stay (ALOS) per inpatient. ALOS has declined by 1.8 days (19.8%) as bed days and separations have increased by 573 (44%).

NT Ambulatory (community) Service Activity

Figure 15: NT Persons seen – ambulatory (community) settings

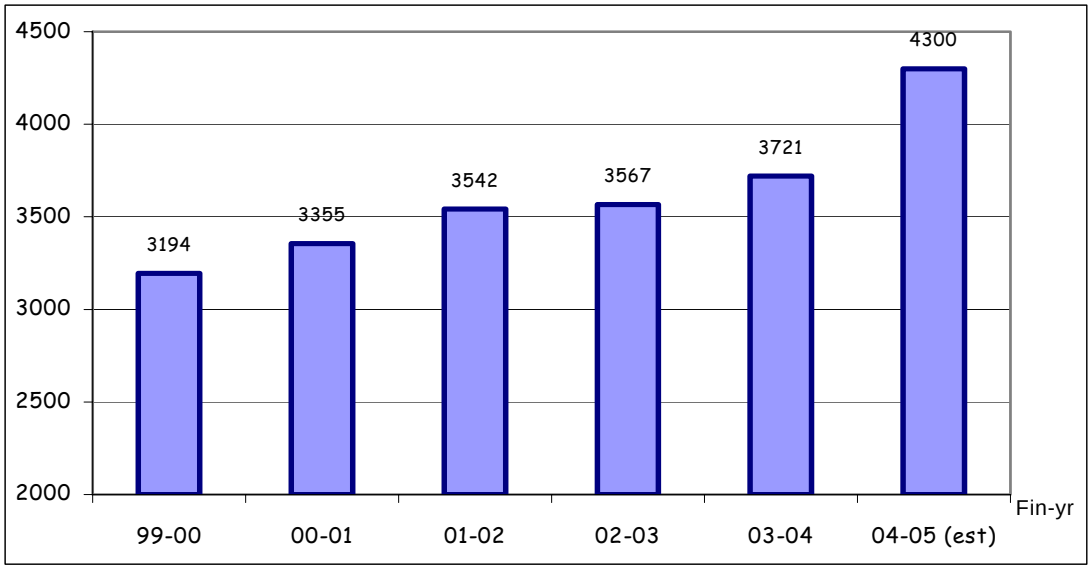


Figure 15 demonstrates steady growth in the number of consumers seen in ambulatory settings in the NT since 1999/2000, with a marked increase in 2004/05. The magnitude of growth is in the order of 1,106 individuals or 35% over the last six-years. In the last 12 months, the rate of growth has accelerated in community service activities by 579 individual consumers or 16%.

The level of engagement of the NT population with public mental health services has also risen from 1.6% in 1999/2000 to 2.2% in 2004/05.

It is estimated 3% of the Australian population have serious mental illness and 20+% experience some form of mental disorder (National Mental Health Report 2002).

FORENSIC MENTAL HEALTH SERVICES

In the NT, there are no long-term forensic mental health facilities. As such, persons found not guilty of a charge due to mental impairment may be subject to a custodial supervision order at a correctional facility.

The only secure mental health unit in the NT is the 10 bed Joan Ridley Unit (JRU), located at Royal Darwin Hospital. The primary role of JRU is to cater for the admission of acutely ill patients from the prison system and from the general population. As this is an acute facility, admissions are usually brief and patients are discharged from JRU as soon as their symptoms have stabilised sufficiently for them to be managed elsewhere. In an extended stay admission the focus is less on symptom-reduction and more on rehabilitation. JRU does not have the capacity to provide extended care or rehabilitation services to prisoners.

The Forensic Mental Health Team provides in-reach to JRU and treatment to forensic consumers in the community or in the correctional facility at which they are detained.

Whilst specialist mental health services are provided to remanded and sentenced adult prisoners at Darwin and Alice Springs Correctional Centres and to people under the age of 18 years at the Don Dale Juvenile Detention Centre in Darwin, the prison

medical service remains responsible for the day to day health needs of people in these facilities.

There are no specialised units for the mentally disordered or other special needs groups within any of the three custodial facilities in the NT.

Service demand in NT Prisons

Forensic Mental Health Services activity data (December 2004) indicates that up to five prisoners in the Darwin Correctional Centre (DCC) and up to four prisoners in the Alice Springs Correctional Centre (ASCC) have intensive mental health needs. An additional 21 prisoners in DCC and 18 prisoners in ASCC have moderate mental health needs. Twelve prisoners from the DCC prison population have previously required admission to a psychiatric inpatient facility.

The NT has a higher proportion of Acquired Brain Injury (ABI) due to substance misuse, and a high proportion of people with ABI are Indigenous. There are unique challenges and extremely high costs associated with providing community based options with appropriate levels of supervision and support to people in this population who have been found not guilty due to mental impairment. As noted, this impact is already being experienced in community disability services. DHCS Disability Services Program is currently managing four individuals in the community on non-custodial orders, two within Correctional facilities and is awaiting the outcome of the Court process in four other matters.

Existing Prison Based Options

Prisoners with mental illness, acquired brain injury or intellectual disability are housed currently either in maximum security or in the mainstream prison. Given the medium to long-term incarceration of many individuals in this category they would clearly be better accommodated in a more appropriate, safe and therapeutic environment oriented toward rehabilitation and community reintegration. No such environment exists in the NT. Establishing such a facility in a very small jurisdiction would require a substantial capital investment and operational funding.

In-reach Specialist and NT Behavioural Support Services to Prisons

Services are currently provided to the prisons in Darwin and Alice Springs on an in-reach basis by Forensic Mental Health teams in both centres and in addition, in Central Australia, by the Positive Behavioural Support Unit (PBSU). PBSU also manages a number of individuals in the community subject to non-custodial supervision orders under these provisions. There is currently only one mental health consumer on a non-custodial supervision order.

The 2005/06 NT Budget includes funding to enhance existing services in order to increase in-reach support to correctional centres. An additional 9 FTE positions will be progressively created across the Mental Health and Disability Services Programs over the next 3 years. These staff will be comprised of mental health nursing, psychology, occupational therapy, disability support and Indigenous AMHW or support worker disciplines.

Review of Forensic Mental Health Services in the NT

A review of Forensic Mental Health Services in the NT is being conducted by the Victorian Institute of Forensic Psychiatry (Forensicare). A draft report is anticipated in the next month and will provide advice and recommendations for improvements to the existing services.

National Statement of Principles for Forensic Mental Health

The NT is currently represented on the National Statement of Principles for Forensic Mental Health – Implementation Framework & Reporting Advisory Group that has been tasked to:

- Develop a national framework for the implementation of the Principles across all Australian States and Territories;
- Identify criteria through which the implementation of the Principles can be assessed; and
- Develop a national framework for reporting implementation of the Principles.

The National Statement of Principles for Forensic Mental Health was endorsed by the Australian Health Ministers' Advisory Council in October 2002.

NT Adult Custodial Services Review

In April 2004, the NT Government endorsed all 71 recommendations of an independent Adult Custodial Services Review. Recommendations directly relevant to mental health are that:

- Corrections pursue recommendations with Health and Community Services to further develop the concept of small-specialized secure mental health units in each of Darwin and Alice Springs Correctional Centres, with security and programs being provided by Corrections and specialised treatment provided by Health. These negotiations would lead to a Memorandum of Understanding that would guide the service and fairly allocate costs;
- These units meet both the Australian Guidelines for Corrections and the relevant health care standards;
- Ambulatory mental health services to the rest of the prison be increased, and that the prisons do more to create an environment that is supportive of such treatment;
- Provision of additional professional staff, roughly on a ratio of one case management officer per 35 to 50 inmates, and one psychologist per 100 to 150 inmates.

In relation to these recommendations progress to date includes the commencement of dialogue between the Department of Justice (DOJ) and DHCS regarding the development of a Memorandum of Understanding to better coordinate service provision to offenders with a mental illness.

The development of a dedicated facility for this consumer group is on the Government's agenda in future years.

Recruitment of additional professional staff and the development of sex offender treatment for adult offenders have commenced.

Interagency Collaboration

Regular interagency meetings between the DOJ and DHCS now occur. This collaboration presents opportunities for joint planning regarding recruitment to ensure a range of disciplines are represented in forensic settings, especially in light of additional funding allocated to both Departments.

Discussions have also commenced regarding future joint clinical supervision and professional support. In addition to enhancing the quality of clinical services it is hoped that increased support may address staff retention issues that may be linked to professional isolation.

Legislative Reform

Amendments to the NT Criminal Code (Mental Impairment and Unfitness to be Tried) Act 2002 allows for individuals who come to the attention of the criminal justice system who have a mental health issue to be assessed, receive treatment and be placed in the least restrictive environment. This legislative change lays the foundation for individuals to be treated more appropriately and is in line with the Standard Minimum Rules for the Treatment of Prisoners 2001.

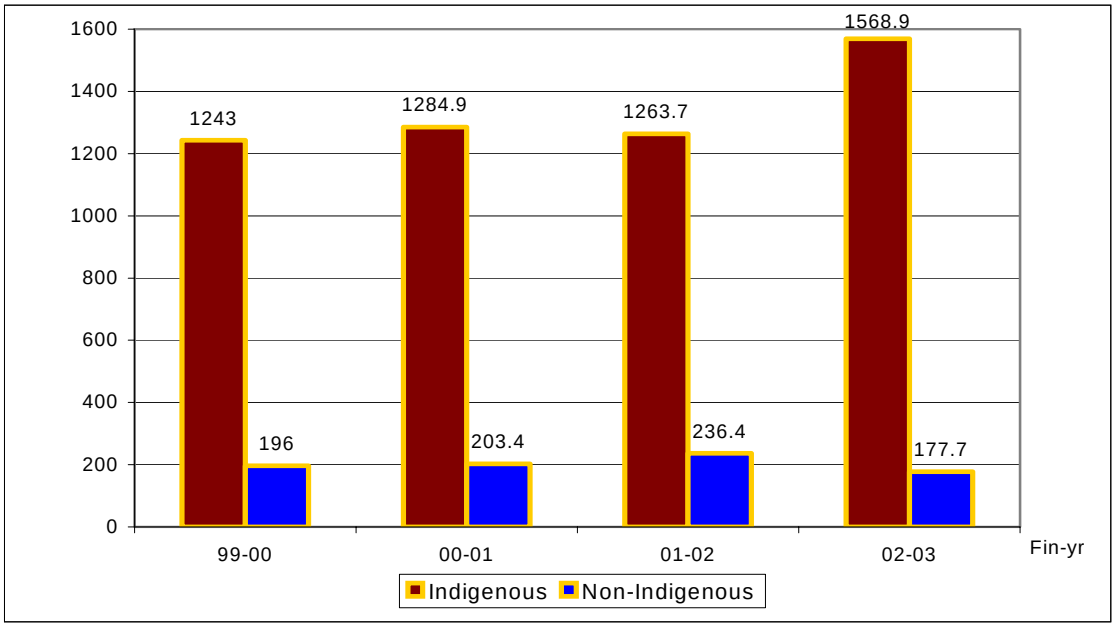
Research and Evaluation

NT Correctional Services is in the process of establishing a research and evaluation position. It is hoped this position will have the capacity to have a partial focus on mental health research within the prison system.

NT Indigenous peoples involvement with the Criminal Justice System

Data between 1999 and 2003 indicates rates of incarceration and community-based sanctions in respect to Indigenous people in the NT have increased in recent years. A current dilemma for the NT is the high occupancy rates being experienced in both adult correctional centres. This factor creates even further barriers to providing specialised, individualised care to offenders in an environment already known to exacerbate symptoms of mental illness.

Figure 16 Adult Indigenous rates of imprisonment per 100,000 Indigenous population



Data Source: Report on Government Services

Figure16: Provides an indication of the high demand for forensic mental health services resulting from the significantly high NT Indigenous incarceration rate. The estimated rate of Indigenous incarceration in 2003/2004 is 1688 per 100,000.

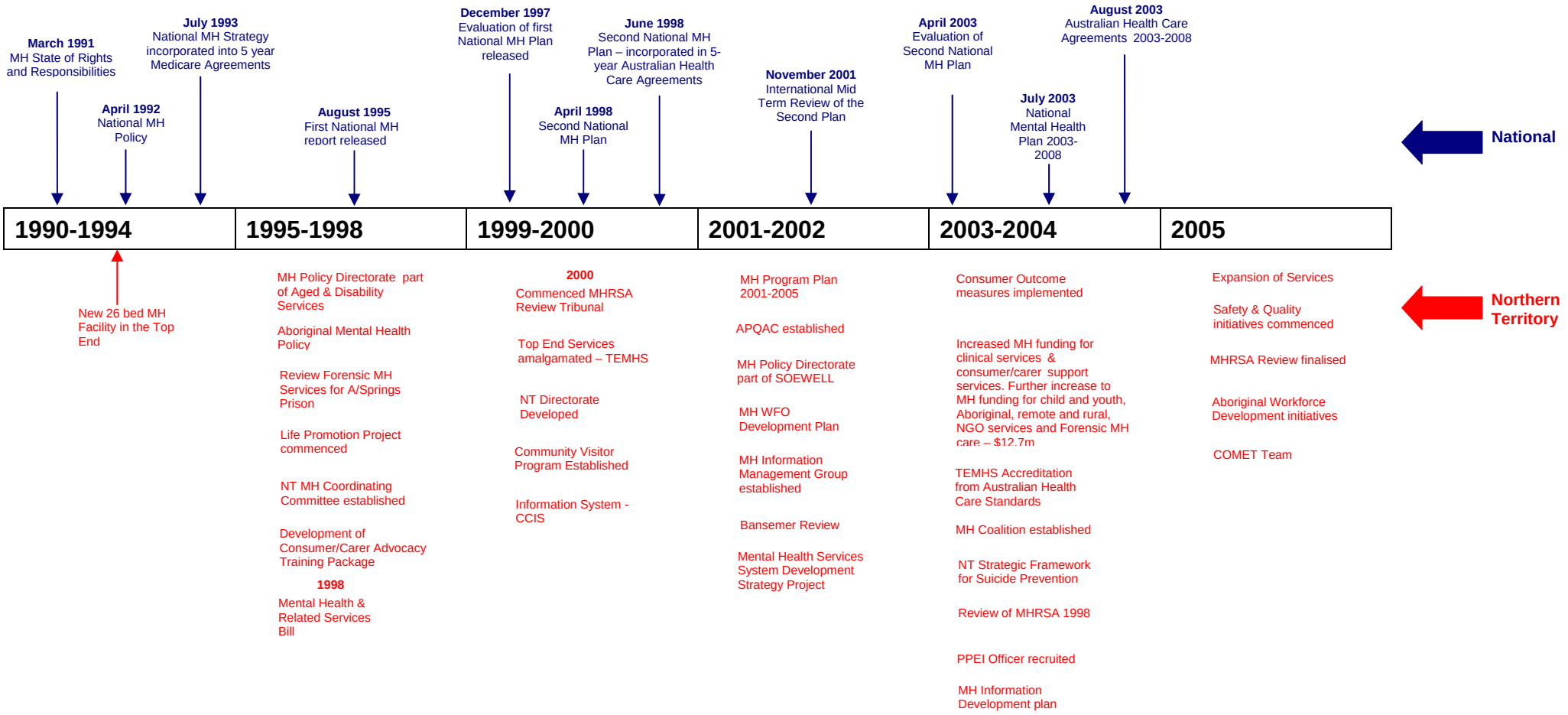
NT Juvenile detention rates

In 2003- 2004 151 (83%) of 183 receptions into detention were Indigenous

Key Mental Health Reforms and Policy Context in the Northern Territory

Figure 17 depicts the major milestones of the National Mental Health Strategy at a national level and NT level.

Figure 17 – Key Mental Health Reforms and Policy Context in the Northern Territory



July 1993 - June 1998 First National Mental Health Plan Medicare Agreements
July 1998 - June 2003 Second National Mental Health Plan Australian Health Care Agreements

1993 – 1998

Whilst a new 26-bed mental health facility was constructed in the Top End during this period the focus of service and policy was to improve community based services and integration.

The new *Northern Territory Mental Health and Related Services Act 1998,* (based on the *Model Mental Health Legislation*), was passed by the Legislative Assembly.

Aboriginal Mental Health Guidelines and Action Plan were completed and implementation commenced. Continued establishment and growth of the AMHW programs including new AMHW positions established in East Arnhem and Alice Springs funded with National Mental Health Strategy funding. Continued service modification to improve cultural appropriateness included the development of a cross-cultural training program.

Funding to NGO's represented 3.9% of total expenditure compared to 2.8% nationally.

A review of Forensic mental health services commenced to cater for the establishment of the new Alice Springs Prison.

NT Mental Health Community Advisory Group on Mental Health (NTCAG) oversighted the development of a Consumer/Carer Advocacy Training Package to provide a resource to improve the skills of consumers affected by mental illness in remote locations.

A 12-month Life Promotion Project commenced with workers based in Darwin and Alice Springs, funded by the Australian Government. This project was subsequently extended for a further 3 years, to work in partnership with individual communities, schools and relevant agencies.

An NT Mental Health Coordination Committee was established to improve the planning and allocation of NT Mental Health funds and service mix using a more strategic approach.

1999-2000

Implementation of the *Mental Health and Related Services Act* and Mental Health Review Tribunal on 1 February 2000.

Implementation of a new mental health information system across the Territory in 1999.

Amalgamation of service delivery units in Katherine, East Arnhem, Darwin Urban and Darwin Rural to create TEMHS in order to improve the service mix, access to and coordination of specialist mental health services in the Top End.

The NT School of Psychiatry commenced operation as a collaborative partnership between Flinders University, Royal Darwin Hospital and Mental Health Services.

Establishment of a discrete directorship position of Mental Health Policy and Program Development to give greater focus to the strategic development of mental health services.

2001 – 2002

Implementation of a collaborative purchasing and planning framework in the NT led to the development of a Mental Health Program Plan 2001-2005 that set strategic directions and high level program outcomes.

Establishment of the NT Community Visitor Program, a requirement under the provisions of the *Mental Health and Related Services Act*. The program was established within the NT Anti-Discrimination Commission.

Initiatives to make services more culturally effective for Aboriginal people living in rural and remote areas included development of the *Leave No Footprints* best practice model of mental health services by the Central Australian Mental Health Service Remote Team and recruitment of AMHWs to work in partnership with primary health and mental health services.

Mental health, other health services staff and non-Government sector staff trained in the provision of *Triple P* parenting skills enhancement program.

Suicide prevention *Life Promotion Program* established across the NT, employing Indigenous and non-Indigenous Life Promotion Officers in the Top End and Central Australia.

The Mental Health, Alcohol and Other Drugs and Health Promotion Programs combined to form the new Social and Emotional Wellness (SOEWELL) Branch.

The SOEWELL Branch established a position dedicated to developing policy and program approaches consistent with the *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health.*

Considerable work completed towards implementation of the National Mental Health Standards in both the Top End and Central Australian regions in order to meet the commitment to have all services accredited by 2003.

NT Mental Health Information Development Plan completed to progress the introduction of standardised outcome measures as part of routine clinical practice as well as undertake related projects aimed at monitoring service performance and quality.

An Approved Procedures and Quality Improvement Committee established under the provisions of the *Mental Health and Related Services Act.*

TEMHS and the Top End Division of GPs established a co-located clinic within a community mental health facility to provide complimentary medical care to clients.

A review into the Department of Health and Community Services recommended the Mental Health Program be disentangled from the SOEWELL structure as a discrete and high priority program. This review indicated that recommendations arising from the Mental Health Services System Development Strategy Project (which occurred simultaneously) be considered and where appropriate implemented.

A key recommendation of the Mental Health Services System Development Strategy Project was for a substantial funding increase in funding to mental health services. This has been actioned by the NT Government.

NT GOVERNMENT INITIATIVES 2003-2008

Mental Health is now a key priority for the NT Government and DHCS. This commitment to improving mental health service delivery across the Territory was

demonstrated initially by increasing recurrent funding for mental health by $12.7 million between 2003/04 and 2005/06.

Whilst this funding boost resulted in significant improvements in the range and quality of mental health services provided, it is acknowledged that further reforms and expansion of services are required and an additional $5.5 million has been subsequently committed over the next 3 years (2005/06 to 2007/08).

In 2002/03 the NT Budget paper allocation for Mental Health was $14.2M, when indirect corporate costs are added the eventual expenditure on Mental Health in 2002/03 was $18.8M. The Budget estimate for 2005/06 is $28.8M, which equates to a budget increase of approximately 53 % over 3 years. As noted previously, per capita expenditure on mental health services in the NT has increased from $89 in 2002/2003 to $129 in 2004/2005, and is expected to reach $144 in 2005/2006.

The priority area for the mental health program has been the urgent need to provide a greater range of service options in the community for people who have a severe and persistent mental illness and those at risk of experiencing or recovering from an acute episode. Greater investment in the community-based system should reduce pressure on inpatient beds, provide greater support to individuals transitioning between hospital and community based care, improve access to specialist mental health care in rural and remote areas of the Territory and improve access to non-Government support services.

New initiatives commenced in the NT since 2003 have aimed to address many of the concerns expressed by consumers, carers and service providers in a number of consultation forums and submissions and include:

Expansion of Services to Rural and Remote Communities

- Increased clinical and AMHW positions and a substantial increase in the travel budget for rural and remote teams.
- Commencement of visiting psychiatrist services to remote communities.
- Mental health education and case review with remote medical officers and nurses.
- Development of a range of specific Indigenous mental health promotion resources which incorporate story form, Indigenous art, a two-way message, and animated computerised NT Indigenous characters (MARVIN) by the Australian Integrated Mental Health Initiative (AIMHI).
- Agreement with the South Australian Government for recurrent funding to provide services to the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands (November 2004).

Expansion of Child and Adolescent Services

- Additional child and adolescent nursing and allied health positions
- Creation of 2 Child and Adolescent psychiatrist positions
- Commencement of visiting services to regional centres

Expansion of Acute Assessment and After-Hours Services

- Creation of Consultation Liaison Nurse positions in Royal Darwin Hospital (RDH) and Alice Springs Hospital

- Redevelopment and expansion of the after hours service with staff rostered to provide assessments in the community and the Emergency Department of RDH after hours.

Safety and Quality Initiatives

- Quality improvement initiatives commenced in the last 12 months include clinical risk management review, clinical audits, critical incident review, case-load acuity measurement and discharge care coordination processes. Revised policies and procedures for risk assessment, complaints management and provision of information to consumers and carers have been implemented.
- Workforce retention and development initiatives include a substantial increase in the education budget for mental health service clinicians, expansion of the Registrar Training Program and commencement of a national and international recruitment strategy for mental health nurses.
- TEMHS achieved ACHS Accreditation in February 2004 (TEMHS delivers services to three quarters of the NT population). CAMHS have completed the self-assessment and ACHS will conduct the first organisation wide assessment in November 2005.
- Modifications to inpatient facilities to address safety issues have been completed in the Alice Springs Inpatient Unit and are nearing completion in the TEMHS Inpatient Unit.

Mental Health and Related Services Act Review

Recommendations of the recently completed review of the *Mental Health and Related Services Act (1998)*, which is based on model mental health legislation, are currently being considered by NT Cabinet. Some of the issues that have been addressed in this review include those that relate to administrative arrangements, reporting requirements, assessment and review time lines, levels of consent, carer and family rights to information and involvement in decision-making, powers of the Court, application of community management orders in remote locations and the capacity to facilitate Interstate Orders. Extensive consultation was undertaken during the review process and draft amendments will be available for comment before an amendments Bill is returned to the Legislative Assembly for consideration.

New or Enhanced Non-Government Services include:

- Expansion of outreach support and rehabilitation programs
- 18 month trial of sub-acute individual care packages
- Expansion of NT ARAFMI occupational and recreational programs in Darwin
- Establishment of GROW in Katherine
- Funding to support Top End Mental Health Consumer Organisation (TEMHCO)

Dual Diagnosis Initiatives

- Mental Health and Substance Misuse Project commenced January 2004. Outcomes to date include development of MoUs between Mental Health and Alcohol and Other Drug service providers, implementation of assessment screening tools and joint training initiatives. The Alcohol and other Drug program are currently developing a Volatile Substance Abuse Prevention Act.

Initiatives will include assessment, treatment, rehabilitation and court diversion programs.

- Implementation of the Primary Health Care Service in Darwin to address the physical health needs of mental health consumers and link consumers with GPs in the community.
- Joint management with Aged and Disability Services and Family and Children Services to meet the needs of complex clients.

Consumer and Carer Participation

- Consultation with consumers and carers regarding what information should be included in National Consumer and Carer 'perception of care' measures has recently been completed.
- Ongoing support for the Northern Territory Community Advisory Group on Mental Health (NTCAG).
- Establishment, recognition and funding support for the NT Mental Health Coalition (which includes membership from all NT consumer and carer organisations and non-government mental health service providers) as the peak body for mental health in the NT.
- Funding to support NT representation on the Mental Health Council of Australia's Consumer and Carer Forum, which meets quarterly.
- Consumer and Carer involvement in service level committees and on recruitment interview panels.

Future Directions 2005 - 2008

Additional funding allocated in 2005/2006 will be utilised to:

- Establish sub-acute (step-down) 24 hour staffed residential services (14 beds) in Darwin and Alice Springs to provide an alternative to hospital admission, facilitate early discharge and provide transitional clinical and non-clinical support for people returning to remote communities.
- Significantly increase clinical and rehabilitation services to prisoners with a mental illness, acquired brain injury and/or intellectual disability in partnership with Aged and Disability services.
- Strengthen the capacity for 24-hour mental health assistance across the Territory.
- Coordinate suicide prevention activities and expand the Life Promotion Program.
- Establish child and adolescent clinical positions in regional centres
- Recurrently fund quality and clinical system coordination positions in TEMHS and CAMHS.
- Support AIMHI Chronic Disease Management trials in 5 remote communities
- Expand the Top End Division of General Practice Aboriginal Mental Health/Substance Misuse Worker programs in remote communities.
- Progress workforce development initiatives including implementation of the National Practice Standards for the Mental Health Workforce.
- Develop an improved framework for consumer and carer participation, including consideration of appropriate remuneration.
- Increase support to primary mental health and acute care services to provide mental health services in rural and remote communities.

- Recurrently fund the existing Tiwi Mental Health Program and explore the feasibility of introducing this model in other large Indigenous communities.

MENTAL HEALTH SERVICES FUNDING.

Since the commencement of the National Mental Health Strategy (NMHS) in 1993 the NT has received a small allocation of Australian Government funding through the various Healthcare Agreements for Mental Health Reform.

Funding Formulas

The Australian Health Care Agreement funding formula is based on a weighted population according to age and gender distribution. It does not take into account any of the other significant cost drivers in the NT, including remoteness and population dispersal, indigenous health status, levels of disability and socio-economic disadvantage.

The cost of delivering services to Indigenous and remote communities is significantly higher than servicing non Indigenous urban communities and additional weighting is required in the allocation of resources for mental health services to meet these higher costs and to facilitate a more equitable distribution of resources to remote communities.

NT Government mental health funding for the Central Australian Region is weighted to reflect the high cost of delivering services. The region has a very high Indigenous population dispersed over vast distances, in addition to the high cost of recruiting and retaining specialist staff. The region has 24% of the NT population and receives 30% of mental health funding.

Morbidity & Burden of Disease

An article entitled 'Burden of disease and injury in Aboriginal and non-Aboriginal populations in the Northern Territory' published in the *Medical Journal of Australia* in May 2004, Vol 180 makes a number of pertinent observations about the burden of disease in the NT and comments on the need for more equity in the distribution of healthcare funding.

The disability-adjusted life-year (DALY) is a population-based health measure to inform health investment. In the *World Health Report*, the World Health Organization (WHO) has adopted the DALY as a standard measure of reporting and comparing population health for individual countries.

Based on this model the leading causes for the total NT burden of disease and injury were cardiovascular disease (14.9%) followed closely by mental disorders (14.5%) including substance misuse. Compared with the national average, the NT also has markedly higher proportions of intentional injury. In 1996 the NT had the highest burden of fatal disease and injury among Australian states and territories.

The DALY has the capacity to inform questions of both the need for and equity of distribution of healthcare funding. It provides a more equitable system than the crude "per capita" method for comparing health status for the purpose of allocating health resources.

Linking burden-of-disease data with expenditure data for the financial year 1996–97 indicates that federal health funding for the whole of Australia was $7890 per DALY, and $6413 per DALY in the NT. This is a level almost 20% below the national

average, before consideration of the higher costs of delivering healthcare services in an environment complicated by remoteness and cultural diversity.

Australian Government National Mental Health Strategy (NMHS) funds have been used in the past to resource critical services in remote areas, including AMHW positions, policy and project positions to progress a range of reforms consistent with the National Strategy including development of new mental health legislation and associated procedures, implementation of National Standards for Mental Health Services, development of information systems and information management capacity, research and policy development in the area of Indigenous mental health, suicide prevention, consumer and carer initiatives and a range of other small time limited projects.

A proportion of new NT Government funding has simply replaced NMHS funding to sustain existing initiatives.

NT funding under current healthcare agreement amounts to approximately $1.2M per annum. This funding has been used to seed many initiatives, however the ability of a small jurisdiction like the NT to sustain these initiatives and expand the range of service and support options is limited without increased funding.

The table below presents a year-by-year proportional comparison between the expenditure of national strategy funds and NT Government funds:

Figure 18: NT Mental Health expenditure history by source of funds (current prices)

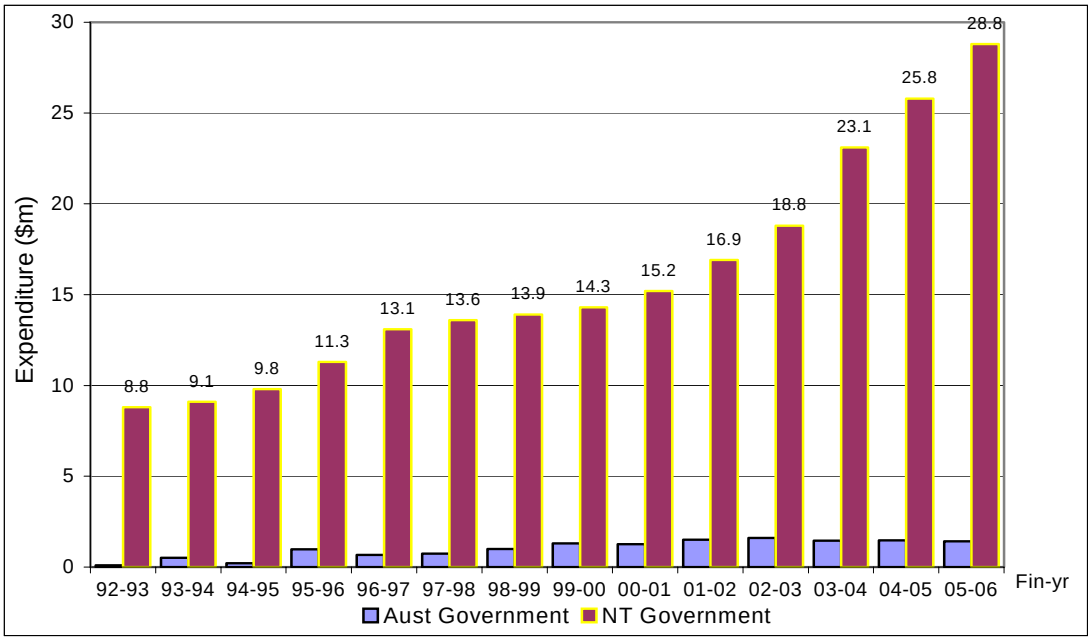


Figure 19 indicates that over the 14-year period since the National Mental Health Strategy commenced expenditure by the NT Government has increased by $20m, or 227%. Since 2003/04 there has been rapid growth as Government has prioritised reform to the mental health system.

By contrast, the quantum of funding allocated to the NT by the Australian Government under successive healthcare agreements for mental health reform under the National Mental Health Strategy has remained relatively low and stable over time.

NT CAPACITY FOR INVOLVEMENT IN NATIONAL MENTAL HEALTH STRATEGY FORUMS AND PROGRESSING KEY NATIONALLY AGREED REFORMS

Representation on National Committees

In addition to NT representation on the National Mental Health Working Group (NMHWG) the NT Mental Health Program also currently funds representation on four NMHWG working parties including the Homeless and Housing, Information Strategy Committee, Safety and Quality and National Forensic Principles. Participation in other critical national forums is also supported where required.

There are many National meetings, forums, conferences and other training opportunities which NT representatives are unable to attend due to the substantial cost associated with travel and accommodation. In order for an NT representative to attend he/she often needs to travel the day before the meeting and depending on return flight availability return the day after which means a two day forum requires 2 additional day absence from the workplace and substantial travel, accommodation and lost productivity costs.

Carer And Consumer Involvement

The Mental Health Coalition has now been endorsed as the mental health peak body in the Northern Territory. Funding has been allocated to support the work of the Coalition, including coordination of mental health promotion activities. A representative from the NT will take a seat on the Board of the Mental Health Council of Australia (MHCA), the National Peak Body.

The Coalition will work together with the Northern Territory Consumer Advisory Group (NTCAG) to increase consumer and carer representation. The NTCAG was one of the earliest to be established under the National Mental Health Strategy and has representation on such committees as the Approved Procedures and Quality Assurance Committee and The Mental Health and Police Liaison Committee and provides consumer and carers representation on selection panels for mental health appointments. Consumers and carers have also provided active participation in 2003/04 within the Top End and Central Australia Service Improvement Projects.

The Top End and Central Australian Mental Health Service have consumer and Carer participation in service management meetings and a variety of service level committees.

Information contained in the 2005 Report on Government Services reveals the NT (with ACT) has the highest rating (100%) for the participation of consumer and carer organisations in local service planning and delivery decision-making.

Information Development

Summary of the development of mental health information systems in the Northern Territory.

Pre National Mental Health Strategy	Key system developments 1993-2003	Future direction/ Next steps
- General Hospital information system in place (Caresys), used by mental health services covering inpatient services only. - Statewide unique patient identifiers in place (community and inpatient). - Separate stand alone community statistical collection systems (FormOHSt) in major centres. - Community mental health data collection performed indirectly by administrative staff. No effective clinical reporting output. - Data accuracy and validation difficulties, no central coordination of information requirements.	- Major investment in development of a corporate Community Care Information System (CCIS), deployed across the Territory. - Client Master Index (CMI) fully integrated across NT community and inpatient information systems. - Generic aggregate service activity reporting available to all users. - Direct clinical data input and on-line access to individual consumer records available in real time and across all service settings and NT service locations. - Data warehouse with dedicated mental health data-mart and end user reporting tool (business objects) to assist in reporting, validation, coordination and improved validation of mental health information.	- Development of reporting and decision support tools to improve utility of information at service delivery, management and program levels. - Seamless integration of patient/client management system across hospital and community mental health services. - Integrated information development workforce training and support systems provided within MH Program.

NT Milestones under the National Mental Health Information Priorities 1998-2003 :

The NT Mental Health Information Management Group (MHIMG) was formed in January 2001 to oversight all mental health information matters.

The NT Mental Health Business Information Development Plan (MHBIDP) 2001-2003 was implemented undertaking six major information development projects including:

- Creation of a Business Information Officer position (now permanently established) to undertake project work and national reporting requirements;
- Development of a consumer outcome measurement collection and reporting system and protocols;
- Improve the user interface of the corporate information collection system;
- Develop a workforce training program for outcome measurement implementation;
- Monitor/review the cultural appropriateness of outcome measures for use with Indigenous consumers;
- Undertake a project to develop a consumer satisfaction survey.

Development of the corporate Intranet as a training reference and clinical resource tool accessible to all clinicians was also undertaken during this period and a mental health program site is operational.

NT Milestones under the Quality Through Outcomes in Mental Health initiative:

The NT Mental Health Business Information Development Plan (MHBIDP) 2004-2006 has been endorsed and will amongst other things undertake three substantial pieces of work including:

- Establishment of a Consumer Outcome Measurement Embedding Team (COMET) to support a renewed commitment to integrate outcome measurement into routine clinical practice and build sustainability in the initiative at the service level;
- Develop and implement a graphical report tool for direct access by clinician users of consumer outcomes information; and
- Develop and implement a standardised management and clinical reporting framework for use at all service and policy levels.