NORTHERN TERRITORY MENTAL HEALTH COALITION

SUBMISSION

MENTAL HEALTH AND SUICIDE PREVENTION AGREEMENT FINAL REVIEW

12 March 2025

ABOUT:

The Northern Territory Mental Health Coalition (The Coalition) is the peak body for community managed mental health services across the Northern Territory. We work in collaboration with a wide network of community mental health organisations, people with lived experience, their families and supporters to advocate at the local and national level to improve the mental health and wellbeing of all Territorians. As a peak body, the Coalition ensures a strong voice for member organisations and a reference point for governments providing advice on all issues relating to the provision of mental health services in the Northern Territory.

On behalf of our members, we welcome the opportunity to make this submission to the Productivity Commission's final review of the National Mental Health and Suicide Prevention Agreement. For further information or clarification, please contact Geoff Radford, Chief Executive Officer on 08 8948 2246 or ceo@ntmhc.org.au

RESPONSE

Complex and interrelated factors impact on the accessibility and quality of mental health services in the NT. The NT has a small population with significant unmet needs that are well documented. The mental health burden of disease in the NT sits at 16.3%, compared to 7.4% nationally. The impact of the social determinants of mental health means people present to services and emergency departments with a greater level of complexity than in other jurisdictions. Young Territorians are overrepresented within mental health services compared to other age groups, with young people aged between 15 and 24 years constituting 25% of all community-based clients, despite being only 15% of the population.

The Mental Health and Suicide Prevention Agreement (Bilateral Agreement) has significantly increased funding of mental health and wellbeing supports to the Northern Territory. This has resulted in:

- increased footprint of services to regions previously un-serviced or under-serviced;
- increase to the suite of services delivered by some community mental health providers.

The Northern Territory has unique and significant challenges when it comes to mental health support provision including remoteness, limited services, critical sector shortages and the high rate of suicide. Whilst the NTMHC welcomes this essential funding we have concerns with the implementation and reporting process.

Following consultation with our members, the following themes emerged - ***transparency, accountability and collaboration.***

The bilateral agreement schedule sets out clear reporting requirements. Neither commissioning body have published any data to understand if:

- the requirements set out in the bilateral schedule have been achieved;
- what progress has been made;
- what may have been amended or changed.

Data is not available to understand or determine if the bilateral agreement has had any impact on:

- reducing mental health transports from remote regions
- reducing mental health presentations to emergency
- cultural safety of service delivery
- equity of access across the NT
- equity of access to supports for vulnerable population groups as described in the agreement - LGBTIQA+SB; Aboriginal and Torres Strait Islander people, and culturally and linguistically diverse communities.

Following consultation with our members, the following themes emerged- ***transparency, accountability and collaboration***.

TRANSPARENCY AND ACCOUNTABILITY

Coordination in the commissioning of services by NT Health and NTPHN has not been clear and transparent. Beyond what is set out in the bilateral agreement, the commissioning bodies have not made it clear what is in scope for commissioning and when/if/what consultation and evidence has informed the decision making. Lack of transparent communication has left unanswered queries on if cost-shifting has occurred and has been effective.

Relationships between commissioning bodies have impacted the sector. At times power dynamics between personalities have resulted in a preferred provider being commissioned by the decision maker rather than a transparent, diverse panel subject to probity.

The majority of services commissioned with funding agreed through the bilateral agreement have been through select, closed expressions of interest. This has not supported a holistic approach from the sector. Transparent and consistent communication on the evidence leading to decision making may have increased cohesiveness and enabled organisations to support and share in the success of the increased resourcing to a community or region. Services commissioned through open tenders have also been subject to similar criticism. Service delivery in the NT is complex, expensive and requires long term commitment and investment by local communities to ensure its sustainability and success. Findings and evidence laid out in the Productivity Commission Review of Expenditure On Children in the NT remain true for this sector; for example,

- grant funding, while increasing in length for NT-Health funded services has not been reciprocated for NT Health (Funding 2.3)
- record keeping (Funding 3.2)
- accuracy to track funding (3.1, 2.2)
- consistency of reporting (4.1)
- limited coordination across levels of government (4.2)
- siloed decision making (5.1)

Communication to the sector has been limited and very much one-way. There has been a pattern of withholding information, and it is not well understood why this has occurred. Progress against the bilateral agreement appears quite limited until a service is commissioned, document published, or an opportunity to provide feedback in a rushed timeframe is offered. Examples from the bilateral include:

- Aftercare services have only been recently funded;
- Addressing needs of diverse cohorts and regional and rural communities

- No knowledge of mix of rotations for students and graduates between acute/primary care settings.
- To our knowledge there have been no local level responses

Frequent engagement outlining the planning, consultation and commissioning of services funded under the bilateral agreement would reduce concerns and criticism on a range of issues for example, the length of time it has taken to commission services.

EXAMPLE – DECISION TO FUND A SATELLITE HEAD TO HEALTH CENTRE

The bilateral agreement describes establishing a Head to Health adult satellite clinic.

- A number of communities and regions have significant unmet need and are suitable locations for a service of this nature
- A thin market means service providers are at various levels of readiness and suitability to deliver such a service
- Preparation of tender documents, service model and program logic remain closed; limiting opportunity to form partnerships and collaboration which often are rushed
- Planning and decisions are made without transparent communication to the sector, leaving questions and criticism of the decision. This results in redistribution of resources and the new service recruiting suitably qualified staff which appears as poaching rather than direct opportunity for collaboration, partnership or collaboration
- Communication is poor at each stage throughout the process, including funding announcements and successful tenders. This results in rumours rather than open, transparent communication with stakeholders.

COLLABORATION

A draft NT plan for mental health and suicide prevention has been developed in collaboration between NIAA, NTPHN, NT Health and AMSANT. NT Mental Health Coalition and members as well as lived experience groups and advocates were invited to provide feedback, however seemed to be deliberately excluded from contributing to its development from the initial stages. This represented a fantastic opportunity for robust codesign and coproduction and the opportunity may have been lost.

The rollout of the bilateral agreement has not been informed by the lived experience of consumer or carers. The NT does not have a peak body for consumers or carers and only recently has a partnership been funded to begin to establish a “collaborative”. The funding is for one year only to build capacity. It will take longer than one year to build a suitable body to provide a voice that is representative of each region and demographic of the NT. Conversely, the commissioning bodies are not well-versed in seeking lived experience input into reforms, let alone it be led by lived experience as per best practice evidence.

Workforce is a major issue affecting the sector nationally as described in the National Mental Health Workforce Strategy. In the NT and especially in remote regions the workforce turnover sits well above 30% each year. The NT Mental Health Coalition conducted a workforce survey in 2022 which confirmed position vacancy rates in community mental health services are high and the sector struggles to retain suitability qualified staff. Staff attrition remains a key challenge with high turnover rates and accompanying loss of skills and knowledge. Service delivery is increasingly undertaken by generalist or Certificate level workers, many of whom have limited training in mental health specific

skills. There are very few Peer Workers and even fewer Peer Work positions. Moreover, training options available to this sector are limited and inconsistent, particularly in smaller organisations who struggle financially to scale-up training needs on a frequent basis. The bilateral agreement describes building structures and supports for the Lived Experience Workforce. To our knowledge the bilateral agreement has not provided any funding to create and increase pathways for the lived experience workforce, instead this has been funded through other ad hoc, unsustainable funding sources. The evaluation of the mental health skills build and other initiatives undertaken by the NT Lived Experience Network such as the Peer Led Education Pilot not only describe the need but demonstrate the effectiveness of these initiatives.

EXAMPLE- TRANSITION OF AFTERCARE

Transition (decommissioning and recommissioning) of universal aftercare services left a significant gap beyond six months; where an aftercare service was not available to Territorians.

- The existing service provider was notified the funding would cease
- A transition plan was not developed in collaboration with all parties
- A new service was funded and took considerable, but realistic time to develop the service model. The existing service provider was deliberately excluded from this process, missing an opportunity to provide valuable insights to inform the new service
- Territorians were not provided a service during this gap

The approach taken while long term may result in increased capacity and potentially a best practice and culturally safe service, has not improved integration across the sector, damaging some relationships particularly between NT Health, community mental health and social and emotional wellbeing providers.

RECOMMENDATIONS

1. Governance of the bilateral agreement be enhanced by inviting representatives from NT Health, NTPHN, AMSANT, The Coalition and persons with Lived Experience to provide leadership and stewardship of the implementation of the bilateral agreement.
2. Regular meetings be held inviting sector stakeholders to receive and share information about progress of the bilateral agreement, upcoming work; providing an opportunity for codesign and coproduction. The meetings must be compliant with the NT Lived Experience Framework.
    i. Members recommended the NT Specialist Homeless Services Reform Group as an example from a comparable sector demonstrating outcomes through collaboration. The terms of reference can be supplied as an addendum.
3. Reporting progress against the bilateral agreements be published and available to the public on a biannual basis.
4. Future bilateral agreements include long term resourcing for a sustainable Lived Experience peak body as in other jurisdictions, that includes separate funding for workforce initiatives to increase the number and capacity of Social and Emotional Wellbeing Workers and Peer Workers.
5. Following the release of the National Stigma and Discrimination Reduction Strategy a subsequent action plan be codesigned by persons with lived experience, their families, carers and kin in the NT that funds practical activities to reduce stigma, particularly in help seeking.

REFERENCES AND RESOURCES

1. NT Government (2024). *Specialist Homelessness Services Reform Group Terms of Reference.* Can be supplied as an addendum to this submission.
2. White, M., Gooda, M. (2017). Royal Commission into the Protection and Detention of Children in the NT.
3. Povey, J., Radford, G., Roadley, B,. Ober, C., Barker-Gibb, M., and Chirgwin, S. (2024). Strengthening the Wellbeing Workforce for a Healthier Future: An Evaluation of a Mental Health Build Skills Initiative in the Northern Territory. Darwin, Menzies School of Health Research
4. Productivity Commission (2020). Expenditure on Children in the NT.
5. Tari-Keresztes, N., Smith, J. & Gupta, H., (2021): Follow-up Evaluation of the Peer-Led Education Pilot in Darwin. Darwin: Menzies School of Health Research.