

NORTHERN TERRITORY GOVERNMENT DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

MENTAL HEALTH SERVICE SYSTEM DEVELOPMENT STRATEGY PROJECT FOR THE NORTHERN TERRITORY

FINAL REPORT

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Executive Summary

The Northern Territory Department of Health and Community Services (the Department) engaged Healthcare Management Advisors (HMA) to undertake a study to:

"assess and make recommendations on the core elements of a Mental Health Service System Development Strategy"

The Terms of reference for the Project were:

- 1. review Department of Health and Community Services Mental Health Program funded services, taking into account the context of services available in the NT;
- 2. make recommendations on the level, mix and integration of services and staff to get the best results within existing resources;
- 3. make recommendations on potential areas of disinvestment and reinvestment within the mental health services, using evidence-based practice as a key decision-making criterion; and
- 4. make recommendations on priorities for future funding in relation to specific mental health services

Specific consideration was also to be given to the following:

- priority areas for reform under the Second National Mental Health Plan;
- the strategic directions and priorities identified in the Mental Health Program Plan; and
- coordination and integration of mental health services with other Programs & sectors, and the extent to which needs might be better met by the private sector.

The project was undertaken in four stages between August 2002 and January 2003, namely:

- project planning and initial discussions;
- case studies:
- circulation of a discussion paper and workshops; and
- preparation of a final report and service development strategy

The development of mental health policy frameworks in Australia since 1992 provides a clear direction for the development of the Mental Health Service Development Strategy in for the Northern Territory. Key directions for the development of the Strategy will require:

- application of a population health approach;
- a focus on the development of cross government and inter-sectoral partnerships to facilitate implementation of the National Action Plans;
- consideration of the current workforce and approaches to enhancing the skills base within both the primary health and specialist mental health sectors;
- improved approaches to the recruitment and retention of the mental health workforce;
- particular emphasis on specific populations including Indigenous people, young people, those living in remote communities, those in the forensic system and older people; and
- commitment to improved monitoring of outcomes and development of effective systems for accountability.

The Northern Territory is characterised by two populations. Those residing in the metropolitan setting of Darwin and those living in smaller, more remote communities across

the Territory, although it can be argued that Alice Springs reflects some of the characteristics of a metropolitan centre, it is nevertheless confronted by conditions similar to rural centres in other jurisdictions. Accordingly, in preparing a service development strategy it is crucial that a one size fits all approach is avoided to take account of the population and their living conditions outside Darwin.

The significant indigenous population and the social, economic and cultural strains placed on those living in remote Aboriginal communities clearly separates the population and service environment of the Northern territory from other jurisdictions. This situation will require the development of service models that are appropriate and sustainable in remote settings as a core focus for the service development strategy. The resources required to operate these services, due to isolation and complexity, are likely to be considerably greater than for provision of services in an urban or regional setting.

Finally, the range of social and economic factors which impact on mental health, and their prevalence within the Northern Territory will require co-ordination of responses across government.

Accepted fractions for estimating the normative need whilst useful in providing a broad understanding of the overall need for mental health services in the Northern Territory are largely derived from research carried out in jurisdictions with highly urbanised populations and profiles representative of the broader population profile. No data developed specifically for the Northern Territory was identified. It is anticipated that the estimates referred to above might underestimate the normative need for mental health services.

The focus of resources on provision of services to those with a serious mental illness appears to generate activity in this area that is comparable to the expressed need estimated above. However, the unit of activity, separations or patients seen, does not provide insight into the scope or quality of services provided, a major concern raised by stakeholders.

The youthful population of the Northern Territory and expected prevalence of mental health problems in the 18-24 age groups suggests that child and adolescent mental health and early intervention should be priorities for service development.

The current allocation of funds to mental health services in the Northern Territory is well below the national average on a per capita basis, and includes a significant component of non-recurrent funding which may not be available after 30 June 2003. Approximately \$3.3 million is required to convert non-recurrent funding to recurrent funding and increase funding to the national average. If it intended to also take account of the additional costs of providing services in remote communities and provide an equitable level of services a weighting of 1.5 for this population would see the additional funding requirement rise by a further \$2.7 million.

This said, the current cost of operating inpatient services in Darwin, which are well above the national average, will be an important focus for investigation to allow reallocation of resources and to ensure there is confidence that available resources are being utilised efficiently.

The allocation of resources at first glance appears to acknowledge the additional cost of providing services in remote areas, however when broken down highlights that the larger centres account for a greater proportion of expenditure than their population suggests.

Whilst expanding the resource base appears to be required, it will be important to ensure that the recruitment and retention of an appropriate mix of staff will be crucial to the implementation of a service development strategy.

The establishment of an integrated mental health service in recent years, was broadly supported by informants. Future development of services should build on this development and ensure that the service is managed through a structure which optimises the continuum, with one mental health service for a defined population.

The emphasis on mental health promotion was considered relatively limited. In order to address this, whilst not necessarily resource intensive, requires collaboration and support across government. Further, a strategic framework for the development of mental health promotion activities across government is required

There appeared to be a limited emphasis on the development and implementation of mental health prevention strategies. The current draft Mental Health program Action Plan (2001 – 2003) whilst representing a beginning point for planning activity in this areas fails to provide concrete strategies for action. As with mental health promotion, action in this area will require collaboration and input from a range of departments and other partners, which in turn will require concrete proposals for action.

The relative scarcity of resources within the mental health service system and its focus on managing the treatment of acute mental illness have seen early intervention poorly addressed within the current system. Accordingly, a considerable focus within the strategy for developing services should be the development of service components which actively, and effectively address early intervention.

The recommendations outlined below are intended to:

- acknowledge the need for allocation of additional resources over the coming five years;
- provide acknowledgement of the additional cost of providing services outside major population centres;
- orient the balance of services to the population;
- expand the breadth of the service system to encompass the whole continuum of care from promotion to long term care;
- promote the application of a whole of government response to supporting mental health promotion and prevention;
- expand the linkages between service sectors to enhance the continuum of care in line with the National Mental Health Standards (Standard 8.1 and 8.2) and increase interaction with the general health system at the community level;
- focus policy, planning and administration of the mental health program to support development;
- increase the involvement of stakeholders in the ongoing planning, development and review of the service system and individual services;
- contribute to an improved working environment for mental health staff to improve recruitment and retention of staff; and
- develop the evidence base to support practice, particularly in responding to the mental health needs of Aboriginal people.

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The recommendations that constitute the strategy are reported below, and Chapter 5 provides a tabulation of recommendations, timeframes, expected outcomes and estimated costs.

Summary of recommendations

Recommendation 1

It is recommended that an additional \$1.3 million be allocated to the mental health program to offset the impact of National Mental Health Reform and Incentive Funding due to expire on 30 June 2003. These funds are currently allocated to areas identified as priorities and evaluation of the projects indicates that they are achieving expectations and should be continued.

Recommendation 2

It is recommended that the allocation of funds to the mental health program be increased to return the Northern Territory to the at least national average per capita level. An additional allocation of \$2.01 million is required to achieve the 1999-2000 national average.

Recommendation 3

It is recommended that consideration be given to allocating a minimum of 1.5 times the national average per capita funding for the population living outside the Darwin and Alice Springs metropolitan areas. Implementing this strategy would require an additional allocation of \$2.7 million.

Recommendation 4

It is recommended that the current weighting of resource allocation between Central Australia and the Top End be retained.

Recommendation 5

It is recommended that the allocation of funding within the Central Australian and Top End be reviewed to ensure that the weighting to rural and remote communities is maintained within each region. This will require analysis of the use of inpatient services by those from remote communities.

Recommendation 6

It is recommended that the level of funding provided to inpatient services in Darwin be brought into closer alignment with the national average bed day cost (\$455). This strategy will require a detailed review of current operations and staffing levels, which presently appear to be consistent with a psychiatric intensive care unit for all patients. Funds released as a result of this process should be redirected to the pool of additional resources proposed in recommendations 1, 2 and 3.

Recommendation 7

It is recommended that should additional resources become available, priority be given to confirming recurrent funding for services currently supported by non-recurrent funding, particularly Aboriginal Mental Health Worker positions, and those services targeting remote communities.

Recommendation 8

It is recommended that as additional resources become available, additional permanent positions should be established. Given the population of the Territory, the objective should be to establish:

- an additional five psychiatry positions, with an emphasis on expanding the use of
 private practice rights by public sector psychiatrists, of which one consultant and
 one registrar position should be located in Alice Springs, and at least one position
 should be a specialist child and adolescent psychiatrist; and
- increase the number of ambulatory care positions to 100.8 FTE from the current level (68.9 FTE) with a particular emphasis on child and adolescent positions.

Recommendation 9

It is recommended that the Department, in consultation with the Northern Territory Aboriginal Health Forum, clarify the role and training requirements for Aboriginal Mental Health Workers, and endeavour to achieve proportional employment of appropriately trained and skilled Aboriginal people within the mental health system. This initiative should also include the provision of training and support structures to facilitate Aboriginal people taking on management roles within the service. Further, consideration should be given to the location of these positions within Aboriginal organisations where possible.

Recommendation 10

It is recommended that where Aboriginal Mental Health Worker positions are created, a sufficient allocation is provided to ensure the positions have access to transport, support, supervision and ongoing training.

Recommendation 11

It is recommended that the Department of Health and Community Services work with other departments to establish a mental health promotion strategy with a five-year horizon, outlining specific strategies to be undertaken across government to promote and enhance mental health.

Recommendation 12

It is recommended that the Department of Health and Community Services develop a mental health prevention strategy by working with an existing interdepartmental and inter-sectoral forum. Should an appropriate forum not exist, it is recommended that a group be established involving stakeholders such as:

- Department of Employment, Education and Training;
- Department of Community Development, Sport and Cultural Affairs;
- Justice Department;
- The Licensing Commission;
- Northern Territory Police Service;

- Department of the Chief Minister;
- the Northern Territory Consumer Advisory Group; and
- non-government organisations

to support the development and implementation of universal and selective prevention strategies such as parenting programs, and resilience training for school children, and support and follow up of young mothers. It is further recommended that these strategies be jointly funded by participating departments and opportunities for involving non-government organisations and consumer/carer representatives in deliberations be pursued.

Recommendation 13

It is recommended that to enhance the capacity of primary health care staff to identify and provide early intervention:

- specialist community mental health teams in Darwin, and if practical in Alice Springs, be co-located with other community health services, to facilitate the transfer of skills and understanding of mental health to the broader range of health professionals;
- negotiations be undertaken with the State Based Organisation regarding the
 development of a program to support routine placement of specialist mental health
 professionals within GP practices (similar to the model outlined by Harmon (et al
 (2000))) to further enhance the role of general practitioners in the identification of an
 early intervention for mental illness;
- that specialist community mental health staff be encouraged to provide services in community based organisations such as supported accommodation, schools and services specifically designed for young people to enhance access to mental health services and support;
- a clear outline of the expectations of mental health workers in this consultant/support role is developed, along with a brief training program.

Recommendation 14

It is recommended that a working group with representation from both the Department of Health and Community Services (including mental health clinicians) and non-government organisations be established to explore opportunities for applying the learning gained from projects such as "Building capacity for mental health" (O'Hanlon et al (2002)) in collaboration with the non-government sector. A particular focus should be on early intervention for children and adolescents. If possible, the allocation of funding to support a small number of pilot projects should be allocated to test and refine approaches. There is a strong case for these projects to be undertaken through non-government organisations.

Recommendation 15

It is recommended that the development of a coherent child and adolescent (those up to 18 years old) mental health service, particularly for Central Australia, be given priority within existing resources, and as new funds become available through savings or allocation of additional resources. Ideally the service should include:

establishment of a child and adolescent psychiatrist position;

- development of training, support and research links with a major child and adolescent mental health centre;
- work toward the establishment of a ambulatory, child and adolescent mental health workforce of 25 FTE; and
- development of a two-bed area within the in patient unit in Darwin appropriate for the care of patients under the age of eighteen, and if possible ensure that one bed is available in Alice Springs. These beds should be available for adult patients when not required for children and adolescents.

Recommendation 16

It is recommended that the Department seek the support of the Commonwealth to fund and commission a program of research over the coming decade to:

- test the validity of contemporary diagnostic frameworks (e.g. DSM IV) within the indigenous population;
- in close collaboration with the Aboriginal community, refine these diagnostic frameworks to take account of the broader conception of health defined in the National Aboriginal Health Strategy;
- develop documentation and training for mental health and primary health staff seeking to work in indigenous communities, or with Aboriginal people; and
- subsequently establish a detailed epidemiology of mental health in the Northern Territory.

Recommendation 17

It is recommended that the current proportion of Aboriginal people employed with mental health services be increased to reflect the population profile (i.e. 28.3%). This will require resources for adequate training, support and clinical supervision.

Recommendation 18

It is recommended that the Department in collaboration with the Northern Territory Aboriginal Health Forum, support resolution of the debate regarding the role of, and qualifications required by, Aboriginal Mental Health Workers.

Recommendation 19

It is recommended that the Department, in line with the outcome of deliberations by the Northern Territory Aboriginal Health Forum regarding the roles and qualifications for Aboriginal Mental Health Workers, initiate a process that results in appropriate acknowledgement of the clinical role of Aboriginal Mental Health Workers in the designation and classification of their positions.

Recommendation 20

It is recommended that the Department collaborate with the Aboriginal Health Forum in reviewing the above recommendations to ensure that the outcomes of the current project to develop a Northern Territory Aboriginal Social and Emotional Well-being Strategy are neither pre-empted, nor undermined by these recommendations.

Recommendation 21

It is recommended that a working group be established to explore options for the improved management of involuntary admissions of patients from remote communities. This working group should include representation from:

- one psychiatrist from the Top End and one from Central Australia;
- one representative of the Mental Health Review Tribunal;
- one representative from the Aboriginal Health Forum;
- one representative from nursing staff at each of the Darwin and Alice Springs inpatient units;
- one District Medical Officer;
- one representative from the Tiwi Islands Health Board;
- one representative from the Central Australian Aboriginal Congress;
- the Chief Health Officer (or a representative);
- a representative from the Northern Territory Police Service;
- one consumer and one carer representative;
- one representative from the Royal Flying Doctor Service or other air evacuation provider; and
- a representative of the Northern Territory Attorney General.

It is further recommended that the terms of reference for the working group include:

- review of a sample of cases where involuntary admissions from remote communities resulted in discharge within 24 hours of admission (including the outcome following discharge);
- identification of any shortcomings in current policy or practice;
- development of strategies to address any shortcomings identified;
- identification of any legislative changes that may be required; and
- revision of protocols and policy to support the implementation of identified strategies.

Recommendation 22

It is recommended that management of the Top End Service Network be required to initiate a detailed examination of the staffing and operation of inpatient mental health services in Darwin with a view to:

- devising strategies for achieving operating costs comparable to the national average cost per bed-day;
- documenting based on the results of an independent costing study the specific circumstances/barriers in the Northern Territory that preclude the achievement of savings of this magnitude (it is our expectation that some savings should be possible even if national average bed costs cannot be achieved;
- staffing levels proposed through this review should be justified on the basis of an analysis of patient mix and benchmarks applied in other jurisdictions, and the evidence base for any variation;
- clear delineation should be made between patients requiring acute care and those who are receiving sub/post acute care;
- alternative venues or arrangements for less acute levels of care should be explored (see Recommendation 24); and
- that this review be completed by 31 August 2003.

Recommendation 23

It is recommended that staff engaged to work in the Ward 1 of Alice Springs hospital be granted access to the same services and support, on the same conditions as are made available to other inpatient staff at the Alice Springs Hospital.

Recommendation 24

It is recommended that following review of inpatient services in Darwin, determination regarding the allocation of non-acute beds to the non-government sector be negotiated with a group representing the non-government sector:

- the process for determining the agency(ies) that will operate the beds;
- the number of beds to be located in the community;
- the basis for providing the ongoing clinical input to the services; and
- the financial support required for the operation of the beds; and
- the sources of funding to be applied.

Recommendation 25

It is recommended that the care of very long stay patients for those unable to achieve independent function in the community be provided predominantly in the nongovernment sector (20 beds). The funding of the accommodation component of care may not be through the mental health budget. However, specialist community mental health staff should provide ongoing contact (approximately one hour per bed per week of each of mental nursing and allied health) and psychiatric review quarterly. In order to facilitate continuity and the development of effective working relationships it may be appropriate to designate specific positions in both Darwin and Alice Springs to provide nursing and allied health care. Further, funding the non-government sector to provide these services may achieve the same result.

Recommendation 26

It is recommended that a process be initiated urgently to explore and develop effective service delivery models for clients with co-existing mental health and alcohol or other drug problems. This process should build on the work published by the NSW Department of Health, Mental Health and Substance Use Disorder – Service Delivery Guidelines. Ideally this process should be chaired by the Chief Health Officer (or delegate) and involve:

- two representatives from both mental health and alcohol and other drugs;
- two representative of the NT Aboriginal Health Forum;
- two representatives from non-government organisations involved in the provision of alcohol and other drug services;
- two representatives of the non-government sector; and
- two consumer and two carer representatives (including members of the Consumer Advisory Group).

It is further recommended that a report outlining the deliberations and conclusions of the group be submitted to the Chief Executive Officer by 31 December 2003.

Recommendation 27

It is recommended that a working group be established with representation from both the Top End and Central Australia to develop protocols and procedures for the establishment of advanced consent, allowing mental health service providers to share defined information with carers. The working group should have representation from:

- mental health clinicians including a psychiatrist, mental health nurse, psychologist, social worker and two Aboriginal mental health workers;
- two carer representatives;
- two consumer representatives; and
- a representative of the Mental Health Review Tribunal as chair.

Recommendation 28

It is recommended that the Department work with the representatives of the non-government sector, the Commonwealth, consumers and carers to explore resources available in communities to support rehabilitation/recovery and subsequently collaborate in the development of a framework and action plan to enhance the linkages between, and access to, these services. Allocation of resources to non-government organisations to develop initiatives in this area is encouraged.

Recommendation 29

It is recommended that the Department, in collaboration with the NT Aboriginal Health Forum develop a formal and agreed protocol for jointly responding to communities in which a suicide occurs to limit the likelihood of a cluster of suicides developing.

Recommendation 30

It is recommended that the funder and purchaser roles (Social and Emotional Wellness Branch) and the mental health position with Service Development Division be amalgamated. The amalgamated Branch should be located under the Chief Health Officer.

Recommendation 31

It is recommended that the General Manager of the Top End Mental Health Service and the General Manager of the Central Australian Mental Health Service be directly accountable to the amalgamated Social and Emotional Wellness Branch for the implementation and monitoring of their service agreements. Routine operational accountability would remain with the service networks.

Recommendation 32

It is recommended that a monthly meeting between SEWB, general managers (TEMHS and CAMHS), a representative of the non-government sector, a consumer an a carer representative provide the focal point for discussion and monitoring of service agreements, planning and priority setting.

Recommendation 33

It is recommended, that provided a suitable candidate can be identified, a Chief Psychiatrist position be established within the amalgamated Social and Emotional Wellness Branch.

Recommendation 34

It is recommended that as earlier recommendations regarding additional resources are implemented, a component be allocated to funding programs in the non-government sector, particularly in relation to:

- selective and indicated prevention, and early intervention;
- support for Aboriginal mental health workers in remote communities;
- services for those with high prevalence disorders;
- sub acute care:
- and rehabilitation.

Decisions about the allocation of such resources to specific programs should be an agenda item in the monthly meeting proposed in Recommendation 32.

Recommendation 35

It is recommended that mental health executive meetings at the Northern Territory, Service Network and regional hub (described in 4.3.4) include a consumer and a carer representative. Where issues requiring discussion of information relating to the management of individual patients is required, agenda papers should indicate the issue, without reference to the client and if necessary these items should be discussed at the conclusion of the meeting without the consumer and carer representative. However, the minutes of the meeting should indicate the issues and resolution in a manner, which protects the patients' confidentiality.

Recommendation 36

It is recommended that minimum staffing for regional hubs include the following positions:

- two adult mental health workers;
- one child and adolescent mental health worker;
- one mental health promotion/community development;
- one specialist position to support Aboriginal mental health workers; and
- support for primary health care workers be a requirement of all positions.

Recommendation 37

It is recommended that a position be created within the amalgamated Social and Emotional Wellness Branch that has responsibility for the development and coordination of a coherent professional development program for mental health staff in both the government and non government sector. Partnerships with tertiary education providers in the Northern Territory to provide ongoing core training elements should be a priority for this position to provide a comprehensive range of training at a manageable cost. The explicit articulation of priorities for supporting presentation of conference papers and attendance at conferences should also be co-ordinated through this position.

1

Introduction

The Northern Territory Department of Health and Community Services (the Department) engaged Healthcare Management Advisors (HMA) to undertake a study to:

"assess and make recommendations on the core elements of a Mental Health Service System Development Strategy"

The development and implementation of the Second National Mental Health Plan, and related policies and directions, required a significant commitment from State and Territory governments to develop a comprehensive range, and appropriate mix, of services to promote and maintain the mental health and well being of their communities. The unique character of the Northern Territory provides a range of challenges to the development and operation of mental health services.

The Department commissioned the project to establish a base for the development of services over the coming decade. The Terms of reference for the Project were:

- review Department of Health and Community Services Mental Health Program funded services, taking into account the context of services available in the NT;
- make recommendations on the level, mix and integration of services and staff to get the best results within existing resources;
- make recommendations on potential areas of disinvestment and reinvestment within the mental health services, using evidence-based practice as a key decision-making criterion; and
- make recommendations on priorities for future funding in relation to specific mental health services.

Specific consideration was also to be given to the following:

- priority areas for reform under the Second National Mental Health Plan;
- the strategic directions and priorities identified in the Mental Health Program Plan; and
- coordination and integration of mental health services with other Programs & sectors, and the extent to which needs might be better met by the private sector.

Following the signing of contracts, the project commenced with a meeting between the consultants and the Steering Committee in Darwin on 19th August 2002. At that meeting the plan for undertaking the project was agreed. During the following fortnight, preliminary discussions were held with a range of stakeholders in both Darwin and Alice Springs to promote the project and gain an understanding of services and the issues confronting them.

Following initial discussions, a range of data and documentation relating to current policies and planning, expenditure and staff, population and services was collected with the assistance of the Department. A document described as a situation analysis was prepared to establish an

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information base for the remainder of the project and was submitted to the Steering Committee in mid September.

In early October, a series of meetings over two days in Darwin and two days in Alice Springs were promoted through the senior officers of organisations. These meetings occurred in Late October and represented a case study of the issues and services in the Top End and Central Australia. Participants were provided with an outline of the issues upon which discussion was sought, a case study framework, to ensure that a considered view was gained at consultations. A copy of the case study framework is provided as Appendix A.

Following case studies, a summary of discussions was prepared and returned to participants through the managers of organisations. Comments were sought to ensure that the information was accurate, complete and reflected the issues covered in the course of the case study meetings. A wide range of comments was received and the case study summaries (see Appendix B) were amended before being finalised.

Subsequent to the case studies, a discussion paper (see Appendix C) was prepared which outlined preliminary findings and proposed broad recommendations for the Service Development Strategy. Workshops were held in both Darwin and Alice Springs to gain feedback on the discussion paper and refine the direction proposed.

After consideration of the feedback received, the final report for the project (this document) was prepared for consideration by the Steering Committee on 30th January 2003. It includes

- (1) An overview of the context in which services operate within the Northern Territory;
- (2) An overview of the distinguishing characteristics of the Northern Territory population, and estimates of the prevalence of mental health problems in sectors of the population;
- (3) A description of the current allocation of resources, range and structure of services available;
- (4) Analysis of the relative adequacy of current resources and services; and
- (5) Proposal of a mental health service development strategy for developing services in the NT including a tabulation of recommendations, allocates responsibility for action, establishes timeframes and provides estimates of the cost of each component.

2

Environmental Context

This Chapter provides a brief description of the environment in which mental health services in the Northern Territory operate, and considers, the geography, the population, social and economic factors, available epidemiological data and its adequacy as well as the broader policy environment. Given the purpose of the current document, it is not intended that an exhaustive coverage of these issues be provided.

2.1 POLICY CONTEXT

In order for the Mental Health Service Development to be effective, it is essential that the directions developed nationally to guide mental health policy and service development are taken into account. Accordingly, the range of National policy and strategy documents which are critical to the Northern Territory Strategy are considered below.

2.1.1 National Mental Health Policy

The 1992 agreement by all health ministers to the National Mental Health Strategy, incorporating the Mental Health Policy (DHHS (1992)), the Mental Health Statement of Rights and Responsibilities (AHMC (1991)), the National Mental Health Plan (DHHS (1992)) and inclusion of Schedule F1 in the Commonwealth/State Medicare Agreements 1993-98, established the base for the development of mental health policy and services over the past decade. The National Mental Health Strategy established 12 priority areas, namely:

- consumer rights;
- linking mental health with other sectors;
- promotion and prevention;
- carers and non-government organisations;
- legislation;
- standards; and

- monitoring and accountability;
- service mix
- primary care services;
- mental health workforce;
- research and evaluation;
- the relationship between mental health and general health services.

The Evaluation of the National Mental Health Strategy (AHMAC (1997)) concluded that considerable progress had been made in the areas of:

- carer and consumer rights and involvement;
- reducing the focus on inpatient services within the overall service mix and bringing mental health services within the structures of mainstream health services;
- key structural steps to improving links between mental health and other sectors had been taken; and
- national initiatives on prevention and promotion needed to be taken to the next stage.

Further, the framework for the future directions outlined in the Evaluation established the basis for development of the Second National Mental Health Plan (AHMAC (1998)). The

Second National Mental Health Plan (AHMAC (1998)) built on achievements of the First National Mental Health Plan (AHMC (1992)) and identified further priority areas, namely:

- promotion/prevention;
- development of partnerships in service reform; and
- the quality and effectiveness of service delivery.

In addition to the development of specific mental health policy and strategic frameworks, the inclusion of mental health, and particularly depression, as one of the seven National Health Priority Areas, further consolidated the focus on enhancing the response to mental health by governments.

2.1.2 Second National Mental Health Plan

As noted above, the Second National Mental Health Plan (AHMAC (1998)) sought to build on progress resulting from the National Mental Health Plan (AHMC (1992)).

In terms of prevention and promotion, the plan emphasised the use of a range of settings in which mental health promotion and community education could occur, and groups of workers who should be targeted to undertake activities in this area. A key development in this area of the plan is development of a population health approach to mental health, with acknowledgement that different groups within the population required different types of services and interventions.

Although the first plan began to enunciate the need for development of linkages and partnerships with a range of groups outside the specialist mental health sector, it was not until the second plan that greater clarity around the groups with whom partnerships should be established, including:

- consumers, families and carers;
- private psychiatrists and the private emergency services; mental health sector:
- the wider health sector;
- non-government agencies;
- the broader community.

- General Practitioners;
- other government agencies;
- community support services; and

In addition, a range of priority partnerships for Indigenous mental health were identified.

The third area upon which the Second National Mental Health Plan (AHMAC (1998)) focussed was improving the quality and effectiveness of mental health services, with emphasis on improving consumer outcomes across the life span. The plan emphasised the need for:

- further development and implementation of the national standards for mental health services:
- preparation and dissemination of clinical standards;
- establishment of benchmarks and best practice models;
- increased use of evidence based practice;
- expansion of education and training to support both specialist mental health and primary health care staff to effectively respond to the changes envisaged within the Plan and enhance the quality and effectiveness of services provided.

2.1.3 National Action Plan for Prevention, Promotion and Early Intervention

Whilst the Second National Mental Health Plan (AHMAC (1998)) broadly identified prevention and promotion as key priorities for action, the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 (CDHAC (2000)) provided a clear articulation of the population health approach to mental health, drawing on Raphael's (2000) monograph on a population health approach. Effectively the approach seeks to develop strategies which attend to the mental health status and mental health needs of whole populations. It acknowledged that:

- health and illness is the result of an interplay between diverse factors including biological, psychological, social, environmental, economic and political factors;
- interventions that secure a benefit for whole populations should be valued, though they may provide relatively limited benefit to specific individuals;
- both risk and protective factors need to be considered;
- long term effort across multiple sectors is required; and
- there had been some resistance to promotion, prevention and early intervention within mental health

The Action Plan emphasised the continuum of care from universal prevention through to long-term individual care and the overlap between prevention, early intervention and treatment. (See Figure 1) and identified fifteen priority groups within the population.

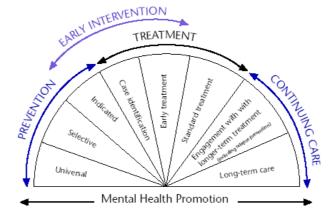


Figure 1 Spectrum of interventions for mental health problems

Source: National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000

Central to the Action Plan is attention to improving family environments, building family friendly workplaces, enhancing parenting skills, reduction of abuse and neglect and increased attention to early identification and intervention.

2.1.4 National Acton Plan for Depression

In a similar vein to the Action Plan for Prevention, Promotion and Early Intervention for Mental Health 2000 (CDHAC (2000)), the National Action Plan for Depression (CDHAC (2000)) builds on the Second National Mental Health Plan (AHMAC (1998)) by applying a population health approach to consideration of depression. Strategies are proposed for:

• enhancing skills to manage adverse events (protective factors)

- introduction of evidence based programs into schools;
- supporting children of parents with depressive disorders;
- enhancing skills of primary health care and specialist mental health providers in screening and intervention for depression; and
- developing culturally appropriate approaches to depression in the Aboriginal and Torres Strait Islander community.

2.1.5 Second National Mental Health Plan Mid-term Evaluation

In 2001, Thornicroft and Betts (2002) were retained to undertake a review of the Second National Mental Health Plan (AHMAC (1998)), providing a commentary on:

- the suitability of the Plan;
- the extent to which objectives for service mix were consistent with international trends;
- the appropriateness of the National Mental Health Policy (AHM (1992)) to deal with international trends; and
- priorities for future development.

In a similar vein to the evaluation of the National Mental Health Strategy (AHMAC (1997)), progress was reported in a number of areas including consumer and carer participation, partnership development; and quality and effectiveness. However, it was emphasised that consolidation was required and options for future directions were proposed.

The Evaluation concluded that there was unequivocal support for a Third National Mental Health Plan, and development was required in:

- expansion and enhancement of the consumer network was warranted, including provision of training;
- expansion of respite and support services for carers;
- increased effort in reducing the stigma of mental illness;
- consolidation of program funding for promotion and prevention;
- integration of universal and selected prevention across service sectors;
- provision of incentives for private psychiatrists to consult to primary care practitioners;
- adoption of beyondblue and MindMatters;
- expansion of the workforce and improving professional education;
- focusing the role of psychologists;
- expansion of services for high prevalence disorders;
- reduction of financial 'silos';
- enhancement of child and adolescent services;
- balancing community and hospital based alternatives to support people in crisis; and
- management of dual diagnosis.

2.1.6 Australian Health Care Agreements

The imminent negotiation of the next Australian Health Care Agreement (AHCA) between the Commonwealth, States and Territories is a key component of the National Mental Health Strategies extension. The AHCA Reference Group Report: Improving Mental Health (CDHA (2002)) draws on the work of Thornicroft and Betts (2002) and proposes:

- reaffirmation of the National Mental Health Policy for 2003-2008;
- consolidation of existing reforms under the first and second national mental health plans;

- emphasis on continuity of care;
- improving access to and the quality of effective primary and secondary interventions within the mental health system;
- enhancing the capacity of services to meet the needs of under served populations, such as Indigenous people and those living in rural and remote areas;
- enhanced governance and clear accountabilities aligned with levels within the governance structure:
- development of consistent national, state and territory action plans, particularly in management of demand, prevention, promotion and early intervention and dual diagnosis;
- returned focus on mental health services for older Australians;
- improved measurement and accountability of services; and
- enhanced training of the mental health workforce; and
- development of linkages between service sectors.

2.1.7 Conclusion

The development of mental health policy frameworks in Australia since 1992 provides a clear direction for the development of the Mental Health Service Development Strategy in for the Northern Territory. Key directions for the development of the Strategy will require:

- application of a population health approach;
- a focus on the development of cross government and inter-sectoral partnerships to facilitate implementation of the National Action Plans;
- consideration of the current workforce and approaches to enhancing the skills base within both the primary health and specialist mental health sectors;
- improved approaches to the recruitment and retention of the mental health workforce;
- particular emphasis on specific populations including Indigenous people, young people, those living in remote communities, those in the forensic system and older people; and
- commitment to improved monitoring of outcomes and development of effective systems for accountability.

2.2 NORTHERN TERRITORY GEOGRAPHY

In the Northern Territory, with the exception Darwin, all communities are classified as either remote (i.e. ARIA score between 5.8 and 9.08) or very remote (i.e. ARIA score greater than 9.08) (ABS. While the population is concentrated in Darwin (54%) and Alice Springs (14%), the remaining 32% of the population live in smaller, dispersed communities (NTDHCS (2002)).

The tropical climate of the Top End sees access to many smaller communities limited during the wet season as unsealed roads become impassable. Further, the dispersion of the population renders the operation of public transport systems uneconomic and access to services is limited to travel by private motor vehicle or buses owned by organisations within individual communities. For those living outside Alice Springs or Darwin, rapid access to tertiary services requires air evacuation.

Implication for services development strategy: In conceptualising the direction for development of services, it is necessary to acknowledge the significant difference between the service models that will be appropriate for urban centres such as Darwin and Alice Springs,

and those for smaller more remote communities. In addition, a number of authors have argued (Swan and Raphael (1995), Health Department of WA (1998), O'Kane and Tsey (1999), Eckstein and Eagar (2001)), and it is generally accepted, that the provision of services to rural and remote populations requires more resources to achieve a similar service level than in urban areas.

2.3 NORTHERN TERRITORY POPULATION

The estimated population of the Northern Territory for 2002 was 201,989, of which 68% of people reside in either the Alice Springs or Darwin Urban areas (NTDHCS (2002)). The remainder of the population is dispersed across the Territory in smaller communities. Bartlett (et al (1997) note that in central Australia, there are only two communities with populations over 800; and there are 209 communities with populations of less than 75 people. They further note that there are numerous outstations with fluctuating populations.

In addition to the geographic dispersion of the population, the Northern Territory has a higher proportion of Aboriginal and Torres Strait Islander people (28%) (NTDHCS (2002)) than other jurisdictions in Australia (2.2%) (ABS (2002)). Further, the relatively late settlement of the Northern Territory sees this group more culturally and linguistically in tact than populations in south-eastern Australia.

This section considers a range of factors that describe the Northern Territory population, including age distribution, ethnic background, family structure, economic and social indicators and general health.

2.2.1 Age distribution

The age distribution of the population is somewhat different to that of Australia as a whole. People over 65 years of age are relatively under represented in the population and as can be seen from Figure 1, with 41% of the population being under 25 years of age. Where only the Aboriginal population is considered, over 50% of the population is under 25 years of age. Condon (et al (2001)) suggests that the high fertility rate and low life expectancy of Aboriginal people explain the concentration of the population under 25 years of age.

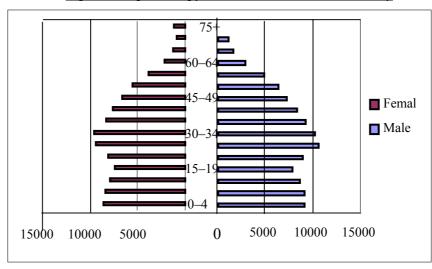


Figure 1: Population pyramid for the Northern Territory

Source: Based on NTDHCS Population Data (2002)

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Age 85+ 80-84 75-79 70-74 85-69 80-64 90-6

Figure 1a: Population pyramid for the Australia

Source: Australian Bureau of Statistics: (2002) Year Book of Australia 2002

Current projections published by the Australian Bureau of Statistics (ABS (2002b)) suggest that the Northern Territory population will age gradually over the next fifty years, though remain the youngest population in the country.

The population data fails to take account of the significant number of tourists that visit the Northern Territory. Approximately 327,000 interstate tourists visit the Northern Territory annually (NT Tourism Commission, 2002). It was suggested in consultations that a significant proportion of tourists experience mental illness and are not taken into account in population based estimates. Further, the seasonal fluctuations in tourist numbers will see the demand generated on mental health services fluctuate.

Implication for services development strategy: 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 (e.g. Rey (1992)). This group represents over 10% of the Northern Territory population and will therefore be a key focus for service development. The eventual Strategy will need to consider the appropriate allocation of resources to this service area and population.

The transient or tourist population attracted to the Northern Territory due to its climate and isolation may result in demand for services being greater than might be estimated from population data. Further, this group will lack social support structures and are likely to require assistance in accessing accommodation should they require care in the Northern Territory.

2.2.2 Ethnic/linguistic background

The Northern Territory has a diverse cultural and linguistic base. Almost 14.5% of the population were born outside Australia, of which 75% were born in non-English speaking countries (ABS (2002c). In addition, over 28% of the population are indigenous (NTDHCS

(2002)). As noted by O'Kane and Tsey (1999), a significant proportion of the indigenous population speaks English as a second language.

Implication for services development strategy: The proportion of the population born overseas is comparatively lower than for other States and Territories. Nevertheless, the availability of interpreter services and use of these services in the provision of mental health services is a consideration. Of greater importance is the development of approaches and models that take account of the needs of Aboriginal people living in the Northern Territory. Again, a number of authors have argued that an additional weighting is required in the allocation of resources for mental health services to meet the needs of indigenous populations (Raphael and Swan (1995), O'Kane and Tsey (1999)).

2.2.3 Family structure

The living arrangements of individuals impact on the extent to which support is available to them. Further, the type of family structure may also provide an indication of other stressors in the environment, which may in turn contribute to a higher prevalence of mental illness.

The proportion of single person households in the Northern Territory (25%) is comparable to the national average (24.6%) (ABS (2002d)). However, the proportion of single parent families with children is higher than the national average for lone father with children under 15 (5% vs. 2.3%) but slightly lower for lone mother families with children under 15 (18.1% vs. 19.3%) (ABS 2002d). It should be noted that these estimates are derived primarily for urban areas in the Northern Territory.

Information available for more remote communities suggests that the number of people living in households increased (O'Kane and Tsey (1999) Bartlett et al (1997)).

The proportion of children born to women under 20 years of age (13.3%) is considerably higher than the national average (4.6%). Further, 62.5% of all births occur to single mothers or those living in defacto relationships compared to the national average of 29.2% (ABS (2002d).

Implication for services development strategy: The proportion of lone households, and the reported propensity for those with a mental illness, particularly schizophrenia, to be homeless emphasises the need for close links between specialist mental health and accommodation providers.

The higher prevalence of mental disorders in the 18-24 age group reported earlier, taken in combination with the proportion of births to women under twenty years of age and the prevalence of single parent families requires that mental health services work closely with agencies able to provide support around parenting. Further, close working relationships will be required to allow planning for children to be cared for where lone parents experience an acute episode requiring admission.

2.2.4 Economic and social indicators

Review of ABS data regarding income and income distribution (ABS 2002e) indicates that the Northern Territory had the second highest average gross household disposable income (\$24,600 per annum). However, the lower representation of residents in remote communities and comparison with data from other sources suggests that this indicator is a poor reflection

of the comparative position of the Northern Territory. Burgess (et al (2002)) using the Index of Relative Socio-Economic Disadvantage reported that of 76 mental health areas (the NT was treated as a single area) the Northern Territory was the 17th most disadvantaged.

Table 1: Northern Territory Social Disadvantage and Education Levels

Measure	Northern Territory position
Index of Relative Socio-Economic	962.08
Disadvantage(1)	17 th (of 76) highest disadvantage (Quintile 2)
Index of Education and Occupation (2)	1003.62
	18 th (of 76) highest education/occupation levels (Quintile 4)

Source: Burgess (et al (2002)

Review of the ABS data upon which the Index of Education and Occupation is based highlights that the data for the Northern Territory is primarily drawn from the urban areas of the NT. Studies undertaken in remote communities, such as those by O'Kane and Tsey (1999) and Bartlett (et al (1997)), highlight high levels of unemployment and poverty in remote communities, particularly for Aboriginal people. O'Kane and Tsey (1999) emphasise that for young Aboriginal people in communities outside Alice Springs, the unemployment rate may be as high as 70%.

Implication for services development strategy: Wilkinson and Marmot (1998) concluded that insecurity, social isolation and lack of control over home and work life amongst other things, have a significant impact on health, and mental health. The greater weight of unemployment and socio-economic disadvantage in non-urban areas, and particularly remote communities, will require a greater emphasis on the provision of appropriate services in this environment than currently appears to be the case.

The range of social and economic factors likely to impact on mental health requires that the strategy incorporate opportunities for developing across government approaches to improving mental health and the factors known to impact on the mental health of individuals and communities.

2.2.5 Conclusion

The Northern Territory is characterised by two populations. Those residing in the metropolitan setting of Darwin and those living in smaller, more remote communities across the Territory, although it can be argued that Alice Springs reflects some of the characteristics of a metropolitan centre, it is nevertheless confronted by conditions similar to rural centres in other jurisdictions. Accordingly, in preparing a service development strategy it is crucial that a one size fits all approach is avoided to take account of the population and their living conditions outside Darwin.

The significant indigenous population and the social, economic and cultural strains placed on those living in remote Aboriginal communities clearly separates the population and service environment of the Northern territory from other jurisdictions. This situation will require the development of service models that are appropriate and sustainable in remote settings as a core focus for the service development strategy. The resources required to operate these services, due to isolation and complexity, are likely to be considerably greater than for provision of services in an urban or regional setting.

⁽¹⁾ Incorporates income, education and occupations.

⁽²⁾ The Index of Education encompasses, education levels, occupations and employment/unemployment

Finally, the range of social and economic factors which impact on mental health, and their prevalence within the Northern Territory will require co-ordination of responses across government.

2.4 EPIDEMIOLOGICAL DATA

In the course of undertaking consultations, reviewing available data and considering the literature the most striking issue that arises is the relative lack of a coherent epidemiology of mental health in non-urban environments. The following section considers the available data and options for assessing need within the Northern Territory, as well as identifying difficulties in applying current data. It should be noted at the outset that a coherent epidemiology of mental health in remote and indigenous communities has yet to be developed.

2.4.1 Prevalence of mental illness

The National Survey of Mental Health and Well Being found that approximately 20% of the population experienced a mental disorder in the twelve months preceding the survey (Andrews et al (2001)). Fuller (et al (2000)) notes that comparisons between urban and rural populations present mixed results.

The New South Wales Centre for Mental Health (2001) developed a comprehensive model for estimating the population likely to experience severe or moderate mental health problems in a 12 month period, as well as the number likely to require targeted prevention or early intervention. Whilst the parameters are likely to vary, given the different characteristics of the Northern Territory population the approach is useful, particularly in seeking to link the allocation of resources, based on evidence based models of care, to the potential population.

Table 2: Estimated population of NT requiring mental health services

Population by age group	0 to 1(1)	2 to 4	5 to 11	12 to 17	18 to 64	65+	Total
	7,009	10,514	23,904	18,884	134,685	6,992	201,988
Prevalence Parameters							
Total 12 month prevalence	407	1,062	3,849	3,890	23,974	776	33,957
Severe	56	221	502	453	3,771	14	5,017
Moderate		315	1,434	1,492	5,657	294	9,192
At Risk/Early Intervention	350	526	1,912	1,945	14,546	468	19,748
Early Intervention for Psychosis					40		
Post Natal depression					13		
ED Attendances (MH DRGs)	10	63	2	55	889	37	1056
Inpatient Separations (all sources)	1	2	10	69	1047	39	1167
Separations from general beds	1	2	3	15	58	12	92
Acute separations			6	53	830	21	911
Acute Bed Days			45	277	2,718	589	3,629
Acute Beds (@85% occupancy)			0.1	1	9	2	11.7
Non acute separations					133	3	137
Non acute bed days					11,613	203	11,815
Non acute beds (@ 85% occupancy)					37	0.5	37.9
Community residential separations ⁽²⁾					8	1	9
Community residential bed days					2,718	322	3,040

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Community residential beds (@100%			7	1	8
occupancy)					
Very long stay separations			18	2	20
Very long Stay bed days			6,342	751	7,093
Very long stay beds			17	2	19

Source: MHCCP V1.11 and NT Epidemiology Branch

- (1) cases related to at risk and neglect
- (2) implies nursing home for psycho geriatrics

Whilst the fractions applied are derived from activity and population characteristics in New South Wales, the predicted number of acute inpatient separations (911) which is relatively close to the actual activity for 2001-02 (872 separations). This suggests the quantum of service currently provided may be marginally below the level required by the population. However, given the limited availability of primary mental health services in many communities, the conceptions of mental health and acceptance of behaviours in remote communities, and the difficulties involved in transportation, this may represent a slight underestimate of the actual need.

However when the number of occupied bed days is considered, the actual bed days (8,838) suggest that the mechanism for counting acute admissions used also includes those who may be classified as no acute. If this were the case, the model predicts 1048 separations and 15,444 bed days. As is discussed in Section 4.2.4.4, this may reflect the dearth of alternative venues for residential care.

Purcell (2002) reports that during 2000-01 there were 3,704 individual clients treated in the community in the Northern Territory, some 25% below the number of people predicted to experience a severe mental illness (4,238. See highlighted cells in Table 2). This may reflect lack of access to these services, particularly for individuals in more remote communities.

The use of multiple methods to develop estimates allows testing of the likely validity of any one method. O'Kane and Tsey (1999) consider a range of estimates based on US studies for mental illness in seeking to determine the need in Central Australia. Table 3 (below) provides a summary of the application of these estimates for the whole of the Northern Territory as they related to Adults. It should be noted that the outcome is comparable to that achieved by applying the MHCCP (Table 2) and provides some confidence that the estimate is appropriate for a normal population, though highlights the lack of fractions that have been validated for remote or indigenous populations. Nevertheless, the estimates provide a starting point for estimating the likely resources required for the provision of an appropriate range and mix of services for the Northern Territory, and in turn the key considerations for development of the Strategy.

Table 3: Estimated prevalence of disorders x NT population over 15 years old

Disorder	ABS (1998)	NT Estimate (2)	ECA High and	NT Estimate ⁽²⁾
			Low (1)	
Schizophrenia			1.5% - 2.8%	2,317 – 4,325
Anxiety Disorders	9.7%	14,619	12.1% - 15.6%	18,690 – 24,096
Affective Disorders	5.8%	8,741	7.9% - 11.9%	12,202 – 18,381
Substance Use Disorder	7.7%	11,604	6.2% - 9.7%	9,576 – 14,619

Source: O'Kane and Tsey (1999)

- (1) Estimates drawn from O'Kane and Tsey's reporting of Reiger et al (1988)
- (2) Based on population over 15 (i.e.154,467)

Table 4 (below) applies the fractions developed by Zubrick (et al (1995)) in relation to Western Australian children to the Northern Territory population. Again the results are

comparable to those in Table 2 and emphasise the importance of developing child and adolescent mental health services.

Table 4 Estimated prevalence of disorders for 4 –16 year olds adjusted to NT population

Age Group	Fraction with Mental Health Problems	Estimated population	Fraction requiring specialist intervention	Estimated Population
4-11	16.0%	4,385	8.3%	2,275
12 –16	20.6%	3 269	10.7%	1 698

Source: O'Kane and Tsey (1999)

Implication for services development strategy: Although it appears that inpatient activity may be lower marginally than expected, for acute inpatient care, the number of bed days suggest that non acute care is also provided due to lack of alternatives. It is reasonable to assume that the limited availability of step down or sub acute residential services and difficulties accessing services from remote communities may contribute to this situation. As can be seen from the case study reports (Appendix 2) this assumption was confirmed during consultations. The development of expanded primary mental health services in a form appropriate to the environment may result in an increase in diagnosis and acute inpatient activity while development of alternative venues for sub and post acute care may reduce the current occupancy of the acute units.

Further, the provision of a comprehensive range of specialist mental health services for young people (i.e. 4 - 16 years) warrants significant weighting in the proposed service development strategy.

2.4.2 Prevalence versus service utilisation

Whilst an estimate of prevalence of conditions within the population is useful in gaining an understanding of the overall (normative) need, and prioritising the application of resources to meet the potential need within identified sub-populations, an alternative approach is to consider the expressed need, or propensity to utilise available services. To simply review existing activity data for the Northern Territory, though straightforward, is likely to provide a significant under-estimate, given the limited availability of services outside Darwin and Alice Springs.

Again the work of O'Kane and Tsey (1999) and development of the MH-CCP are useful. Table 5 (below) is derived from O'Kane and Tsey (1999) and the estimates developed in Section 2.3.1 (above) to provide estimates of the expected, and actual expressed need in the Northern Territory.

Table 5 Estimates of expressed need

		-	
Service Level	12 month prevalence	Expected population	2000-2001

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		for NT	Activity
Adults suffering from mental	$17.8\%^{(1)} - 25.0\%^{(2)}$	24,750 - 35,419	
illness in the community			
Consulting GPs	23%	32,585	
Identified by GP as having Mental	10%	14,167	
Illness			
Seen by Specialist MH Service	$2.4\%^{(2)} - 2.8^{(1)}\%$	3,400 – 3,966	3,704
Psychiatric inpatient care	0.6% ⁽²⁾ - 1% ⁽¹⁾	850 – 1,382	913

⁽¹⁾ Estimates drawn from O'Kane and Tsey (2) Estimates underlying the MHCCP

As can be seen from Table 5, the expected or normative need is relatively close to the actual activity, in terms of clients seen and separations. However, given the comparative scarcity of General Practitioners and alternative services it may be argued that those who do not meet criteria for treatment within the specialist mental health service system have few choices regarding the arena in which they seek intervention, if at all. Further, activity alone provides no insight into the quality, content or effectiveness of interventions provided.

Discussions with stakeholders highlighted the limited availability of services for those with high prevalence disorders and the actions by both the Top End Division of General Practice and the Central Australian Division of Primary Health Care to support development of services in this area.

Implication for services development strategy: It appears the activity within the specialist mental health services is consistent with the normative need for the population, if it is assumed that there are no differences to a more urbanised population and that similar fractions apply. However, the suggestion that additional resources are required to meet the needs of rural, remote and indigenous communities needs to be borne in mind. As was highlighted in the course of consultations with a wide range of stakeholders, there are general concerns regarding the capacity of existing services to provide high quality services to clients, particularly outside the two major centres.

In considering the service development strategy, it would be reasonable to assume that the actual need will be at the upper end of estimates and that the resources required to achieve that level of activity, and provide high quality care will be greater than for an urban population.

2.4.3 Shortcomings of available data

There has been ongoing argument that the environment and population of the Northern Territory are unique, making the direct application etiological fractions derived from other jurisdictions difficult to apply with any degree of confidence. The general health of the population suggests that Territorians are less healthy than the average Australian population (ABS 2002). They die younger, men have a greater risk of suicide, are more likely to die in motor vehicle accidents, a greater proportion of men drink heavily, are more likely to smoke and less likely to exercise.

While not a direct indicator of mental health, consideration of the social and economic characteristics of the population, particularly outside Darwin suggest that the stressors impacting on the population may be higher than for other populations. The estimates developed above provide a useful starting point for the planning and development of services. However, the identification of funds to support a range of epidemiological studies to improve

the understanding of mental health issues, particularly within the indigenous population would allow more accurate targeting of services and assessment of needs.

2.4.4 Conclusions

Accepted fractions for estimating the normative need whilst useful in providing a broad understanding of the overall need for mental health services in the Northern Territory are largely derived from research carried out in jurisdictions with highly urbanised populations and profiles representative of the broader population profile. No data developed specifically for the Northern Territory was identified. It is anticipated that the estimates referred to above might underestimate the normative need for mental health services.

The focus of resources on provision of services to those with a serious mental illness appears to generate activity in this area that is comparable to the expressed need estimated above. However, the unit of activity, separations or patients seen, does not provide insight into the scope or quality of services provided, a major concern raised by stakeholders.

The youthful population of the Northern Territory and expected prevalence of mental health problems in the 18-24 age groups suggests that child and adolescent mental health and early intervention should be priorities for service development.

2.5 MODELS OF RURAL AND REMOTE MENTAL HEALTH SERVICES

For the purposes of the current document, the terms rural and remote will be used in line with the definitions used in development of the Accessibility/Remoteness Index for Australia (ARIA) which classifies communities in terms of their access to goods, services and social interaction. Accordingly, with the exception of Darwin, all communities are classified as either remote (i.e. ARIA score between 5.8 and 9.08) or very remote (i.e. ARIA score greater than 9.08).

The decision by an individual to access mental health services will to some extent be predicated upon their conception of their own circumstances and their perception of the role and purpose of mental health services. Fuller (et al (2000)) found that residents of north and western South Australia perceived mental health services as primarily for those with serious disorders and tended to approach a range of other service providers and resources within the community to discuss their problems. Malcolm (2002) notes that the stigma associated with mental illness, particularly in rural areas, and that this in addition to the lack of motivation associated with depression requires a multifaceted approach to providing services.

Several models have been described in the literature. One type of model applied to providing mental health services involves linking mental health professionals into primary care teams within communities. These models have been shown to:

- increase access to mental health services (Marks et al (1981));
- increase referrals by primary health care providers (Van Hook et al (1998));
- increase understanding or roles (Van Hook et al (1998);
- improve knowledge and confidence of General Practitioners (Harmon et al (2000));and
- increase uptake of services by consumers (Malcolm (2002)).

An alternative approach is to move to integrate mental health into the skills base and practice of primary care providers. Central to this approach is the provision of training to a range of

primary care staff regarding the identification and response to mental health problems in those presenting for primary care services. This approach has a considerable history in developing countries, such as India and Iran (Murthy (1998)). These approaches have been shown to:

- improve the quality of care provided to those with a mental illness (Sokhela (1999));
- facilitate earlier recognition of symptoms and more appropriate referrals (Aoun et al (2002)); and
- enhance the capacity of specialist staff to provide effective support and intervention (Sheldon (2001)).

A comparison of the relative benefits of the two approaches was not identified in the literature. Nevertheless, it should be noted the approaches are not mutually exclusive. The approach applied in Milikapiti, Belyuen and Daly River in the mid 1990s (Maher et al (1996)) provides an example of a mixed integration and linkage model working effectively in the Northern Territory. It was reported that this model continues to some extent in the Darwin Rural Mental Health Team.

A third, approach identified involved the establishment of small teams (generally two mental health nurses) working to assertively follow up patients in small, isolated rural communities on a regular basis (Worley et al (1996)). This type of arrangement was shown to reduce the re-admission of patients and enhance the involvement and capacity of family and neighbours of the patient in supporting recovery.

In addition to the provision of diagnosis, treatment and ongoing care in rural communities is enhanced by both linkage and integration models, it is noted that this does not obviate the need for acute inpatient care for some patients as a component of their treatment. Issues identified as important for consideration in developing appropriate service models for rural and remote areas include:

- information for local residents on how to access services;
- a broad community development approach involving consumers;
- appropriate support education and training for healthcare workers;
- improved co-ordination between agencies; and
- access to reliable transport (O'Meara et al (2002)).

The literature emphasises the need for engagement of and linkage with primary healthcare providers if timely and appropriate access to mental health services is to be available to people living in rural and remote communities.

The availability of telemedicine has provided significant opportunities for psychiatry, and mental health more generally. This has particularly been the case for:

- provision of training and staff development (Rees et al (2001), Kennedy et al (2001), Mitchell et al (2000), Mitchell et al (2001));
- provision of child and adolescent consultations (Dossetor et al (1999), Gelber et al);
- provision of treatment in rural hospitals (Hawker et al (1998), D'Souza (2000)); and
- undertaking assessment (Yellowlees, 1997).

Nevertheless, the availability of the necessary communications infrastructure, such as ISDN access will preclude application of this technology in many locations.

3

Services and resource allocation

This section considers the current arrangement of services and allocation of resources, before considering current ratios for staffing where these are available. Further, the level of funding provided for mental health services in the Northern Territory will be discussed.

3.1 CURRENT SERVICE ARRANGEMENTS

It is not intended to provided a detailed description of current services here, as this has been provided in the case study summaries prepared as a result of consultations undertaken between 21 and 25 October

3.1.1 Program management structures

Mental Health Services in the Northern Territory fall within the responsibilities of the Department of Health and Community Services. The Social and Emotional Wellness Branch is responsible for overseeing the development of policy for mental health, alcohol and other drugs and mental health promotion. The role of the Branch is described as that of funder, providing the broad frameworks and priorities for the allocation of available resources.

The service development or purchasing role occurs within the Service Development Division, which is organisationally and physically separate from the Social and Emotional Wellness Branch. The Service Development Division works with funded organisations to prepare funding agreements and service plans for the services to be provided in return for the funds provided. Service agreements with government providers are also developed through the Service Development Division, and define the range and mix of services to be provided for funding received.

The provision of mental health services in both the Top End and Central Australia is the responsibility of the Top End and Central Australian Service networks respectively. A manager for mental health service is appointed in each service network and is responsible for the operation of mental health services. In the course of consultations, informants had difficulty identifying which level within the existing structure was responsible for making particular decisions.

3.1.2 Current service structure

Table 6 and Table 8 (below) provide a summary of the existing service system. In reviewing these tables, it is evident that the focus of the service system, particularly that in the government sector is the provision of services to adult patients in the acute phase of major mental illness. Advice provided during the course of consultations suggested that the focus of services had narrowed over recent years, apparently to allow services to continue operating within resource constraints.

The situation in the Top End is significantly different to that in Central Australia, accordingly each will be discussed separately.

3.2 TOP END SERVICES

This section provides an overview of the way in which services are structured in the Top End before providing a detailed outline of services identified in the course of the project.

3.2.1 Top End Service Structure

The mental health service provision system in the Top End consists of two distinct components, namely those services targeting the Darwin population, and satellite services to meet the needs of the rural area surrounding Darwin, Katherine and East Arnhem Land.

Public sector services in Darwin principally cater for those with a current, acute, major mental illness provided primarily from a bio-psychosocial conceptualisation of mental health. The inpatient service located on the grounds of the Royal Darwin Hospital provides services to the whole Top End. In recent years, the extent to which inpatient and community based services are integrated has increased. A key concern raised in discussions with stakeholders was the lack of appropriate inpatient facilities for young people requiring a period of inpatient care.

Community based services are provided primarily from the Tamarind Centre, a large physical structure readily identified by the community, and well signposted, as a specialist mental health service. All Darwin community mental health services are located within the centre, though clinics are provided through the "Health Precinct" at Palmerston, and very occasionally some services have been provided for young people at Anglicare's premises.

It was emphasised in a number of discussions with staff at Top End Mental Health Services (TEMHS) that they work within a recovery model. Whilst the model itself was not articulated, it was assumed that term related to a conception of managing mental illness consistent with that discussed by Anthony (1993) and Deegan (1996). This model would require that specialist mental health services take an active role in working with clients to develop a positive relationship, and in turn to utilise a range of effective support structures to facilitate their return to a degree of function that could be described as remission. It acknowledges that a significant proportion of clients find effective means for managing their conditions, independent of professional input.

The establishment of an Early Intervention Team has provided a focus for provision of services to young people. Again, it appeared from discussions with stakeholders that this service was predominantly centre based, though steps had been taken to increase the service's efforts to utilise alternative settings.

The rural area surrounding Darwin received psychiatry input from Darwin and utilised both mental health nurses and Aboriginal Mental Health Workers to provide services to clients.

The teams located in Katherine and Nhulunbuy work closely with generalist health services located in communities within the regions they serve. Psychiatry input is provided through Darwin, though it was noted that there are limited opportunities for psychiatrists to have regular input and communications infrastructure was identified as a barrier to applying telemedicine extensively for assessment and support of local staff.

Healthcare Management Advisors

The establishment of the co-ordinated care trial on the Tiwi Islands had seen the relationship between TEMHS and clients on Bathurst and Melville Islands diminish considerably from the levels reported in the mid 1990s. On the other hand, arrangements associated with the Katherine co-ordinated care trial were not identified as resulting in a significant change for the provision of mental health services.

Non-government services in the Top End complement, rather than duplicate services provided by government. In particular, non-government agencies in Darwin provide those services that extend beyond the assessment and treatment of clients within a bio-medical model. Further, the development of responses to Aboriginal Mental Health, high prevalence disorders, child and adolescent mental health and prevention/promotion has occurred in the non-government sector.

Table 6: Mental Health Services in the Top End

Service	Urban /Rural	Support/ Maintenance	Prevention /Promotion.	Assessment	Early Intervention	Child and Adolescent	High Prevalence	Adult	Psycho- geriatric	Population served. (1)
Management										
Darwin Urban Adult	Urban									67,750
Darwin Early Intervention Team	Urban									41,137
Darwin On Call Team	Urban									108,900
Education and Training Unit	Urban									
Forensic Service	Urban									
Inpatient Service										
East Arnhem	Remote									14,034
Katherine Team	Remote									18,858
Katherine MHRI										
Life Promotion	Urban									
Darwin Rural	Rural									12,667
Rural MHRI										
Psychiatrists	Urban									
	/some rural									
NGOs										
Anglicare TE	Urban									41,137
Grow NT										
Naiyu Nambiyu	Remote									
NT ARAFMI	Urban									
TEAM Health	Urban									
Tiwi Health Board	Remote									
TEDGP	Urban/Re									
	mote									
Danila Dilba										

(1) Estimated population served

3.2.2 Description of Services operated by the Top End Service Network

The Top End Mental Health Service encompasses all mental health services provided by the Department of Health and Community Services in the area known as the Top End, effectively all areas north of Katherine. There are conceptually four distinct components to the service, namely:

- Darwin Mental Health Services;
- Inpatient Services (Cowdy Ward);
- Darwin Rural Mental Health Services; and
- Katherine and Gove (Nhulunbuy) Remote Mental Health Services.

A description of each distinct service is provided below and is drawn from discussions held during the case study, advice provided subsequent to the case study and review of available documentation.

Darwin urban adult mental health team

The Darwin urban adult mental health team has a reported establishment of one psychiatrist, one psychiatry registrar, four professional officers (two psychologists and two social workers) and six mental health nurses. One of the professional officer positions is responsible for management of the team and one of the nursing positions is designated as a Clinical Nurse Consultant (CNC). Psychiatrist time is also allocated to the team.

The service provides assessment and case management for people over the age of twenty-five, resident in the Darwin region, a population of 67,750 (those over 25 in the Darwin urban area), who present with mental health problems and disorders. In addition to assessment and case management services, the team is also required to participate in prevention and promotion activities. The team is reported to manage an average caseload of 250 clients (Nagel (2002)). This figure was supported by caseload data drawn from the CCIS system.

It was reported that the formal admission criteria for the service were:

- symptomatology that required regular monitoring and review of treatment;
- risk of harm to self or others as a result of mental illness; and
- impaired ability to function in the community as a result of their mental illness.

However, discussions with informants in the course of the case study indicated that the service primarily deals with adult clients with an acute psychiatric illness. It was suggested that due to average caseloads of 30 clients, the admission criteria to the service are relatively tight allowing only those assessed as most in need of ongoing case management are admitted to the service. Where clients are admitted to the service they receive a comprehensive psychiatric assessment and individualised case management. It was emphasised that case management was conducted within a rehabilitation framework. Whilst not specifically defined in the course of discussions it appeared that the focus of case management was to support clients toward functioning within the community with decreasing involvement from the adult mental health team.

Clients are generally referred to the service through the On-Call Team (described below), or from inpatient services. The TEMHS Adult Team makes referrals to a range of services. These include to TEAM Health, particularly where supported accommodation is required, to GPs and Private Psychiatrists where appropriate and within the financial means of clients.

The service reported that its links with TEAM Health are relatively strong. It was also indicated that difficulties are often encountered in finding suitable arrangements for the ongoing management of clients in the community due to the cost of general practitioner and private psychiatry services for those with limited income.

Darwin early intervention team

The Darwin Early Intervention Team has an establishment of five staff, including three nursing positions, one family therapist and one psychologist. Documentation relating to staff establishment indicated that in addition, a psychiatry registrar provides one session per week, though subsequent advice suggested that this was in fact between six and ten sessions per week and that a further two sessions were provided by a consultant psychiatrist. The caseload reported by CCIS was 134 (approximate average caseload of 27).

The service aims to provide assessment and case management to individuals under the age of 25 experiencing mental health problems or disorders in the Top End region within a recovery framework. The target population is 41,137. In a recent internal review of services, (Neill (2000)) it was argued establishment of the Early Intervention Team had improved the capacity of the service to work effectively with other agencies, such as Anglicare, in the development of strategies to meet the needs of young people. It was also suggested that the establishment of the team had increased the focus on working with families, rather than simply the individual experiencing a first episode of mental illness. The service provides detailed psychiatric assessment and ongoing case management for clients with a mental illness. In addition, education is provided to both consumers and their families regarding mental illness.

Discussions in the course of the case study indicated that age and presence of a serious mental illness were primary criteria for admission to the service. Clients and their families generally become aware of the service following admission of the client to the inpatient unit, through specific youth services, such as Anglicare or through word of mouth from other young consumers.

Subsequent to the case study, advice was received indicating that the EIT had established a service to work with the five to fifteen year age group, specifically focussed on management of challenging behaviours, along with anxiety, depression, eating disorders, ADHD/ADD and behavioural problems associated with loss and grief.

The extent to which clients are referred to other services was not covered in detail during meetings associated with the case study. Nevertheless, it was indicated that efforts are made to link clients with a GP but that limited availability of bulk billing presented some difficulties in this area.

Darwin on call team

The Darwin on-call team has an establishment of four nursing positions and receives coverage equivalent to a full time psychiatry position provided by three psychiatry registrars (subsequent advice suggests that there is one full time registrar and a consultant psychiatrist one to two sessions per week). The team is the intended first point of contact with mental health services for those referred for, or seeking a mental health service. The service operates Monday to Friday during normal business hours with after hours referrals being dealt with by one of two on-call workers (including a registrar) drawn from TEMHS staff.

This model was intended to facilitate a consistent intake process and establish a knowledge base of referral options and links with providers such as GPs (Neill (2000)). Further, it was suggested that separation of the on-call service had allowed a more considered approach to case allocation and expanded the capacity of staff to manage their caseloads. The team receives an average of 33 referrals each week, though it was suggested that the CCIS information system represents an underestimate with referrals thought to be approximately 45 per week.

Referrals are received from a number of sources, including general practitioners, mental health services in other states with clients moving to Darwin, members of the general public, a range of agencies in contact with potential clients and direct contact from clients.

It was reported in the course of the case study meetings that clients are often referred where the primary diagnosis relates specifically to alcohol or other drug use. This was thought to reflect the lack of inpatient detoxification services and an alcohol and other drugs extended hours service.

Approximately 30% of cases referred to the On-Call team are referred to other agencies with attempts made to link clients with a general practitioner. It was reported that these links had improved considerably and that the extended care items in the Medical Benefits Schedule had provided a means for GPs to be remunerated for working with the team around individual clients. It was subsequently reported that less than 20% of clients from the On Call team are subsequently referred to another mental health team.

Training and education team

The education and training team has an establishment of two professional officers and one technical officer. The team is intended to provide focussed education and training opportunities for people with mental health disabilities.

The team operates a range of groups at the inpatient facility and at Tamarind Centre. These are targeted at specific diagnostic groups, within the client population covering areas such as those with chronic anxiety. Alternatively, it was reported that groups are organised around individual areas of disability, and include development of individualised programs. In addition, the unit was reported to take a role in providing training to other government services, such as police, and providing support and supervision to workers employed by non-government organisation.

Forensic mental health service

The forensic mental health service has an establishment of four, including three professional officer positions (two psychologists and one social worker) and one nursing position. In addition, a consultant psychiatrist is allocated to the team for five sessions per week (.5 FTE). The service aims to provide assessment, care and treatment to individuals with a mental disorder in the criminal justice system. A key focus of activity is assessment of offenders for pre-sentence reports and provision of care at Darwin Correctional Centre.

The recorded case load for the forensic team reportedly fluctuates between 80 and 90 cases. It is unclear at this point if this is a result of inaccurate data or the limited services required by those registered with the service. Advice provided by the Forensic Team indicated that approximately half of their client load related to clients in the community and that referral of clients, though predominantly through the criminal justice system, was increasingly through the community mental health teams and the inpatient unit. Where clients move to areas remote from Darwin they are referred to the nearest mental health team. Where they remain in Darwin they are retained by the Forensic Team, until their bond or parole order has expired, or they fail to engage in serious antisocial behaviour for a period of six months and may be transferred to the community team. It was nevertheless noted that there are few such transfers.

Inpatient services (Cowdy)

The inpatient service operated through the Cowdy Unit (including sections of the facility such as the Joan Ridley Unit) on the grounds of Royal Darwin Hospital has an establishment of 40.2 Full Time Equivalent (FTE) positions, of which two positions are primarily management positions. There are three psychiatry registrars (aligned with each of the Early Intervention team, Adult Team and Rural Team), a vacant resident medical officer position and approximately .9 FTE of a consultant psychiatrist allocated to inpatient services. It aims to provide specialist, acute, inpatient care to individuals affected by mental disorders across the Top End Service Network.

The unit consists of 12 acute beds, six aftercare beds and eight forensic beds. It was noted the forensic beds are generally only used for four months each year. A medical review undertaken in 2002 (Nagel (2002)) noted that demand for inpatient services had seen all beds occupied with up to 28 patients. Review of activity data for 2000-01 and 2001-02 is provided below in Table 7. Separations declined marginally from 682 in 2000-01 to 668 in 2001-02 while bed days increased from 6,061 to 6,886.

Statistics 2000-01 2001-02 **JRU** JRU Cowdy Total Cowdy Total Separations 33 649 682 27 641 668 945 Bed Davs 541 5.520 6.061 5.941 6.886 16.3 8.5 8.9 35.0 9.3 **ALOS** 10.3

Table 7: Top End inpatient activity 2000-2002

Data supplied by Social and Emotional Wellness Branch

The average cost per bed day for 2000-01 was reported to be \$915, while the national average was \$455 (Purcell 2002). While comparable data is not yet available for 2001-02, direct expenditure for the unit for 2001-02 was \$3.06 million, excluding psychiatrists, unofficial advice from the Department suggests that the total bed day cost has increased.

Patients are referred to the service through:

- the Emergency Department of Royal Darwin Hospital;
- self-referral by clients and their families;
- evacuation from remote communities;
- apprehension by police;
- referral from TEMHS teams; and
- referral from the criminal justice system.

The unit is staffed on the basis of one nursing position to every three patients on day shifts and one nursing position to four patients on afternoon and evening shifts. Staff do not work overtime, rather agency staff are used (it was reported that these are often the same staff). If all patients were in the acute phase of their illness and required stabilisation this staffing arrangement is well placed to provide high quality of care. However, it was suggested that patients remain in the unit for extended periods (up to several months). Although a detailed analysis of the length of stay of patients was not undertaken, it would appear that there is considerable scope for providing care after the first 14 days in more appropriate environments, thereby enhancing quality of service to clients and reducing the costs incurred by the unit.

It was indicated in the course of meetings for the case study that the inpatient and community based services are well integrated and that upon discharge, clients are referred back to their existing case manager, or where a case manager is not appointed, a referral is made to the most appropriate community team.

The three Aboriginal Mental Health Workers employed by the TEMHS to service Darwin are located within the inpatient unit.

Consultation liaison service

The Consultation Liaison Service provides psychiatry advice, input and consultation, to units within the Royal Darwin Hospital during normal hours, including advice regarding mental health presentations in the Emergency Department. Where appropriate, assessment, management advice and initiation of treatment are provided.

The Consultation Liaison Service refers approximately 50% of clients to the On Call Team, 10% to the inpatient mental health services, 30% to general practitioners and the remainder to non-government organisations, such as Amity House.

East Arnhem mental health service

The East Arnhem mental health service has a stated establishment of three mental health nurse positions. The aim of the service is to provide assessment, case management and treatment services to a reported population of 14,034 people. The service maintains a caseload of approximately 120 clients

The service seeks to meet the needs of all mental health client groups within East Arnhem Land, with referrals made predominantly through clinics in communities. Where clients are evacuated for inpatient care in Darwin it was reported that the team in East Arnhem are consulted regarding discharge planning.

Katherine district mental health service

The Katherine district mental health service has an establishment of three mental health nursing positions. In addition, funding through the National Mental Health Reform Incentive funding program has been provided for two additional positions, one a nursing position and the other an Aboriginal mental health worker. This funding will cease from 30 June 2003.

The service is intended to provide assessment, case management and treatment services as well as to develop prevention, promotion and early intervention strategies for a population of 18,858. Review of data from CCIS suggested that the caseload is relatively low at approximately 75, however the considerable distances between communities has a significant impact on the capacity to engage with a greater number of clients.

Life Promotion Team

The life promotion team is designed to provide resources to support the management and treatment of suicidal behaviour and support the application of a community development model to enhance the community's capacity to respond to suicidal behaviour. The team consists of one professional officer who co-ordinates the service and 1.6 FTE life promotion officer positions. It was reported that close linkages are developing with a range of organisations, particularly Anglicare and TEAM Health.

Darwin Rural Mental health Service

The Darwin rural mental health team had a reported establishment of two nursing positions and two Aboriginal mental health workers. The team provides services to a reported population of 12,667 people living in rural communities around Darwin. The team has a caseload of approximately 75-85 clients.

The service targets patients living in the rural areas surrounding Darwin, including ore remote locations such as Wadeye and Managrida who suffer from a mental illness, though it was emphasised that in many cases lack of access to a psychiatrist precluded formally establishing a principal diagnosis. The criteria for admission are comparable to those of the Early Intervention team and the Darwin Adult Team reflecting a focus on acute mental illness. However, it was reported that in order to take account of the significantly different cultural environment, in which services are provided, a broader conception of mental health (described in terms of social and emotional well being) is applied.

The service visits communities every four to six weeks and provides support to primary health staff in the communities to manage. In submissions to the review, it was emphasised that the limited capacity of the service to effectively respond to the needs of clients in communities

where social disadvantage and dysfunction. Further, it was suggested that the limited capacity of the service often saw patients admitted that might otherwise have been managed within the community.

Conclusion

The range of mental health services available in the Northern Territory has expanded significantly in the past 15 years. However, it is evident that the system of public services is largely focused on the provision of services to adults with a major mental illness. Further, within Darwin, the location of all community based services within a single facility and establishment of an array of quite defined teams may contribute to limiting access to services. It appeared that considerable benefits could accrue in enhancing access, and increasing the engagement with and support of primary health care staff if mental health teams were located in community health centres.

The demarcation of services at 25 years of age fails to acknowledge the significance of 18 years of age, in terms of diagnostic criteria and likely family circumstances along with the need to develop competence in adult clinicians in dealing with those in their early twenties. Given the dearth of services for children and adolescents, it is difficult to support stretching the available resource for this group to include those over 18 years of age.

Finally the unexplained high cost of inpatient care requires investigation and resolution with a view to the reallocation of resources.

3.2.3 Description of Top End non-government services

The Department of Health and Community Services and the Commonwealth provide financial support to a number of non-government organisations providing mental health related services to the area covered by the Top End Service Network. These services are outlined below.

Anglicare Top End

One off funding of \$154,000 has been provided to Anglicare for the period 1 July 2001 to 30 June 2003. The funds for this grant were derived from the National Mental Health Reform Incentive funding. The focus of the funded project, Bridging the Gap, is to enhance the access of young people to the full range of mental health services from prevention through to treatment services, including the development of a needs assessment and identification of risk assessment tools.

The ASSIST program, also supported by Commonwealth funding, aims to support the development of infrastructure to support young people's access to services and enhance the skills within the sector to identify and respond to those young people experiencing mental health problems or contemplating suicide.

Clients of the service reported hearing about Anglicare's services through word of mouth and other service providers, such as TEMHS and schools. Anglicare offers a range of support services to the broader youth community, applying a variety of criteria for entry to a range of programs it operates. These services inleude:

- Anglicare Youth Housing Program;
- Health Connections for youth; and
- Connect Youth Homelessness Early Intervention Programs.

Where young people in contact with Anglicare appear to require mental health services, efforts are made to link these people with the early intervention team, though it was emphasised that this was an area that could be significantly improved.

Grow NT

Recurrent funding of \$53,970 per annum is provided to support the activities of GROW. These activities are consistent with the operation of GROW nationally and involve the provision of support to consumers. The "Program for Growth to Maturity" is the framework for this service. Discussions indicated that those with a history of mental illness receive information about Grow from service providers and through word of mouth.

Nauiyu Nambiyu Community Government Council (Daly River)

Funding of \$61,600 (inclusive of GST) was provided to the Nauiyu Nambiyu Council to employ an Aboriginal family and school support worker. The project is designed to support participation by the community and service providers in strategies to reduce behavioural problems in the school. The funding is not recurrent and expires on 30 June 2003.

NT ARAFMI

The Association of Relatives and Friends of the Mentally Ill (ARAFMI) is located in Darwin, although a group meets in Alice Springs. Recurrent funding of \$65,081.50 (inclusive of GST) is provided. Additional, recurrent funding has been provided to offset the cost of rent for premises occupied by ARAFMI in Darwin. ARAFMI provides social support, carer education and advocacy for carers of those with a mental illness. Limited financial support is provided to the group in Alice Springs.

A day centre, "Pete's Place" is operated three days per week though the service is not funded and relies on in-kind support from a range of agencies, including input from the Training and Education Team two mornings per week. Participation is largely determined by those attending the service, rather than on the basis of fixed criteria. Nevertheless, the program is primarily used by those with a mental illness.

Discussions during the course of the case study indicated that carers and family members gain information about the operation of ARAFMI through service providers and through word of mouth.

Top End Association for Mental Health Incorporated (T.E.A.M Health)

TEAM Health receives a number of grants from the Department, as well as a range of other programs and provides a range of services. It is the largest non-government service providers specifically focussed on those with a mental illness. Services include:

- provision of short term supported, transitional accommodation for people with a mental illness (\$68,882 inclusive of GST), located in a facility known as "the Manse", adjacent to the Tamarind Centre. Referrals are generally made through the Tamarind Centre and as a result of contact with clients in the provision of other services;
- provision of long term supported accommodation for people with mental health problems (\$65,944). It was noted in the course of discussions that the population using this service is relatively static though demand for this type of accommodation with support services continues to grow;
- practical support to assist consumers move towards independent living (\$92,133 p.a. inclusive of GST);
- co-ordination and support of the full range of services provided by TEAM Health (\$75, 462 p.a. inclusive of GST);
- life skills training for consumers of mental health services affected by functional deficits (\$126,500 inclusive of GST). This service is provided in collaboration with the Training and Education Team. In order to access this service, clients must be clients of the Tamarind Centre (TEMHS);
- collaborative project with Danila Dilba to reduce the stigma of mental illness in indigenous communities (\$55,000 including GST). The project is being undertaken within an action research framework and focuses on educating identified individuals in indigenous communities to present information to young people in the identified communities; and
- operation of a mental health support workers for Supported Accommodation Assistance Program services (\$95,179 p.a. inclusive of GST). The service provides support to those living in supported accommodation service to enhance linkages with TEMHS and expand the access of this group to appropriate services.

In the course of discussions, it was reported that although TEAM Health operated the Manse and Kurrajong House to provide accommodation for those with a mental illness, the turnover of residents was lower than the demand for places and as a result there was significant unmet need.

TEAM Health maintains close links with TEMHS and other service providers and is a focus for referrals from a range of agencies. Given this organisations central position within the service system, it also actively refers clients to the most appropriate available services.

Tiwi Health Board

The development of a co-ordinated care trial involving the Tiwi Islands saw establishment of the Tiwi Health Board which has responsibility for purchasing and co-ordinating services to the Tiwi Islands. Funding of \$45,000 per annum was transferred from the Department to the Tiwi Health Board as a component of the funding pool created for the co-ordinated care trial. A senior mental health nurse is employed by the Board to oversee the operation of services.

Two Aboriginal Mental Health Worker positions have recently been established on Tiwi in collaboration with the Top End Division of General Practice. Clients are referred to the service through the clinics on Bathurst and Melville Islands, or as a result of concerns raised with workers by members of the communities. Where required, clients are evacuated to the Cowdy Unit in Darwin.

Top End Division of General Practice

The Top End Division of General Practice has applied funding provided through the More Allied Health Services (MAHS) program to the employment of Aboriginal Mental Health Workers in six communities. A collaborative arrangement has developed with Batchelor College, the Northern Territory University, the Department and Beyond Blue to expand this program further. Beyond Blue required establishment of an MOU between the players before agreeing to contribute to the establishment of additional positions. The MOU provides for close collaboration between the players and evaluation of the program.

Aboriginal Mental Health Workers employed under the program work closely with General Practitioners in the communities where they are located and where available staff from the TEMHS.

Katherine West Health Board

The Katherine West Health Board purchases mental health services from the Katherine Mental Health Team.

Danila Dilba regional emotional and social well being centre

Danila Dilba, located in Darwin operates a regional emotional and social well being centre funded under the Emotional and Social Well Being Action Plan. The service provides generalist counselling and support to Aboriginal people and reported effective links with mainstream mental health services. A particularly strong link has developed with TEAM Health through the planning of the project referred to above.

Conclusion

The non-government sector was characterised by uncertainty of funding and a degree of frustration in establishing effective links with government services around issues such as post acute care, and the care continuum generally. A key consideration in developing the strategy will be provision of a structure to support collaborative planning across the service system.

3.3 CENTRAL AUSTRALIAN SERVICE

This section provides an overview of the way in which services are structured in Central Australia before providing a detailed outline of services identified in the course of the project.

3.3.1 Central Australian Service Structure

The size and scope of services in Central Australia is limited in comparison to the Top End, given that the population is significantly smaller. Table 8 provides a summary of services in central Australia. Again, the focus of government mental health services at the time of this project was largely management of those in an acute phase of a major mental illness. In Alice Springs it was reported that difficulties recruiting to established positions, with 40% vacancies in the community team and significant shortages for inpatient positions, had precluded staff from taking a role beyond the management of clients in crisis.

Those teams providing services outside Alice Springs, that is the Remote team and Barkly team seek to provide support to generalist staff working in communities where clients with a major mental illness have been identified. The extent to which this support can be provided is dependent on the availability of generalist staff who have an interest and experience in mental health. Staff turnover in remote clinics poses a challenge to the provision of mental healthcare in these communities. As will be discussed below, the conception of mental health and mental illness in indigenous communities presents a challenge to the traditional conceptions of mental health, which underpins the development of the services. Psychiatry input to these services has been limited in recent years, following the reported deletion of a registrar position.

Congress, through the operation of its social and emotional well-being service provides an alternative framework for considering mental health, particularly in Aboriginal communities. A view was expressed by Aboriginal organisations that non-government services may be better placed to provide a primary mental health care role in these communities. It was further suggested that public sector services might be more effectively used to focus on the provision of assessment, pharmacotherapy and management of acute phases of mental illness that cannot be managed in the community.

Maintenance and rehabilitation services are largely centred in the non-government sector, with Anglicare providing maintenance type services (supported accommodation and outreach) and the Mental Health Association providing suicide prevention and targeted rehabilitation services.

A single position is available to provide child and adolescent services to the region, and again the availability of appropriate facilities for inpatient care of young people was identified as a key shortcoming in existing services.

Table 8: Mental Health Services in Central Australia

Service	Urban /Rural	Support/ Maintenance	Prevention/ Promot.ion	Assesment	Early Intervention.	Child and Adolescent	High Prevelance.	Adult	Psycho- geriatric	Population served.(1)
Central Australian Mental Health	Urban									28,580
Forensic Service	Urban									
Child and Adolescent	Urban									9,078
Inpatient Service	Rural and									
	Remote									
Remote Service	Remote									11,692
Barkly Mental Health	Remote									7,261
CADPHC	Urban									
Anglicare (St Mary's	Urban									
Ltyentye Apurte	Remote									
Mental Health Association	Urban/Re									
	mote									
Yuendumu	Remote									

(1) Estimated population served

3.3.2 Services operated by the Central Australian Service Network

The Central Australian Mental Health Service provides mental health services to 23.5% of the Northern Territory population, of which approximately 40% reside outside Alice Springs. In addition, it was reported that a significant population of tourist, seasonal workers or those travelling as a lifestyle pass through Alice Springs. Specific services include:

- community mental health service;
- forensic mental health service:
- a child and adolescent mental health service
- acute inpatient mental health services;
- remote mental health service which provides and supports community based services in remote communities; and
- the Barkly mental health service.

Alice Springs Community Mental Health Service

The Central Australian Community Mental Health Service has its primary focus on the provision of services to the population of Alice Springs. The service commenced operation in the late 1980's and consolidated with appointment of a resident psychiatrist in 1993. The service, and particularly inpatient services, initially had significant involvement with those with physical and intellectual disabilities, as well as those with a mental illness. It was noted that it was not until the mid 1990's that the service focussed specifically on mental health and that the recent provision of Commonwealth funding had seen involvement with the disabled cease in recent years.

The service provides assessment, case management and carer support. The establishment for the team providing this service consist of a team leader, nine clinical staff, which at the time of writing included a social worker, a psychologist (.7FTE, .2FTE is allocated to drug and alcohol services and .1 FTE to Tennant Creek though a full caseload is carried in Alice Springs), four mental health nurses and an Aboriginal Mental Health Worker. Four positions were vacant though the factors contributing to this were addressed subsequent to the case study. Funding for the Aboriginal Mental health Worker position is non-recurrent and will cease in June 2003. It was reported that the visits to Tennant Creek provided an opportunity to access a range of psychological tests that were not available in Alice Springs.

It was emphasised by consumers, carers and staff that the ongoing shortage of staff had required the service to reduce the scope of the service provided, nevertheless extend hours (8:00 am to 9:30 pm) and on-call services continued to operate after hours. The current service is focused on those adult clients in crisis or those in urgent need of intervention. Where clients are assessed as requiring assistance but do not meet the criteria for services at the current time, efforts are made to link these clients with other services within the community. Accordingly, it was reported clients of the service are primarily those with a major mental illness in a time of crisis with a limited capacity to provide effective ongoing case management.

The team operates a caseload of approximately 190 clients, of whom it was reported approximately 90 are actively case managed, though it was argued subsequently that available resources limit the level of case management.

Referrals to the service come through the hospital's emergency department, general practitioners, non-government organisations in the community, the police and clients. It was

noted or implied in a number of discussions that there were still some expectations in the community that mental health services would support those with intellectual disabilities and acquired brain injury.

Where clients are under the care of Alice Springs Mental Health Service, referrals are made to resources within the community that may be positioned to address specific needs. These services include:

- the Mental Health Association for assistance in gaining meaningful employment, developing living skills and access to community based support;
- Centrelink for assistance in finding employment and accessing training;
- (until recently) Anglicare (St Mary's) for supported accommodation and a living skills program;
- local GPs for ongoing medical care and management.

Forensic Mental Health Team

The Forensic Mental Health Team provides assessment, treatment and case management to individuals with a mental disorder within the criminal justice system, including the provision of assessments for pre-sentence reports. The service has an establishment of a psychiatrist, one mental health nurse and an Aboriginal Mental Health Worker (AMHW) position. The Aboriginal Mental Health worker position has been vacant for a three to four years. CCIS data indicates a caseload of 223 clients. Similar to the Top End forensic team, it appears that very high caseloads are reported (though it was subsequently suggested that only 0 cases would be active at any time).

A major barrier to the recruitment of AMHWs to the Forensic Service has been the requirement that they not have a criminal record. The extent of efforts to negotiate arrangements with the Department of Correctional Services was not reported during the discussions. Generally, relatives of prisoners who require support due to mental illness provide support and receive input from the Forensic Service.

Clients of the service are generally referred to the service prior to sentencing or shortly after incarceration for assessment. There is limited follow-up of clients upon release.

In addition to the high Aboriginal population, it was also reported there is a significant number of Indonesian prisoners held in Alice Springs Gaol as a result of offences related to assisting illegal immigrants.

Child and Adolescent Mental Health Service

There is a single professional officer (psychologist) position allocated to the operation of a child and adolescent service in the Central Australian region. A relatively low caseload (approximately 24) is allocated to this service. The service only covers children and adolescents living in Alice Springs, as there is limited capacity for a single officer to provide a consistent service over a wider area and maintain the service in Alice Springs. The service maintains close links with schools in Alice Springs and provides a consultant service to the mental health staff working in the Region. The service also offers group work and is developing programs such as Suicide Talk and Suicide Awareness, the Wrap Around (a collaborative inter-agency consultation).

There are no school counsellors in Alice Springs to screen cases or receive referrals from the child and Adolescent Psychologist.

Acute inpatient mental health service

The Acute component of the Central Australian Mental Health Service operates an 8 bed acute unit. The establishment for the unit is one Clinical Nurse Consultant, a Senior Specialist Psychiatrist, 13 nursing positions, one administrative officer and a "physical officer". A new facility was commissioned approximately 18 months prior to the current project. At the time of the case study, it was reported that ongoing recruitment problems had required that staffing be established at one registered mental health nurse per shift with a range of other staff including Enrolled Nurses assisting to care for patients.

Admission to the unit is generally through the Emergency Department following review by the psychiatrist or the on call team in consultation with the Psychiatrists. Current staffing limits the capacity to provide a therapeutic program to patients and there was no availability to occupational therapy. A barbecue is held on Fridays to provide a limited diversion for patients.

The design of the unit does not allow locking of the front door and was reported as a major concern in managing involuntary patients.

When patients are discharged, if they are resident in Alice Springs, they are referred to the Community Mental Health Team, while those from more remote communities are referred to the team covering their area of residence. With the exception of Tennant Creek where there is a resident service, these patients receive follow-up when their community is next visited.

Activity in 2000-01 saw 231 separations and 1,758 bed days, representing an average occupancy of 4.8 beds. The average length of stay was 7.6 days, and average bed day cost was estimated at \$781.84. The funding allocation for inpatient services increased from \$1.25 million in 2001-02 to \$1.63 million, an increase of 30%.

Remote mental health service

The remote mental health service has an establishment of three, though one nursing position is funded through National Mental Health Reform Incentive funding and will cease to be funded from 30 June 2003. In addition, a senior psychiatry registrar training post was located within the team though this position has been deleted. The service endeavours to provide specialist mental health services to remote communities across the Central Australian region, encompassing a population of almost 17,000 people (40% of the population in the Central Australian Region and including some communities in northern South Australia). Key roles for the service are provision of advice and support to isolated Aboriginal Mental Health Workers in Yuendumu and Santa Theresa and development of partnerships with communities and generalist health staff in those communities around prevention, promotion and management of those with a mental health problem.

Unlike other remote services in the Northern Territory, a relatively high caseload (266 is reported). However discussion with staff indicated that this reflected the difficulties involved in following clients and maintaining contact in some of the smaller communities and outstations, with input for individual clients remaining relatively low.

The basis for referral can vary significantly depending on the needs within communities at a given time. The Team seeks to maintain a flexible approach to its role to maintain a positive profile in communities. The Team works through the health clinics in communities they visit and actively seek to educate generalist health staff about the management of mental health clients and develop their understanding of the role of AMHWs. It was reported that turnover in generalist health staff ensures this process of education is ongoing.

The psychiatrist attached to the service provides one and one half sessions per week, which precludes regular visits to communities. In the past year, it was reported visits were restricted to one visit to each of Yuendumu, Mutujulu and the Yulara, and a small number of one day visits to communities in the Pitinjara lands of South Australia. In addition, a clinic is operated through Congress in Alice Springs for one session every three weeks.

There are limited options for referral of patients from the Rural and Remote Team beyond the clinics in communities. Referrals to the remote team come mainly through the local clinics in each community. Families and carers want both western treatments as well as traditional healing. The latter can take the form of Ngangkaris (or traditional healers), bush medicine, support from elders with authoritative status, getting back to country, ceremonial 'business', or extended family support. It was argued that traditional healing practices need to be acknowledged and fostered, which may require practical support or payment of Ngangkari services, or support via promotional or preventive activities.

Barkly Mental Health Service

The Barkly region of Central Australia encompasses a population of 7,261 located in small communities. The service has an establishment of two nursing positions with recurrent funding. In addition, non-recurrent funding supports an Education and Family Support position, which is currently vacant. Additionally, of funding currently allocated to the Barkly service, 60% is not recurrent and will cease to be available from June 2003. The service is only available during normal business hours, which was reported to place significant strain on hospital staff once or twice per month when an admission occurs after hours and advice could only be sought from Alice Springs.

The service focuses primarily on managing clients with a major mental illness, visiting Elliot every two weeks and Alycurung every four weeks. Other communities are visited when required. Medical input is available to the team three days per month though psychiatry input has declined with the lack of a registrar in Alice Springs.

Where patients in the Barkly require evacuation due to mental illness, it was reported that they are triaged to the bottom of the list by the Royal Flying Doctor Service and the facilities in Tennant Creek were considered inappropriate for housing mental health patients for extended periods. Subsequently, it was confirmed that where a patient is brought to the Tennant Creek hospital and it is thought appropriate that an Order be made, contact is first made with the Psychiatrist in Alice Springs. Should an Order be required, the Departments remote section is contacted and the District Medical Officer on duty is then responsible for tasking the RFDS. The patient is sedated until transport is available. It suggested that as the patient is under care in an acute hospital, the tasking of the RFDS by the responsible DMO might see a wait of up to 24 hours, though where the patients is in a smaller community these cases are given priority. Discussions with the RFDS indicated that scheduled patients and petrol sniffers are managed identically for transport.

Referrals of clients are made to local health clinics and the Barkly Team provides consultation and follow up. Interventions are discussed with local generalist staff and recorded in local medical records.

Conclusion

Informants in Central Australian consultations presented a consistent view that public sector mental health services were in crisis. The absence of a clear focus on the child and adolescent population requires a response within the strategy.

The importance of non-recurrent funding in supporting core activities, employment conditions for psychiatrists that are less favourable than those available in Darwin, limited allocation of resources to supporting remote communities and apparent lack of collaboration between components of the health system identify Central Australia as a priority for support and development.

3.3.3 Central Australian Non-government Services

A number of non-government organisation receive funding to provide services intended to reduce the impact of mental illness on the community, provide support to those with a mental illness and to provide treatment. The results of discussions in the course of case studies and information available in documents identified in the course of the project are summarised below.

Anglicare (St Mary's Family Services)

Anglicare is funded to provide two services in Alice Springs. The first service related to the provision of outreach support to enhance the capacity of individuals with a mental illness to live independently within the community. The second was for the provision of supported accommodation including respite care for people with a mental illness. It was reported changes had recently occurred to both programs, with the focus of the accommodation service shifting and perceived to have reduced the availability of such accommodation, while the outreach support service was reported to have undergone a restructure and was now no longer targeting those with a mental illness.

Subsequent discussions with St Mary's indicated that the outreach service experienced fluctuations in demand and saw significant periods of under utilisation. Accordingly, the service now incorporates residents of the lodge, who were described as a relatively transient population with a high prevalence of social and mental health problems. While referrals from the mental health service continue to be readily accepted, it was considered that the current arrangements more fully utilised available resources and provided intervention for clients who may otherwise experience a crisis and require admission to the High Dependency Unit.

The respite service was reported to have relatively low occupancy and a limited resource allocation. It was indicated that in negotiating the current service plan with the Department of Health and Community Services that the respite service was deleted. It was nevertheless emphasised that respite accommodation was still available if the client had a carer available to provide support.

Central Australian Aboriginal Congress

Healthcare Management Advisors

Congress provides a wide range of health services in Alice Springs and outreach services to communities within the region. An emotional and social wellbeing centre was established as a component of the Commonwealth's Emotional and Social Wellbeing Action Plan. The service provides generalist counselling and support services. As noted above, a psychiatrist from the CAMHS provides one session every three weeks at Congress.

Congress operates a youth outreach and counselling service, which is funded by the Commonwealth until 2003.

Waltja Tjutangku Palyapayi Aboriginal Association

Waltja Tjutangku Palyapayi received funding under the National Suicide Prevention Strategy. The funds are utilised to provide support into remote communities and assist in the development of infrastructure to address suicide.

Ltyentye Apurte Community Government Council (Santa Theresa)

The Ltyentye Apurte Council employs an Aboriginal Health Worker in the Santa Theresa community, which has a population of approximately 550. The position receives support from the Rural and Remote Team to maintain individuals in the community with a mental illness.

Mental Health Association of Central Australia

The Mental Health Association of Central Australia operates three programs in Alice Springs. These are:

- a life promotion project to support the development of effective community responses to suicide. This project seeks to link agencies within the community(ies) to respond effectively to suicides and suicide attempts. Two indigenous staff operate the program using a range of existing resource (e.g. ASSIST, Suicide talk, and Suicide Aware). A key strategy of the service is provision of training to leaders in communities. It was reported that the workers are now being invited to communities;
- operation as a peak body in Central Australia to advocate for, and assist in the development of community based, carer and consumer initiatives; and
- a community based rehabilitation program for those affected by mental health problems. This service provides an individualised service to those with a mental illness to support reintegration into the community. The service seeks to identify and place clients in educational and vocational programs that will assist them in achieving goals they set. In addition, the service also provides a range of social and support activities.

Yuendumu Community Government Council

Yuendumu Council receives funding toward the employment of a male and female Aboriginal Mental Health Worker in Yuendumu. Although the service was originally established to provide services across the Walpiri language group, the loss of funding for a motor vehicle was reported to have prevented the service extending beyond Yuendumu. Discussions indicated that communities surrounding Yuendumu were eager to access the two AMHWs but transport represented a significant challenge to this.

The AMHW have been active in supporting those with a mental illness in collaboration with the Rural and Remote Team, as well as working more broadly with their community to develop initiatives that improve the community such as targeting drunkenness in the community.

Central Australian Division of Primary Health Care

The Division provides support and development of programs involving general practitioners across Central Australia. GPs in central Australia, through the Division have a growing interest in mental health issues, and have identified difficulties in providing interventions to those with high prevalence disorders as a focus. Funding provided under the More Allied Health Services (MAHS) program has been used to fund sessions with private psychologists resident in Alice Springs. Reports during consultations suggested that there has been a considerable demand for this service.

Conclusion

Whilst the resources available to the non-government sector appear relatively limited, the need for a collaborative planning forum to draw the efforts of government and non-government sectors together emerged as an avenues for perhaps gaining greater benefits within available resources. The non-government organisations demonstrated a commitment to a broader approach to mental health and actively sought to extend and adapt there services to those living outside Alice Springs.

The strategy accordingly seeks to identify changes which may enhance the collaboration and co-ordination between services and acknowledges the limited resources available to services in Central Australia.

4

Analysis of service and resource adequacy

The development of a strategy to guide the development of mental health services over the coming decade requires consideration of the current situation against assessed need, and the expectations of stakeholders. This section draws together the information gained through review of documentation, advice provided in the course of the two case studies, subsequent comments in workshops to review the discussion paper, and application of estimates based on the population profile for the Northern Territory. Recommendations made in this section are translated into a table suggesting responsibility, time frames, outcomes and resource implications in Chapter 5.

4.1 RESOURCE ALLOCATION

A recurrent theme in discussions with all groups was the lack of available resources to support a comprehensive mental health service. This section considers the current allocation of resources from a number of perspectives, namely:

- total allocation of resources in comparison to other jurisdictions;
- distribution of resources across service areas;
- risks and stability associated with current resources; and
- availability of skilled personnel.

4.1.1 Total resource allocation

The total expenditure on mental health services in the Northern Territory has increased considerably since the start of the First National Mental Health Plan. However, the per capita expenditure has been in decline since 1998-99 when the per capita expenditure equalled the national average, to the point where expenditure was approximately 10% below the national average in 1999-2000 (DHA (2002)). The decline is the result of strong population growth and relatively stable funding, with total expenditure in 2000-2001 reported at \$14.5 million. Accordingly, increasing expenditure to the 1999-2000 national average of \$81.76 per capita would require an additional allocation of approximately \$2 million.

Burgess (et al (2002)) sought to test a range of models to estimate the allocation required for Area Mental Health Services, based on population characteristics, availability and use of private providers and current allocations nationally. Fortunately, for the current discussion, the Northern Territory was treated as a single Area Mental Health Service in the analysis. Whilst confirming that the Northern Territory is under funded, it emphasised that expenditure on publicly funded private services was significantly below the levels in other areas. Review of the 2002 National Mental Health Report (DHA (2002)) suggests that expenditure on private provision of services has increased marginally though is considerably below expenditure in other jurisdictions.

A key concern in planning for the future is acknowledgement that of the \$14.5 million currently allocated, \$1.3 million (\$6.60 per capita) is not recurrent funding and will expire in 2003-04.

In addition, the estimate proposed above does not take account of the additional costs of services to small remote communities. Weightings for remote and Indigenous communities of between 1.5 times the national average cost (O'Kane and Tsey (1999)) and \$200 (Raphael and Swan (1995)) have been proposed. If a weighting of 1.5 was applied to those living outside Darwin and Alice Springs, a total allocation of \$19.2 million would be required, representing an increased allocation of approximately \$4.7 million for the current population. Weightings established by the Commonwealth Grants Commission (1999) suggest a weighting of 4.8 times for the Northern Territory (p.41). As socio-demographic characteristics, dispersion, isolation and administrative scale were the major contributors to this weighting, it appears that the weighting for isolated communities outside Darwin is considerably greater.

Finally, in seeking to bring mental health funding in the Northern Territory to a point where it is comparable to the national average, and taking account of the need for additional funding to allow equity of access to services, it will also be necessary to take account of the additional demands on forensic services that the Criminal Code (Mental Impairment and Unfitness to Plead) Act may have. Future allocations will need to take account of the adjustments to allow management of additional demands generated by the legislation.

Implications for strategy: Development of a comprehensive mental health service system may require an increase in funding to at least the national average. In order for this to occur, an initial priority will be identifying funds to cover those positions currently funded using non-recurrent funding (\$1.3 million). Achievement of the national per capita average will require a further allocation \$2 million. If the equitable provision of services to those living in remote communities is proposed, and the additional costs associated with providing services into these communities is estimated using the lowest available estimate (i.e. 1.5 times) an additional allocation (approximately \$2.7 million) is required. It will be important to ensure that any additional funding is allocated to priority areas in line with national directions, rather than to providing more services focussed on urban adults in the acute phase of a major mental illness.

The impact of the Criminal Code (Mental Impairment and Unfitness to Plead) Act will need to be monitored and adjustments made to funding to account for additional activity.

Recommendation 1

It is recommended that an additional \$1.3 million be allocated to the mental health program to offset the impact of National Mental Health Reform and Incentive Funding due to expire on 30 June 2003. These funds are currently allocated to areas identified as priorities and evaluation of the projects indicates that they are achieving expectations and should be continued.

Recommendation 2

It is recommended that the allocation of funds to the mental health program be increased to return the Northern Territory to the at least national average per capita level. An additional allocation of \$2.01 million is required to achieve the 1999-2000 national average.

Recommendation 3

It is recommended that consideration be given to allocating a minimum of 1.5 times the national average per capita funding for the population living outside the Darwin and Alice Springs metropolitan areas. Implementing this strategy would require an additional allocation of \$2.7 million.

4.1.2 Distribution of resources

Available resources are not distributed on the basis of population. There appears to be clear acknowledgement that the costs of providing services to small remote communities is higher than in large urban settings, with a weighting on funds provided to Central Australia (23.5% of the population receives 28.9% of the funds). Table 9 (below) provides a breakdown of current resource distributions. The current distribution equates to weighting of 1.5 times per head of population for those living outside the Darwin metropolitan areas.

2000-01 % % of \$m population Central Australia Urban 2.8 19.3 14.1 Central Australian Rural and Remote 1.4 9.6 9.4 28.9 23.5 **Central Australia Total** 4.2 Top End Urban 7.2 49.7 53.9 Top End Rural and Remote 3.1 21.4 22.6 **Top End Total** 71.1 10.3 76.5 **Grand Total** 14.5 100 100

Table 9: Resource allocation 2000/01

Source DHCS Mental Health Services Resource Equity Review 2000-01

The cost of providing services in rural and remote areas appears to have been accepted in the process of the Department allocating funds to the Service Networks (ie weighting for population outside Darwin). Within the Service Networks, however, the allocation of resources between urban and rural and remote does not reflect a continuation of this approach. Resources are closely linked to population with only a slight weighting toward remote communities when the regional role of inpatient services is considered.

Central Australia has a greater proportion of its funding drawn from non-recurrent sources (\$1.052 million or 25%) than the Top End (\$1.361 million or 13%). Accordingly, the funding environment for Central Australia is proportionately less secure than for the Top End.

Of the total expenditure 58% is allocated to community based services, including NGOs, while the remaining 42% is allocated to inpatient services. The weighting toward expenditure on inpatient services is greater in the Top End (45.8%) than in Central Australia (29.5%). Whilst the proportion of expenditure allocated to inpatient services is comparable to that in other jurisdictions, the reported bed day cost is significantly higher, particularly in the Top End.

Implications for strategy: The current allocation of resources at the regional level appears to take account of higher costs in rural and remote areas, though this weighting is relatively low when the suggested additional costs involved in providing services in rural and remote communities are taken into account.

Recommendation 4

It is recommended that the current weighting of resource allocation between Central Australia and the Top End be retained.

Recommendation 5

It is recommended that the allocation of funding within the Central Australian and Top End be reviewed to ensure that the weighting to rural and remote communities is maintained within each region. This will require analysis of the use of inpatient services by those from remote communities.

Recommendation 6

It is recommended that the level of funding provided to inpatient services in Darwin be brought into closer alignment with the national average bed day cost (\$455). This strategy will require a detailed review of current operations and staffing levels, which presently appear to be consistent with a psychiatric intensive care unit for all patients. Funds released as a result of this process should be redirected to the pool of additional resources proposed in recommendations 1, 2 and 3.

4.1.3 Stability and risks of funding

A key consideration for planning is the stability of funding into the future. Review of documents outlining the allocation of non-recurrent funding indicated that Central Australia relies on non-recurrent funding for a greater proportion of its services than the Top End. Further examination indicates that Aboriginal Mental Health Workers, NGOs and services to remote communities are more likely to be funded with grant funding. Accordingly, services relying on grant funding are at risk if non-recurrent funds are not replaced from other sources and the Northern Territory government is unable to allocate resources where alternative funding is not identified.

Implications for strategy: In order to ensure that services can develop in a strategic manner, replacement of non-recurrent funding for core services with recurrent funding will be a high priority.

Recommendation 7

It is recommended that should additional resources become available, priority be given to confirming recurrent funding for services currently supported by non-recurrent funding, particularly Aboriginal Mental Health Worker positions, and those services targeting remote communities.

4.1.4 Availability of skilled personnel

The capacity to recruit and retain appropriately skilled staff was a point of discussion in most of the meetings held with stakeholders. Darwin stood out compared with all other areas in terms of its capacity to attract recruits for the majority of positions, though recruitment of medical staff was identified as an issue across the board. In considering this area, discussion will focus on the current staffing mix, and where possible refer to benchmarks for various

professional groups, before examining the appropriateness and implications of the current mix.

The Australian Medical Workforce Advisory Committee (AMWAC) undertook an examination of the Psychiatry workforce in 1999 and reported that the World Health Organisation has proposed a benchmark of 10 Psychiatrists per 100,000, while Canada had modified this to 11.9 per 100,000 (AMWAC, 1999). At the time of writing, similar benchmarks had not been identified for mental health nurses, psychologists, social workers or Aboriginal Mental Health Workers.

At the time of the project, there were 13 psychiatrists or registrars resident in the Northern Territory, including three private psychiatrists in Darwin and one public psychiatrist exercising limited rights of private practice. This equates to 6.5 positions per 100,000 or one position for every 15,500 people. Only two psychiatrists were resident in Alice Springs (4.2 per 100,000), and there were no child and adolescent psychiatrists. The Royal Australian and New Zealand College of Psychiatrists argues that in rural or remote areas a population of between 20,000 and 30,000 is required to support a resident psychiatrist, though it is unclear if this estimate relates to private practice.

In the course of discussions, it was reported that there was discrepancy in the conditions under which psychiatrists in Darwin and Alice Springs are employed. Those in Alice Springs are subject to Fringe Benefits Tax, whilst those in Darwin are not, acting as an additional barrier to recruitment in Alice Springs.

Mental Health Nurses make up the majority of those employed by the Department to provide mental health services, and with approximately 70 positions, this equates to one position for every 2,900 people. Although it was reported that within Cowdy Ward the staffing was relatively stable, in the community and Alice Springs High Dependency Unit a significant, though unmeasured, level of turnover was reported.

Psychologists and social workers constitute the remainder of the non-indigenous, clinical workforce. Again, population based ratios for the number of each group required to meet mental health needs have not been identified. This may be a result of significant overlap in the roles undertaken by mental health nurses, psychologists and social workers within community mental health teams and limited action by professional bodies to clearly delineate professional domains.

The national average ratio of ambulatory care FTE to population is 33.3 FTE per 100,000 would see a benchmark of 67.3 FTE for the Northern Territory, though the impact of remoteness in terms of travel time and inefficiencies in servicing small populations would again require weighting for such a benchmark to be useful. If the weighting of 1.5 is again applied, a benchmark of 100.8 FTE (50 FTE per 100,000) is achieved. This compares with a reported 34.1 FTE per 100,000 for 1999-2000(DHAC (2002)) and average 29.2 in 2001-2002 (Purcell 2003 personal communication).

The situation in the Top End and Central Australia differ significantly, with Central Australia currently holding numerous vacant positions due to inability to recruit. It is understood that a component of this issue, associated with the rostering of staff and resultant expenditure, was resolved in December 2002.

Within the public system the role of Aboriginal Mental Health Workers appears to be somewhat limited. The recent activity of the Top End Division of General Practice has significantly expanded the workforce, particularly in remote communities. The provision of adequate support, ongoing training and professional recognition for these positions has been identified as a key factor in determining their effectiveness. Further the inclusion of AMHWs within an administrative, rather than clinical award structures provides a structural barrier to their clinical work being recognised.

Whilst firm data regarding staff turnover was not identified, it would appear that recruitment is a less significant challenge than retention of staff. Indeed, discussions with staff suggested that a culture of frustration, helplessness and despair had evolved. Strategies that contribute to retention include:

- development of transparent decision making systems, with clear and consistent points for decision making;
- establishment of effective, objective and reliable systems for providing staff evaluation that are linked to professional development opportunities; and
- support for professional development, including access to ongoing training and supervision, encouragement to undertake research and preparation of conference papers describing the work environment and innovative developments (which in turn aid recruitment.

Implications for Strategy: It will be essential that the Strategy incorporate approaches to both improving recruitment and enhancing retention of appropriately skilled and qualified personnel. Further, it will be important for the strategy to provide some guidance regarding an appropriate mix of staff required to support development of a comprehensive service system.

Recommendation 8

It is recommended that as additional resources become available, additional permanent positions should be established. Given the population of the Territory, the objective should be to establish:

- an additional five psychiatry positions, with an emphasis on expanding the use of private practice rights by public sector psychiatrists, of which one consultant and one registrar position should be located in Alice Springs, and at least one position should be a specialist child and adolescent psychiatrist; and
- increase the number of ambulatory care positions to 100.8 FTE from the current level (68.9 FTE) with a particular emphasis on child and adolescent positions.

Recommendation 9

It is recommended that the Department, in consultation with the Northern Territory Aboriginal Health Forum, clarify the role and training requirements for Aboriginal Mental Health Workers, and endeavour to achieve proportional employment of appropriately trained and skilled Aboriginal people within the mental health system. This initiative should also include the provision of training and support structures to facilitate Aboriginal people taking on management roles within the service. Further, consideration should be given to the location of these positions within Aboriginal organisations where possible.

Recommendation 10

It is recommended that where Aboriginal Mental Health Worker positions are created, a sufficient allocation is provided to ensure the positions have access to transport, support, supervision and ongoing training.

4.1.5 Conclusions

The current allocation of funds to mental health services in the Northern Territory is well below the national average on a per capita basis, and includes a significant component of non-recurrent funding which may not be available after 30 June 2003. Approximately \$3.3 million additional is required to convert non-recurrent funding to recurrent funding and increase funding to the national average. If it is intended to also take account of the additional costs of providing services in remote communities and provide an equitable level of services a weighting of 1.5 for this population would see the additional funding requirement rise by a further \$2.7 million.

The current allocation of resources at first glance appears to acknowledge the additional cost of providing services in remote areas, however when broken down within regions it acb be seen that the larger centres account for a greater proportion of expenditure than their population suggests. Whilst expanding the resource base appears to be required, the recruitment and retention of an appropriate mix of staff will be crucial to the successful implementation of the service development strategy.

4.2 GAPS IN THE EXISTING SERVICE SYSTEM

This section considers the current service system in light of the information provided in Chapter 2 and Chapter 3 as well as themes arising in the course of the case studies, constituting the response to the first term of reference:

"review Department of Health and Community Services Mental Health Program funded services, taking into account the context of services available in the Northern Territory."

4.2.1 Mental Health Promotion

The Alma Ata Communiqué (WHO (1978) and the Ottawa Charter (WHO (1986)) provide the conceptual foundations for contemporary health promotion. Integral to this conception is acknowledgement that health is not simply the absence of illness, in this case mental illness. Improvement in health, and mental health, requires a secure foundation in the eight fundamental conditions and resources for health, namely:

- Peace;
- education;
- income;
- sustainable resources; and

- shelter;
- food:
- a stable eco-system;
- social justice and equity.

Consideration of the apparent disadvantage of remote and indigenous communities remains an impediment to the achievement of good mental health within the Northern Territory that is beyond the terms of reference for the current project. Nevertheless, if growing demand for mental health services is to be effectively managed, activity at the political and bureaucratic levels is required to addresses mental health promotion in the broader context.

The draft Mental Health Program Action Plan 2001-2003 refers broadly to the development of promotion and prevention strategies in collaboration with a wide range of potential partners, though does not establish specific initiatives, allocate responsibilities nor identify resources. The extent of implementation of the promotion component of the Action Plan was not established in the course of consultations or review of available documentation.

One position currently exists within the Department to drive development of mental health promotion activities. The role of specialist mental health staff in mental health promotion, particularly increasing mental health literacy within the community was identified as an area of interest, though staff reported they had limited time to actively develop programs in this area.

The relatively high proportion of children and young people in the population is not currently reflected in the service system. Accordingly, the development of mental health promotion strategies that target children and adolescents is a priority.

The social and economic conditions faced by Aboriginal people, and other people living in more remote communities within the Northern Territory require that broad mental health promotion activities for these groups are a priority.

Conclusion. The emphasis on mental health promotion was considered to be relatively limited. In order to address this issue collaboration and support across government is required. Further, a strategic framework for the development of mental health promotion activities across government is required.

Recommendation 11

It is recommended that the Department of Health and Community Services work with other departments to establish a mental health promotion strategy with a five-year horizon, outlining specific strategies to be undertaken across government to promote and enhance mental health.

4.2.2 Prevention

The three levels of prevention (universal, selective and indicated) again were identified by stakeholders as an area for development. Although limited input was received from other government departments, the emphasis on development and implementation of effective prevention strategies was limited to activity at the departmental level, with service networks focussed primarily on providing treatment services.

The development of responses to universal prevention, prevention aimed at the whole population, again is primarily occurring at the departmental level with limited engagement of the service networks. The development of mental health promotion (see Section 4.2.1) will to a large extent begin to address the development of universal prevention strategies. It should be emphasised that the majority of activity will occur in settings outside mental health services. An example of a universal activity would be the introduction of programs in all schools to develop children's resilience to failure or adverse events.

Limited information was gained regarding selective prevention strategies, those that seek to target groups within the population that may be identified as being at higher risk than other

groups. A range of concrete strategies or programs are identified in the National Action Plan for Promotion, Prevention and Early Intervention (DHAC (2000)) though the current draft Mental Health Action Plan fails to articulate the strategies to be pursued for the Northern Territory. A clear articulation of the strategies or programs to be pursued would enhance communication about this area of activity and assist in clarifying the role of specialist mental health staff, if any. An example of a selective prevention strategy would be development of systems to support and enhance the parenting skills of young mothers with premature babies.

Indicated prevention, strategies or activities designed to target specific groups or individuals who as well as experiencing a range of risk factors also show signs of moving beyond being at risk, and overlaps considerably with early intervention. A significant theme drawn from case studies was the apparent lack of activity in this area. Given the overlap with early intervention, this issue will be discussed in more detailed in the following section.

The factors which contribute to identifying groups as being at risk of mental health problems are common with factors associated with development of a diverse range of social problems, and include socio-economic disadvantage, limited access to employment and education. Given the common factors, a response involving a range of departments will be required.

Conclusion

There appeared to be a limited emphasis on the development and implementation of mental health prevention strategies. The current draft Mental Health program Action Plan (2001 – 2003) whilst representing a beginning point for planning activity in this area fails to provide concrete strategies for action. As with mental health promotion, action in this area will require collaboration and input from a range of departments and other partners, which in turn will require concrete proposals for action.

Recommendation 12

It is recommended that the Department of Health and Community Services develop a mental health prevention strategy by working with an existing interdepartmental and inter-sectoral forum. Should an appropriate forum not exist, it is recommended that a group be established involving stakeholders such as:

- Department of Employment, Education and Training;
- Department of Community Development, Sport and Cultural Affairs;
- Justice Department;
- The Licensing Commission;
- Northern Territory Police Service;
- Department of the Chief Minister;
- the Northern Territory Consumer Advisory Group; and
- non-government organisations

to support the development and implementation of universal and selective prevention strategies such as parenting programs, and resilience training for school children, and support and follow up of young mothers. It is further recommended that these strategies be jointly funded by participating departments and opportunities for involving non-government organisations and consumer/carer representatives in deliberations be pursued.

4.2.3 Early intervention

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Although established as a priority in national policy, the current mix of services suggests that the limited availability of resources has seen a focus within the mental health service system on the management of acute episodes of major mental illness. The establishment of an early intervention team in Darwin provides a concrete example of the public system seeking to respond to those for whom an intervention is indicated, but who are not yet experiencing a sufficiently acute condition to require hospitalisation.

Further, a range of activities in the non-government sector are clearly focused on early intervention, including work by:

- Anglicare through its Bridging the Gaps Program and Assist suicide prevention program;
- Tiwi Health Board in seeking to develop responses to those at risk of suicide;
- The Top End Division of General Practice, in relation to those experiencing high prevalence disorders.

However, information provided during case studies, particularly by youth services struggling to deal with young people experiencing first episodes of mental illness, indicated that a considerably greater emphasis was required.

The establishment of partnerships with primary health care and community service providers which see specialist mental health staff providing support and input within these services is an approach which is showing promise (e.g. Harmon et al (2000), O'Hanlon et al (2002) also current pilots in Victoria).

The geographic characteristics of the Northern Territory suggest the need to engage primary health care staff and the broader range of community service organisations (e.g. schools, police and CDEP) to identify individuals who are at risk or experiencing the early stages of a mental illness, need to be engaged. The reorientation projects facilitated and evaluated by the Australian Network for Promotion, Prevention and Early Intervention for Mental Health (O'Hanlon et al (2002)) emphasise the need to develop the workforce in agencies and ensure that specialist mental health support is available. Further, the active support of senior management within agencies was required to ensure that where necessary operation policy was reframed to take account of an early intervention focus.

Conclusion

The relative scarcity of resources within the mental health service system and its focus on managing the treatment of acute mental illness have seen this area poorly addressed within the current system. Accordingly, a considerable focus within the strategy for developing services should be the development of service components that actively and effectively address early intervention.

Recommendation 13

It is recommended that to enhance the capacity of primary health care staff to identify and provide early intervention:

 specialist community mental health teams in Darwin, and if practical in Alice Springs, be co-located with other community health services, to facilitate the transfer of skills and understanding of mental health to the broader range of health professionals;

- negotiations be undertaken with the State Based Organisation regarding the
 development of a program to support routine placement of specialist mental health
 professionals within GP practices (similar to the model outlined by Harmon (et al
 (2000))) to further enhance the role of general practitioners in the identification of an
 early intervention for mental illness;
- that specialist community mental health staff be encouraged to provide services in community based organisations such as supported accommodation, schools and services specifically designed for young people to enhance access to mental health services and support;
- a clear outline of the expectations of mental health workers in this consultant/support role is developed, along with a brief training program.

Recommendation 14

It is recommended that a working group with representation from both the Department of Health and Community Services (including mental health clinicians) and non-government organisations be established to explore opportunities for applying the learning gained from projects such as "Building capacity for mental health" (O'Hanlon et al (2002)) in collaboration with the non-government sector. A particular focus should be on early intervention for children and adolescents. If possible, the allocation of funding to support a small number of pilot projects should be allocated to test and refine approaches. There is a strong case for these projects to be undertaken through non-government organisations.

4.2.4 Treatment Services

The provision of treatment services is the major focus of the mental health program. The services provided to people living in Darwin and Alice Springs are more comprehensive than those available to those in outlying communities. Whilst the small populations in outlying communities, the cost of providing services and the difficulties recruiting staff to live outside major centres all present challenges in equitably providing services, the current arrangements see those in communities outside Darwin and Alice Springs at a significant disadvantage.

The resources available to support mental health treatment services, with the exception of inpatient services in Darwin, are below the national average. It was reported that services were increasingly focussed on the management of patients with acute, major mental illness in order to manage within the existing resources for the government sector.

Despite the population profile, the resources allocated to children and adolescents were limited as a proportion of current resources. Accordingly, the allocation of resources and development of services to target this group is considered a priority for action.

Discussions with carers, consumers and non-government organisations resulted in a number of consistent themes, namely:

- lack of consistent carer and consumer input into the planning, development and operation of services within the public sector;
- difficulty in raising concerns and gaining a constructive response, touching on issues of accountability;
- the need for greater interaction between specialist public mental health services, primary health care providers and other service groups within the community;

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- limited development of effective, open and productive partnerships with other agencies;
- lack of a continuum of care, particularly for those recovering from an acute episode and those in a prodromal phase; and
- awareness of a lack of resources and demands placed on components of the public treatment system.

Two fundamental areas for development within the current treatment system, independent of the challenges posed by limited resources were:

- the need to establish planning processes at the regional and community level, which
 engages with the range of services and organisations that will have contact with, and may
 support the management of people at risk of developing, or currently experiencing mental
 illness; and
- provision of services in a range of settings to better meet the needs of consumers.

A number of issues arise when specific services areas are considered, in particular:

- child and adolescent services;
- service for Aboriginal people;
- management of acute, inpatients admissions from remote communities;
- post acute care for people following an inpatient admission;
- management of those with concurrent mental health and substance abuse problems;
- development of effective links with primary healthcare providers;
- carer involvement in care; and
- support for rehabilitation of those with a chronic mental illness.

Each of those areas will be discussed below.

4.2.4.1 Child and adolescent services

Despite the relatively high child and adolescent population in the Northern Territory, the proportion of available resources allocated to this area is limited, particularly in Central Australia where there is a lone child and adolescent position. Whilst the level of staffing is somewhat greater in the Top End, with five positions, including a family therapist, it was reported by young people that the service was primarily focused on services provided at the Tamarind Centre, which young consumers considered an unpleasant environment.

Although it is evident that there has been some action to address the needs of this segment of the population, it stands out as an area for urgent development. Key priorities should include:

- development of skills within the generalist mental health workforce if additional resources for child and adolescent services can not be found or reallocated within the existing budget;
- establishment of concrete arrangements to support the provision of child and adolescent mental health services in a range of settings such as schools, youth services or community health centres;
- collaboration through the Department to facilitate development of early intervention strategies in mainstream government and non-government agencies that have contact with children and young people who may be at risk, with particular emphasis on ensuring that specialist mental health staff are available and committed to providing support (see Recommendation 14);

- arrangements for recruitment of or otherwise engaging a specialist child and adolescent psychiatrist (see Recommendation 8);
- development of culturally appropriate response to child and adolescent mental health within the indigenous community (see recommendations 8 and 9); and
- development of an appropriate environment within inpatient facilities to meet the estimated demand for child and adolescent admission (322 bed days per annum).

Recommendation 15

It is recommended that the development of a coherent child and adolescent (those up to 18 years old) mental health service, particularly for Central Australia, be given priority within existing resources, and as new funds become available through savings or allocation of additional resources. Ideally the service should include:

- establishment of a child and adolescent psychiatrist position;
- development of training, support and research links with a major child and adolescent mental health centre;
- work toward the establishment of a ambulatory, child and adolescent mental health workforce of 25 FTE; and
- development of a two-bed area within the in patient unit in Darwin appropriate for the care of patients under the age of eighteen, and if possible ensure that one bed is available in Alice Springs. These beds should be available for adult patients when not required for children and adolescents.

4.2.4.2 Aboriginal Mental Health

The large indigenous population in the Northern Territory establishes Aboriginal mental health as core business, and places some priority on developing the Aboriginal workforce within the service system. Although the Top End Division of General Practice has been active in establishing Aboriginal Mental Health Worker positions across the Top End, the public sector has been somewhat less active. Further, where Aboriginal Mental Health Workers are employed within the public sector, they are employed under a clerical and administrative award, undermining the establishment of clinical credibility.

In the course of consultations it was evident that the role and training of Aboriginal Mental Health Workers was the subject of a significant debate nationally, and it was strongly suggested that the current process not seek to pre-empt the outcome of that debate.

An underlying challenge for the system as a whole is establishing a knowledge base which translates Aboriginal conceptions of mental health, as opposed to seeking to apply western conceptions. It was suggested, and articulately argued during consultations, that there is no evidence base to support the application of western diagnostic structures, largely validated on mid-western American populations, to Aboriginal people.

As with child and adolescent mental health, which is particularly important for Aboriginal people in the Northern Territory, significant development is required in this area (see recommendations 8 and 9 above).

Recommendation 16

It is recommended that the Department seek the support of the Commonwealth to fund and commission a program of research over the coming decade to:

- test the validity of contemporary diagnostic frameworks (e.g. DSM IV) within the indigenous population;
- in close collaboration with the Aboriginal community, refine these diagnostic frameworks to take account of the broader conception of health defined in the National Aboriginal Health Strategy;
- develop documentation and training for mental health and primary health staff seeking to work in indigenous communities, or with Aboriginal people; and
- subsequently establish a detailed epidemiology of mental health in the Northern Territory.

Recommendation 17

It is recommended that the current proportion of Aboriginal people employed with mental health services be increased to reflect the population profile (i.e. 28.3%). This will require resources for adequate training, support and clinical supervision.

Recommendation 18

It is recommended that the Department in collaboration with the Northern Territory Aboriginal Health Forum, support resolution of the debate regarding the role of, and qualifications required by, Aboriginal Mental Health Workers.

Recommendation 19

It is recommended that the Department, in line with the outcome of deliberations by the Northern Territory Aboriginal Health Forum regarding the roles and qualifications for Aboriginal Mental Health Workers, initiate a process that results in appropriate acknowledgement of the clinical role of Aboriginal Mental Health Workers in the designation and classification of their positions.

Recommendation 20

It is recommended that the Department collaborate with the Aboriginal Health Forum in reviewing the above recommendations to ensure that the outcomes of the current project to develop a Northern Territory Aboriginal Social and Emotional Well-being Strategy are neither pre-empted, nor undermined by these recommendations.

4.2.4.3 Management of acute, inpatient admissions from remote communities

The arrangement of the admission of acutely mentally ill people from remote communities was identified in a number of consultations as an issue. It was reported that there are occasions where, after enormous efforts in communities to arrange for acutely unwell members patients to be restrained and airlifted to either Alice Springs or Darwin, the patients are discharged within twenty-four hours on the basis that when assessed they do not meet the requirements for involuntary admission. Discussion with inpatient staff suggested that these instances relate to patients who after sedation for the flight and a good night's sleep do not meet the requirements for involuntary admission. It was further suggested that these patients are often affected by substance use. Regardless of the basis for discharge, it was evident that the development of strategies to more effectively manage these situations is required.

Recommendation 21

It is recommended that a working group be established to explore options for the improved management of involuntary admissions of patients from remote communities. This working group should include representation from:

- one psychiatrist from the Top End and one from Central Australia;
- one representative of the Mental Health Review Tribunal;
- one representative from the Aboriginal Health Forum;
- one representative from nursing staff at each of the Darwin and Alice Springs inpatient units;
- one District Medical Officer;
- one representative from the Tiwi Islands Health Board;
- one representative from the Central Australian Aboriginal Congress;
- the Chief Health Officer (or a representative);
- a representative from the Northern Territory Police Service;
- one consumer and one carer representative;
- one representative from the Royal Flying Doctor Service or other air evacuation provider; and
- a representative of the Northern Territory Attorney General.

It is further recommended that the terms of reference for the working group include:

- review of a sample of cases where involuntary admissions from remote communities resulted in discharge within 24 hours of admission (including the outcome following discharge);
- identification of any shortcomings in current policy or practice;
- development of strategies to address any shortcomings identified;
- identification of any legislative changes that may be required; and
- revision of protocols and policy to support the implementation of identified strategies.

4.2.4.4 Current operation of inpatient mental health services

Although there was clear evidence that the bed day costs for inpatient care were significantly higher than the national average (\$915/bed day in 2000-01 compared to the national average of \$455/bed day), no coherent explanation for the magnitude of the cost differences was provided in the course of discussions with management. Nevertheless, the reported staff to patient ratio of one RN to three 3 patients on day shift and one RN to four patients on afternoon and night shifts may go some way to understanding the costs.

It appears that the staffing levels allow high quality care to be provided to those who are acutely unwell and requiring stabilisation (that is up to 14 days). However, the extended length of stay of some patients suggests that care could be provided in a less restrictive environment, enhancing the quality of patient care and allowing resources to be reallocated to alternative forms of care.

The provision of inpatient care to children and adolescents was consistently identified by staff, consumers and carers as an issue, specifically the availability of an appropriate environment for this form of care. The estimated demand for these services given the

population (approximately 322 bed days per annum) precludes the establishment of stand alone services, consideration should be given to developing appropriate environments within existing facilities for this group (see Recommendation 15).

The occupied bed days, when compared with estimates for the population suggest that a level of lower level of care is also being provided within the units. Analysis of the patient mix and exploration of alternative modes of, or venues for care may allow reallocation of resources.

The conditions applying to staff employed by the unit in Alice Springs were reported to differ significantly from those employed in other units within the hospital, most notably access to staff accommodation. It was suggested that this acted as a barrier to recruitment and contributed to the reported critical staffing issues facing the unit.

Recommendation 22

It is recommended that management of the Top End Service Network be required to initiate a detailed examination of the staffing and operation of inpatient mental health services in Darwin with a view to:

- devising strategies for achieving operating costs comparable to the national average cost per bed-day;
- documenting based on the results of an independent costing study the specific circumstances/barriers in the Northern Territory that preclude the achievement of savings of this magnitude (it is our expectation that some savings should be possible even if national average bed costs cannot be achieved;
- staffing levels proposed through this review should be justified on the basis of an analysis of patient mix and benchmarks applied in other jurisdictions, and the evidence base for any variation;
- clear delineation should be made between patients requiring acute care and those who are receiving sub/post acute care;
- alternative venues or arrangements for less acute levels of care should be explored (see Recommendation 24); and
- that this review be completed by 31 August 2003.

Recommendation 23

It is recommended that staff engaged to work in the Ward 1 of Alice Springs hospital be granted access to the same services and support, on the same conditions as are made available to other inpatient staff at the Alice Springs Hospital.

4.2.4.5 Post acute care for patients following an acute admission

A recurrent issue raised in consultations was the need for enhancement of services to support the care of patients following an acute admission. Informants reported that follow-up was generally poor and that the availability of options for periods of residential care following discharge was a significant gap in the existing service system. The provision of the residential component of care is likely to be more effectively and efficiently managed in the non-government sector. Nevertheless, specialist mental health services would be required to actively provide support and assistance to these services to manage mental health clients, and provide direct clinical services required by these clients.

Based on the modelling summarised in Table 2 the population warrants facilities including 38 non acute beds, seven community residential beds (excluding the one nursing home bed) and 19 very long stay beds. The location of the residential component of this type of care should bridge the government/non-government boundary, with more acute cases managed in the public sector, and patients moving to the non-government sector as their condition improves. The fundamental requirement is that the level of specialist mental health input required is maintained across the two settings.

If the criterion for non-acute care is established at lengths of stay exceeding 14 days, it is reasonable to assume that approximately half non or sub acute care beds will operate within the government sector (18 beds), and the remaining beds (20 beds) would be effectively operated in the non-government sector. Support from community mental health teams to the beds in non-government organisations would require approximately two positions. This is estimated on the basis of approximately 50% of staff time being allocated to direct clinical care, 72 of the 137 admissions being treated in non-government agencies, and each receiving:

- one 90 minute initial assessment;
- two 45 minute review assessments; and
- 17 continuing contacts of 45 minutes each.

Where patients are discharged to remote communities, it was argued that a detailed discharge plan, involving education of family members, relevant community members and primary health care staff regarding the condition of the patient, what they might expect, and how to effectively manage the patient.

Recommendation 24

It is recommended that following review of inpatient services in Darwin, determination regarding the allocation of non-acute beds to the non-government sector be negotiated with a group representing the non-government sector:

- the process for determining the agency(ies) that will operate the beds;
- the number of beds to be located in the community;
- the basis for providing the ongoing clinical input to the services; and
- the financial support required for the operation of the beds; and
- the sources of funding to be applied.

Recommendation 25

It is recommended that the care of very long stay patients for those unable to achieve independent function in the community be provided predominantly in the non-government sector (20 beds). The funding of the accommodation component of care may not be through the mental health budget. However, specialist community mental health staff should provide ongoing contact (approximately one hour per bed per week of each of mental nursing and allied health) and psychiatric review quarterly. In order to facilitate continuity and the development of effective working relationships it may be

appropriate to designate specific positions in both Darwin and Alice Springs to provide nursing and allied health care. Further, funding the non-government sector to provide these services may achieve the same result.

4.2.4.6 Management of those with concurrent mental health and substance abuse problems

A recurrent theme in consultations, particularly in the Top End, was the interaction between mental health services and drug and alcohol services. The significant overlap between client groups presents a challenge within the current service system. The interim review of the Second National Mental Health Plan (Thornicroft and Betts (2002)) argues that the division between mental health and drug and alcohol services is of little benefit at the clinical level.

Ideally, alcohol and other drug clinicians should have a sound understanding of mental health and similarly mental health clinicians should have a comprehensive understanding of alcohol and other drug issues. This would allow comprehensive care to be provided to the significant number of clients who require or seek interventions in both fields. Two documents published by the NSW Centre for Mental Health provide a useful framework for developing a response to those with co-existing mental health and substance use problems (NSWHD (2000) and (2000a). The service delivery guidelines (NSWHD (2000a)) provide service delivery models across the spectrum of interventions from promotion to ongoing care.

Recommendation 26

It is recommended that a process be initiated urgently to explore and develop effective service delivery models for clients with co-existing mental health and alcohol or other drug problems. This process should build on the work published by the NSW Department of Health, Mental Health and Substance Use Disorder – Service Delivery Guidelines. Ideally this process should be chaired by the Chief Health Officer (or delegate) and involve:

- two representatives from both mental health and alcohol and other drugs;
- two representative of the NT Aboriginal Health Forum;
- two representatives from non-government organisations involved in the provision of alcohol and other drug services;
- two representatives of the non-government sector; and
- two consumer and two carer representatives (including members of the Consumer Advisory Group).

It is further recommended that a report outlining the deliberations and conclusions of the group be submitted to the Chief Executive Officer by 31 December 2003.

4.2.4.7 Development of effective links with primary health care providers

The need to provide services in small remote communities, the relative scarcity of resources and the emphasis on development of partnerships in policy documents, requires the maintenance of close links with primary healthcare staff.

It was evident from case studies that some progress had been made in remote communities, with specialist mental health staff developing a consulting role to support primary healthcare workers to manage clients in their communities. However, given the resource constraints across the service system, there was limited evidence to suggest that resources had been

allocated to building effective partnerships with primary healthcare providers in the larger centres.

Development of skills within primary healthcare providers (Harmon et al (2000)) and collocation of specialist mental health staff in primary health care settings (O'Hanlon et al (2002)) provide opportunities to increase the coverage of mental health services, improve early identification and intervention, and increase mental health literacy. Accordingly, a considerably greater emphasis in this area may produce a return for a relatively limited investment, given the existing level of resources.

See recommendation 13

4.2.4.8 Carer involvement in care

Discussions with carers consistently identified involvement and input into the care of the client for whom they cared as a shortcoming in the current service system, along with mechanisms or forums to support their involvement. Discussions with mental health service staff emphasised that the maintenance of clients' confidentiality was the primary consideration and a barrier to discussing the condition or treatment of an individual.

While it is acknowledged that the issues confronting consumers, and those confronting carers will often be conflicting, the use of advance agreements, which establish consent for the provision of information to carers when a consumer is sufficiently well to provide consent can be considered. Action in this area, whilst improving the capacity of carers to prepare for the care of their relatives will also ensure that service providers begin to work in partnership with the carers and consumers, rather than on the periphery.

The second area of concern raised by carers was a perceived unresponsiveness of mental health services when they sought assistance as consumers began to deteriorate. Management of relapse was more generally identified as a shortcoming in the existing service system, though it was argued that this was a reflection of the limited resources available. Nevertheless, inclusion of carers and consumers actively in management meetings may increase the accountability of services and service provided for timely intervention, and assist in the development of strategies to achieve this, even within the current resource environment.

Recommendation 27

It is recommended that a working group be established with representation from both the Top End and Central Australia to develop protocols and procedures for the establishment of advanced consent, allowing mental health service providers to share defined information with carers. The working group should have representation from:

- mental health clinicians including a psychiatrist, mental health nurse, psychologist, social worker and two Aboriginal mental health workers;
- two carer representatives;
- two consumer representatives; and
- a representative of the Mental Health Review Tribunal as chair.

4.2.4.9 High Prevalence Disorders

Advice was consistently provided in the course of consultations suggesting that there was very limited activity within the public sector relating to high prevalence disorders. It is acknowledged that this area of care can, with appropriate specialist support be effectively managed within a primary healthcare setting. Accordingly, the recommendations related to early intervention are equally applicable to the development of a primary mental health care system which would encompass the management of routine presentations of high prevalence disorders. (See Recommendation 13) Opportunities to support the non-government sector in developing some service components for those with high prevalence disorders should be pursued.

4.2.4.10 Support for rehabilitation of those with a chronic mental illness

In the course of consultations the provision of services intended to enhance the capacity of those recovering from acute mental illness, or seeking to manage a chronic mental illness was raised as a shortcoming in the existing system. In part this related to the current focus on the relatively short-term management of acute mental illness. The central issue of concern was the perceived lack of support for services that aimed to support mental health consumers to establish effective strategies to managing their mental illness, gain education or employment, and develop full and rewarding lives despite their mental illness.

The recently published Framework for Rehabilitation for Mental Health (NSWHD, 2002) provides a good framework for conceptualising rehabilitation and development of strategies to improve the availability of appropriate resources to support the rehabilitation of people with a mental illness. It should be noted that the range of services required extend well beyond those for which the Department has responsibility and will require an inter sectoral approach. The Commonwealth has a significant role in services associated with the provision of a comprehensive rehabilitation system, through involvement in areas such as vocational education and training, and provision of ongoing financial support.

Recommendation 28

It is recommended that the Department work with the representatives of the non-government sector, the Commonwealth, consumers and carers to explore resources available in communities to support rehabilitation/recovery and subsequently collaborate in the development of a framework and action plan to enhance the linkages between, and access to, these services. Allocation of resources to non-government organisations to develop initiatives in this area is encouraged.

4.2.4.11 Response to suicides

The propensity for suicides to occur in clusters was emphasised in consultations, and it was noted that the Tiwi Islands have recently experienced a number of suicides. It was suggested that there was not a formal process for responding to communities in which a suicide had occurred to limit the likelihood of a cluster of suicides occurring. The responses developed in Cape York have been documented by Earnest Hunter and provide a framework for beginning to develop a systematic response in the Northern Territory.

Recommendation 29

It is recommended that the Department, in collaboration with the NT Aboriginal Health Forum develop a formal and agreed protocol for jointly responding to communities in which a suicide occurs to limit the likelihood of a cluster of suicides developing.

4.3 STRUCTURAL/ORGANISATIONAL ISSUES

This section outlines issues that relate to the organisation, range mix and integration of services. In part it provides a response to the second term of reference:

"make recommendations on the level, mix and integration of services and staff to get the best results within existing resources."

4.3.1 Current organisational structure

The separation of policy (funder), planning (purchaser) and operations (provider) was raised in many consultations as a barrier to progress. It was argued that the funder was largely divorced from activities and issues at the coalface. The recent development of service agreements was identified as a positive step, in terms of translating expectations into concrete terms, though it was evident that the flow of information between the two service networks (providers) and the Service Development Branch (purchaser) was less than free.

Whilst the overall structure of the Department is beyond the terms of reference for the current project, and is subject of a separate review, achieving the best results from available resources will benefit from a more integrated structure, particularly at the policy and planning levels.

Further, it is apparent that a considerable amount of focussed activity will be required to facilitate the development of a mental health service system that can effectively confront the challenges imposed by the Northern Territory environment. The existing placement of clinical services within service networks places an enormous demand on network management to develop mental health services whilst also managing the myriad issues confronting the health system more generally.

The lack of perceived clinical experience and credibility at the policy level was relayed in a number of consultations as a basis for undermining or ignoring stated policy directions. It is noteworthy, that in other jurisdictions a chief psychiatrist position draws together clinical and administrative accountability for the service system (e.g. New South Wales and Western Australia), giving added weight and credibility to policy directions at the coalface.

Discussion the application of a similar structure in the Northern Territory during consultations elicited support, provided the position was placed within a broader bureaucratic structure and that a candidate with a sufficiently broad understanding of population based conceptions of mental health could be found. An added advantage would be the capacity of such a position to carry additional weight in negotiations across government and between governments.

Whilst consideration was given to the notion of establishing a single organisational structure for the management and operation of mental health services across the Northern Territory, the option was discarded as it raised issues including:

- where clinical accountability would rest;
- risk of friction at the service delivery level if mental health were a completely separate structure that may result in the establishment of an undesirable 'silos' approach to management and service development;

- implications if the Department directly employed the mental health workforce, rather than their being employed through service networks (ie the service delivery role of staff may be overlooked in assessments of the size of the department); and
- likelihood of increasing layers of management, rather than streamlining decision making.

Accordingly, we propose that the funder and purchaser roles be amalgamated so that the there is closer alignment between policy, planning and service development. Further, the process of developing and monitoring service agreements will ensure that information from the coal face is incorporated in to policy and planning. Should a chief psychiatrist be established and recruited, the position would be located within this structure. We will refer to this combined structure as the Social and Emotional Wellness Branch (SEWB).

Further, we propose that the two mental health services remain to obviate the need for establishing a completely separate infrastructure. However, we propose that the general managers of these services be directly accountable to the amalgamated for implementation of the service agreements, while remaining accountable to the service networks for day to day operation of services. Accountability for implementation of service agreements will require that a regular (monthly) meeting occur between general managers and SEWB. The focus of these meetings should be review of progress in implementing service agreements, analysis of the implications and suitability of developing policy directions, and development of agreed priorities. Ideally, these monthly meetings would also include representation from the non-government sector, consumers, and carers (It is expected that the meeting would involve only seven or eight participants).

Finally, the trend in more populace states to appoint a chief psychiatrist to draw together policy, planning and clinical accountability is noted. Tasmania has not established a position of this kind, and the ACT has a part-time Chief Psychiatrist with a relatively focussed role. It is considered that, provided a suitable applicant can be identified, such a position would be of benefit to mental health service development in the Northern Territory. The role of the position would include:

- provision of clinical leadership to mental health services in the Northern Territory;
- contribute to the strategic development of mental health policy, research and services within the Northern Territory;
- provision of comprehensive advice regarding the development and operation of mental health services in the Northern Territory to the Department;
- promotion of evidence based best practice in mental health across the Northern Territory;
- representation of, and advocacy for mental health in the Northern Territory in professional, territory, national and international forums; and
- support the recruitment and development of the mental health workforce.

It is acknowledged that clinicians have input into the development of policy and it is not intended that the chief psychiatrist role obviate this input, rather the intention is to provide support for balancing clinical, policy and practical considerations to achieve the best outcome for mental health in the Northern Territory.

Should a suitable applicant be recruited, if that applicant wishes to maintain a level of clinical practice, it will require that review functions currently vested in the Chief Health Officer would remain in that position. The extent to which this position would assume the role of director of overall mental health policy and planning, or the Social and Emotional Wellness

Branch for that matter can not be determined at this stage, as an exceptionally skilled individual with a commitment to a population health approach, prevention, promotion and integration would be required to effectively amalgamate these roles.

Recommendation 30

It is recommended that the funder and purchaser roles (Social and Emotional Wellness Branch) and the mental health position with Service Development Division be amalgamated. The amalgamated Branch should be located under the Chief Health Officer.

Recommendation 31

It is recommended that the General Manager of the Top End Mental Health Service and the General Manager of the Central Australian Mental Health Service be directly accountable to the amalgamated Social and Emotional Wellness Branch for the implementation and monitoring of their service agreements. Routine operational accountability would remain with the service networks.

Recommendation 32

It is recommended that a monthly meeting between SEWB, general managers (TEMHS and CAMHS), a representative of the non-government sector, a consumer an a carer representative provide the focal point for discussion and monitoring of service agreements, planning and priority setting.

Recommendation 33

It is recommended, that provided a suitable candidate can be identified, a Chief Psychiatrist position be established within the amalgamated Social and Emotional Wellness Branch.

4.3.2 Level mix and integration of services

Sections 4.2 and recommendations 11 through to 28 largely address the issue of service mix and integration. Nevertheless, a number of structural issues are of importance. There was a view expressed in a number of consultations that a benchmark for the allocation of funds to non-government organisations should be established. However, it is our view that the provision of specific services through either the government, or non-government sector should be determined on the basis of the sector or organisations which are best placed to provide particular services at a given time and have therefore not sought to establish a benchmark. Nevertheless, in the course of our investigations and consultations it was apparent that considerable energy and innovation was being applied to meeting the mental health needs of the community within the non-government sector.

Accordingly, a number of service delivery areas appear well suited to location within the non government sector and should additional resources become available a component should be directed toward the non-government sector for project in these are, including:

- aspects of promotion and prevention that require community engagement with limited requirement for government participation;
- enhancing access of groups such as young people and Aboriginal people to services and development of strategies to support early intervention;

- development of strategies to support rehabilitation and negotiation of support arrangements with education and employment providers;
- provision of settings that facilitate engagement of those with chronic mental illnesses;
- implementation of strategies to support interventions for high prevalence disorders;
- supporting Aboriginal Mental Health Worker positions in communities; and
- determining and responding to the broader support needs of consumers and carers.

Recommendation 34

It is recommended that as earlier recommendations regarding additional resources are implemented, a component be allocated to funding programs in the non-government sector, particularly in relation to:

- selective and indicated prevention, and early intervention;
- support for Aboriginal mental health workers in remote communities;
- services for those with high prevalence disorders;
- sub acute care;
- and rehabilitation.

Decisions about the allocation of such resources to specific programs should be an agenda item in the monthly meeting proposed in Recommendation 32.

4.3.3 Consumer and carer input

A view was universally expressed by both consumers and carers that the opportunities for, and extent of their involvement in the planning, development and review of services was limited, though it was acknowledged that at the Territory level, the Consumer Advisory Group (CAG) was generally engaged. The CAG appears to provide an appropriate forum for consumer and carer input at that level. Where carers and consumers had been involved at the service network level, frustration was expressed regarding the limited level of engagement, lack of feedback and limited impact that their input appeared to have.

In one discussion, it was suggested that if service networks were required to meet the out of pocket expenses of carers and consumers for their attendance, as well as offset any lost income higher value may be placed on their input. The development of consumer consultants in a number of jurisdictions has provided a means of explicitly paying identified representatives to undertake a range of roles focused on enhancing consumer input. However, where payment for participation in specific processes is considered, meeting reasonable expense, plus payment of a participation fee raises a number of issues, particularly where social security payments may be affected.

The inclusion of consumers or carers in meetings that discuss the management and development of services was identified in a number of discussions as inappropriate where issues of individual patient care might be discussed, thus raising issues of confidentiality.

The development and operation of services will benefit significantly from consumer and carer participation, limiting the extent to which the perception of service providers about their services diverge from the experience of those who use, or are expected to use them.

Efforts in Victoria to increase the involvement of consumers and carers in planning and policy decisions gained momentum in 1996 with the establishment of consumer consultants in

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Area Mental Health Services and the promulgation of guidelines for consumer participation. Two key components of the guidelines were establishment of consumer networks and preparation of consumer participation plans.

An evaluation in 1999 found that while considerable progress had been made, there was significant variation across the state (Department of Human Services (1999)). It was recommended that:

- support and training be provided to consumers to enhance their capacity to become actively involved;
- provision of training to staff to develop skills and attitudes appropriate to facilitating consumer involvement;
- integration of consumer feedback into quality improvement processes; and
- consideration of incentives based on consumer participation.

In addition to consumer involvement, Victoria has developed a useful information kit for carers which describes the mental health system, identifies support services and clearly articulates carers' rights.

In a similar vein to Victorian arrangements, the New Zealand Mental Health Commission reports that establishment of consumer consultants on a variety of arrangements, has contributed significantly to the development of consumer networks, and increasing the range of participation (NZMHC (1999)). Again, the inclusion of consumers within an overall system of feedback and service development is considered central to improving the quality of services.

Recommendation 35

It is recommended that mental health executive meetings at the Northern Territory, Service Network and regional hub (described in 4.3.4) include a consumer and a carer representative. Where issues requiring discussion of information relating to the management of individual patients is required, agenda papers should indicate the issue, without reference to the client and if necessary these items should be discussed at the conclusion of the meeting without the consumer and carer representative. However, the minutes of the meeting should indicate the issues and resolution in a manner, which protects the patients' confidentiality.

4.3.4 Establishment of enhancement of regional hubs

The significant distances between remote communities and need to provide a consistent and adequate critical mass of skilled staff to support professional peer support, and in turn retention, has been acknowledged by the development of teams in Nhulunbuy, Katherine, Tennant Creek and the Darwin Rural teams.

In line with preceding recommendations regarding resource allocation (recommendations 1, 2, 3, 5, 7, 8, 14 and 15) the regional hubs be developed such that specific positions in each hub are established to address child an adolescent mental health, Aboriginal mental health, mental health promotion and support primary health care providers.

Recommendation 36

It is recommended that minimum staffing for regional hubs include the following positions:

- two adult mental health workers;
- one child and adolescent mental health worker;
- one mental health promotion/community development;
- one specialist position to support Aboriginal mental health workers; and
- support for primary health care workers be a requirement of all positions.

4.3.5 Recruitment, retention and professional development

An important factor related to decisions regarding remaining in a position or seeking employment elsewhere is the extent to which employees believe they are valued and supported in their role. Key indicators of this are:

- access to constructive, regular appraisal and feedback;
- linkage of appraisal outcomes to targeted training and development opportunities;
- support for research and documentation of innovative areas of practice;
- opportunities to present in professional fora.

Questionnaires completed by mental health staff provided insight into the perceived access to training and perceived training needs. Four areas of in particular demand were:

- Aboriginal culture and language;
- psychopharmacology, particularly in relation to more recent medications;
- child and adolescent mental health; and
- treatment methods (particularly cognitive behavioural therapy).

The predominant areas of recent professional development were:

- cultural awareness;
- CCIS; and
- treatment methods.

Of interest, only 27 of the 70 staff responding to the questionnaire had received training in the past twelve months. Key reasons identified for training, and conference attendance not being available were lack of opportunities locally and resources not being available to attend courses interstate.

In order to allow a focussed effort to maintain and advance the mental health workforce, coordination of training and education across the Territory is required. Opportunities to provide training locally, significantly reducing the unit cost and establish long term partnerships with the Northern Territory University, Bachelor College, Menzie's School of Health Research, and the University Department of Rural and Remote Health in Alice Springs need to be explored. Further collaboration with these organisations to research, develop and provide core training elements on an ongoing basis at a reasonable cost would establish a base for the ongoing development of the workforce.

Further, establishment of clearly articulated priorities for submission and presentation of papers, or attendance at conferences would act as a professional development and recruitment tool.

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Whilst remuneration was frequently reported as a barrier to recruitment, the benefits of increased remuneration in attracting candidates is of no value in retaining staff, hence our emphasis on enhancing the professional development opportunities.

Recommendation 37

It is recommended that a position be created within the amalgamated Social and Emotional Wellness Branch that has responsibility for the development and coordination of a coherent professional development program for mental health staff in both the government and non government sector. Partnerships with tertiary education providers in the Northern Territory to provide ongoing core training elements should be a priority for this position to provide a comprehensive range of training at a manageable cost. The explicit articulation of priorities for supporting presentation of conference papers and attendance at conferences should also be co-ordinated through this position.

4.4 IMPACT OF AMENDMENTS TO THE CRIMINAL CODE

Although the recent introduction of the Criminal Code (Mental Impairment and Unfitness to be Tried) Amendment Act presents a possible, additional demand upon specialist mental health services, no attempt has been made to quantify the implications of this legislation on resources, or operation of the system. While there estimates of the implications of the new legislation vary considerably, it is anticipated that current discussions at the departmental level, and change as familiarity with the legislation and its utility is developed will limit the effect. However, the Department, independently of this project is undertaking a detailed analysis of the legislation and assessing its impact. Accordingly, we have not sought to address this issue, beyond acknowledging that the impact of the legislation will need to be monitored and taken into account in determining appropriate levels of funding (See 4.1.1).

5

Service Development Strategy

This section outlines the proposed service development strategy for the Northern Territory in a tabular form, applying the recommendations above:

- in order of priority;
- allocating responsibility for the delivery of components of the strategy;
- proposing a time frame for completion;
- proposing outcomes upon which to determine achievement; and
- estimating the likely cost implications.

Recommenda tion No	Description	Responsibility	Timeframe	Outcome	Cost Estimate \$,000
	Funding and Resource distribution				
1 (p. 53) 7 (p. 55)	Allocate \$1.3 million to offset impact of NMHRI expiring on 30 June 2003	CEO	30/6/03	Core activities and positions funded by MHHRI continue	\$1,300
2 (p. 53)	Allocation of an additional \$2.01 million to achieve 2000-01 National per capita expenditure	CEO	30/6/03	Resources allocated	\$2,010
3 (p. 54)	Allocation of \$2.7 million to allow 50% weighting to per capita expenditure for those living outside Darwin and Alice Springs	CEO	30/6/03	Per capita expenditure on mental health services for people in communities outside Darwin and Alice Springs	\$2,700
4 (p. 55)	Relative weighting of resource allocation between Top End and Central Australia be maintained			Implied weighting of 50% for communities outside Darwin and Alice Springs is retained	Nil
5 (p. 55)	Review application of weighting in Top End and Central Australian service networks	Top End and Central	30/6/03	The extent to which 50% weighting is applied within service networks is confirmed and strategies for realignment if necessary are developed.	nil
6 (p. 55) 22 (p. 67)	Review of mental health inpatient services in Darwin to address apparently high bed day cost	Top End Service Network	31/8/03	Basis for high bed day cost established and remedial strategies implemented	Saving

Recommenda tion No	Description	Responsibility	Timeframe	Outcome	Cost Estimate \$,000
	Cross Government Initiatives				
11 (p. 59)	Development of cross government mental health promotion strategy	CEO	30/6/05	Commitment and role of all departments in promoting mental health agreed.	Nil direct cost
12 (p. 60)	Working group established to develop and implement universal and selective prevention strategies.	Chief Health Officer	30/6/05	Working group established by 30/6/03 Strategy developed by 30/6/04 Prevention strategies operating across government by 30/6/05	To be determine d
	Service Developments				
	General				
8 (p. 57)	Establish Child and Adolescent Psychiatrist	Chief Health Officer/ Executive Director Service Development	31/12/03	Child and Adolescent Psychiatrist Recruited	\$250
8 (p.57)	Establish four additional psychiatry positions	Chief Health Officer/ Executive Director Service Development	30/6/05	Additional psychiatrists are recruited to Darwin and Alice Springs	\$1,000
8 (p.57)	Increase ambulatory care positions to 100.8 FTE	Chief Health Officer/ Executive Director Service Development	30/6/07	Ambulatory FTE increases at a rate greater than population growth with 50% weighting given to communities outside Darwin and Alice Springs	\$2,075

Recommenda tion No	Description	Responsibility	Timeframe	Outcome	Cost Estimate \$,000
9 (p. 57)	Increase proportion of Aboriginal people employed within the mental health system to 28%.	Chief Health Officer/ Executive Director Service Development	31/12/08	Increase in appointment of appropriately trained and skilled Aboriginal people at 30 June each year	Nil additional
	Prevention/Early Intervention				
13 (p. 61)	Mental Health teams be co-located with community health teams in Darwin and Alice Springs	Executive Director Service Development/ Service Network General Managers	30/12/04	Agreement on location and accommodation of staff by 30/6/03 Relocation of Mental Health Teams by 1/7/04 Alternative use or sale of Tamarind Centre by 30/12/04	Cost neutral if Tamarind Centre is sold
14 (p. 62)	Development of early intervention pilots with NGOs	Chief Health Officer/ Executive Director Service Development	31/12/03	Working group established by 30/6/03	\$100 pa over five years
	Treatment Services				
15 (p. 64)	Establish child and adolescent psychiatry position	Chief Health Officer/ Executive Director Service Development	31/12/03	Child and Adolescent Psychiatrist Recruited	Counted in Rec. 8 above
15 (p. 64)	Establish links with a tertiary child and adolescent mental health service	Chief health Officer	31/12/02	Formal link established	Nil
15 (p. 64)	Work toward establishment of child and adolescent workforce of 25 FTE	Top End and Central Australian Mental Health Managers	31/12/07	Increase to 3 FTE in Central Australia by 31/12/03 Expansion by at least 4 FTE annually thereafter until target is achieved	Counted in Rec. 8 above

Recommenda tion No	Description	Responsibility	Timeframe	Outcome	Cost Estimate \$,000
15 (p. 64)	Development of appropriate child and adolescent accommodation in existing inpatient units	Tope End and Central Australian Mental Health Managers	30/6/03	Accommodation for two patients in Cowdy unit and one patient in Ward One are appropriate for use by children and adolescents as required.	\$20
21 (p. 65)	Improve management of involuntary admissions from remote communities.	Chief Health Officer	30/9/03	Working Group established by 31/3/03 Recommendations made by 30/9/03	Nil direct costs
24 (p. 68)	Plan allocation of non-acute beds to the non-government sector	Chief Health Officer and Executive Director Service Development	31/12/04	Establish working party by 1/9/03	Cost of MH care included in Rec. 8
25 (p.68)	Establishment of very long stay beds to bring pool to 20 beds	Executive Director Service Development	31/12/06	Establishment of support positions to provide nursing and allied health input into long stay beds by 30/6/04	Counted in Rec.8 Accommo dation funded through other programs.
27 (p. 70)	Development of Advanced Consent protocols	Chief Health Officer	30/6/03	Working group established by 31/3/03 Protocols established by 30/6/03	Nil

Recommenda tion No	Description	Responsibility	Timeframe	Outcome	Cost Estimate \$,000
29 (p.71)	Development of protocol regarding response to suicides in communities	Chief Health Officer	30/9/03	Establishment of process to develop protocol by 31/3/03 Protocol developed and implemented by 30/9/03	Nil
	Structural and System Issues				
30 (p. 73)	Consolidation of mental health funder and purchaser roles	CEO	1/7/03	Policy and service development roles are amalgamated. Single point of advice, information and accountability established for mental health	Nil
31 (p. 73)	Top End and Central Australian mental health services be directly accountable to the consolidated mental health policy/service development unit for implementation of service agreements.	CEO	1/7/03	Formal and direct accountability of Top End and Central Australian mental health managers to the mental health policy/service development unit established.	Nil
32 (p. 74)	Establish monthly meetings to ensure implementation of service agreements and align planning and policy development.	Chief Health Officer	1/10/03	Policy informed by coal face Service agreements monitored NGOs, consumers and carers have active role in ongoing planning, policy development	

Recommenda tion No	Description	Responsibility	Timeframe	Outcome	Cost Estimate \$,000
				and review.	
33 (p. 74)	Establishment of chief psychiatrist position	Chief Health Officer	Dependent on appropriat e candidate		Counted in Rec. 8
34 (p. 74)	Focus on enhancement of services in the non-government sector	Chief Health Officer	31/12/03 and ongoing	Collaborative and co-ordinated planning of service development in the non-government sector	Included in Rec. 1,2,3 and 22
35 (p. 76)	Inclusion of consumer and carer representatives at mental health executive meetings at Territory and service network levels	Chief Health Officer and Network Mental Health Managers	31/03/03	Consumer and carer input to planing, development and operation of services	Minimal
36 (p. 76)	Enhancement of regional hubs	Chief Health Officer/ Executive Director Service Development	30/6/2007	Core staffing of hubs agreed Proportion of additional resources allocated to positions located within hubs	Counted in Rec. 8
37 (p. 77)	Establishment of Training and development co-ordinator	Chief Health Officer	1/7/03	Coherent training and development strategy established. Partnerships developed with education providers Recruitment and retention improved	\$160 over two years
24 (p. 68)	Inpatient mental health staff in Alice Springs have access to the same services	_	31/3/03	Barriers to recruitment diminished	Nil

Recommenda tion No	Description	Responsibility	Timeframe	Outcome	Cost Estimate \$,000
	and support (particularly staff accommodation) as generalist inpatient staff	Service Network			
	Aboriginal Mental Health				
19 (p. 65)	Support resolution of the debate regarding the role and qualifications of AMHWs	Chief Health Officer		Agreement established for the roles and qualifications required by AMHWs	Nil
20 (p. 65)	Transfer of AMHWs to a clinical rather than administrative award classification	CEO	30/6/04	AMHWs are recognised industrially and in terms of data collection as holding a clinical, rather than administrative role	Unknown
21 (p. 65)	Review of Service Development Strategy with NT Aboriginal Health Forum	Chief Health Officer	30/6/03		
27 (p. 70)	Initiate process to explore amalgamation of Mental Health and Alcohol and Other Drug structures	Chief Health Officer	31/12/03	Position established regarding integration of mental health and drug and alcohol programs.	Nil

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Appendix 1
Case Study Framework

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Appendix 2
Case Study Summaries

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Appendix 3 Discussion Paper