12th April 2019

Dear Commissioners,

NTCOSS welcomes the opportunity to respond to the Productivity Commission's inquiry into *The Social and Economic Benefits of Improving Mental Health*.

NTCOSS is a peak body for the Northern Territory community sector and is a voice for people affected by social and economic disadvantage and inequality. The community sector in the Northern Territory is made up of community managed, non-government, not for profit organisations who work in social and community service delivery, sector development and advocacy.

The community sector plays a vital role in creating social wellbeing for all Territorians and in building safe and healthy communities by providing services that enable people to access and participate in health services, education, employment, economic development, and family and community life.

NTCOSS represents a service sector with a high level of contact with people with mental illness and their families. While a number of organisations are funded to provide targeted services to people with mental illness, many social service organisations support people with mental illness indirectly through the provision of a wide range of social services including homelessness support, children, youth and family support services, alcohol and drug support, employment services and other health and wellbeing services.

Investing in evidence-based mental health services and supports significantly increases the opportunities for people with mental illness to engage socially and economically in society. Research by the World Health Organisation shows that internationally, investment in mental health treatment and supports to improve economic participation by 5% will result in significant savings in health services as well as a substantial payoff in ecomonic activity. It is a reasonable expectation that increased social and economic participation of people with mental illness, hand in hand with greater community education and awareness, will also enhance efforts to counter the prevalence of stigma around mental illness.

Human rights and the broader benefits of mental health services
Mental health care and treatment is a fundamental and inalienable human right and therefore people with mental illness are entitled to receive quality support. The rights of people living with mental illness are upheld in the Disability Discrimination Act 1992. Despite these protections discrimination against people suffering mental illness in broader society and the workplace is persistent and poses challenges to efforts to improve economic participation, productivity and economic growth. Any efforts to enhance economic participation of people with mental illness cannot be dealt with in isolation from an understanding of the impact of systemic social issues including discrimination, poverty and social disadvantage and the flow on consequences of unemployment and homelessness, domestic violence, drug and alcohol misuse on people living with mental illness or possessing a vulnerability to mental illness.

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NTCOSS welcomes the Productivity Commission's consideration of social as well as economic concerns through this inquiry and believes it is critical for policy makers to recognise that the goal of enhancing economic participation and productivity of people with mental illness is inextricably linked to broader social outcomes that are as important but less easily quantified. These include addressing mechanisms for reducing discrimination against people living with mental illness and identifying and addressing the broad social determinants of mental health that hamper greater social and economic inclusion.

It is NTCOSS' view that the impact of greater social and economic participation for the individual can result in a wide range of positive life circumstances such as improved relationships with family and friends, greater hope for the future, improved general health and social harmony. The capacity to engage in meaningful employment can improve the emotional health of families and early experiences for children by reducing financial stressors. For families and carers, the benefits are also felt including reduced caring responsibilities and greater capacity for their own social and economic participation. While the economic benefits of these outcomes may not be immediate they will inevitably enhance economic productivity and economic growth over time by reducing the ripple effect of social harm generated by mental illness.

Key considerations for the Northern Territory

The burden of disease and high levels of social disadvantage in the NT

The Northern Territory has the highest rate of burden of disease in Australia.[1] Mental health conditions contribute 16.3% of the burden of disease in the NT compared with 7.4% nationally by mental illness and substance use disorders.[2] NT residents experience the second highest rate of mental health-related emergency department visits nationally.[3] In the NT, mental illness is often underreported or underdiagnosed. In part this is due to a lack of services funded to repond to mental health issues among the Aboriginal population in a culturally sensitive and specialised manner.

Investment in mental health services alone will not entirely improve people's mental health. It is criticial that the social determinants of poor physical and mental health, such as poverty, homelessness, malnutrition, poor education and a lack of meaningful employment, are recognised and addressed to both prevent and provide holistic support for people with mental illness. In the Northern Territory, social and economic disadvantage is experienced particularly acutely, with rates that exceed the national average in homelessness, child removals, adult and youth incarceration, domestic and family violence and significantly lower than average rates of educational attainment levels and health outcomes. Research shows that there is a strong correlation between socioeconomic status and mortality and morbidity rates in the NT. The burden of disadvantage is disproportionately felt by the Aboriginal population. Approximately a quarter to a third of the NT Aboriginal health gap is due to social disadvantage.[4] NTCOSS recognises the significant rate of

[1] Australian Institute of Health and Welfare. *Australian Burden of Disease Study 2015: fatal burden preliminary estimates.* Cat. No. BOD 18. Canberra: AIHW (2018).

[2] Northern Territory Primary Health Network. *The NT PHN Mental Health and Suicide Prevention Needs Assessment.* Canberra: Department of Health (2016).

[3] Ibid.

[4] Zhao, Yuejen et al. "Health inequality in the Northern Territory, Australia". *International Journal for Equity in Health* 12(79) (2013).

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homelessness in the NT, including its contribution to mental ill health and disproportionate impact on Aborginal people and endorses NT Shelter's submission. As ACOSS highlighted in their submission to this Inquiry, there is a strong correlation between poverty, employment, income and mental ill health.

There is a strong economic argument for addressing the Aboriginal health gap in the NT. Research shows that the Aboriginal Health Gap in the NT costs $16.7 billion every 5 years which includes 22% relating to higher health expenditure, 35% for lost productivity caused by illness and 43% associated with lost life-years.[5]

NTCOSS recommends that Federal and Territory Governments work collaboratively to address disadvantage to both prevent poor mental health and provide holistic support to people experiencing mental illness.

Remoteness

The level of remoteness in the Northern Territory represents significant challenges for service provision and economic participation. Over 43% of the NT population reside in remote or very remote locations.[6] There are over 600 communities and remote outstations in the NT, all with small populations. The vast majority of people living in remote and very remote locations in the NT are Aboriginal, with approximately 80% of Aboriginal Territorians residing outside of urban areas.

Service provision faces a number of challenges servicing the vast areas. Many services are underresourced and struggle to cover the large regions allocated under their service agreements. In some cases, services are simply not available unless people travel to access them. Community-based, early intervention services are significantly lacking in remote communities, particularly for children and adolescents. Coupled with a high turnover of staff and difficulty attracting highly qualified professionals in rural and remote locations, the quality and accessibility of services is significantly impacted. NTCOSS notes that these challenges are not unique to the mental health sector. This means that other professionals who come into contact with people with mental illness do not always have the training or expertise to correctly identify early warning signs and refer people to support appropritately.

There is a significant proportion of the population who act as informal carers in the NT. In particular, Aboriginal women and young people in remote communities are often unpaid carers.[7] In remote locations, Aboriginal carers play a vital role as there is reduced access to services. Rates of informal care in the remote areas of the NT are as high as 17.6% of the population.[8] However, it is likely that the number of Aboriginal

[5] Zhao, Yuejen, Vemuri, Siva R. and Arya, Dinesh. "The economic benefits of eliminating Indigenous health inequality in the Northern Territory". Medical Journal of Australia 205(6) (2016): 266-269.

[6] Northern Territory Department of Health. *Annual Report 2015-16* Darwin: Department of Health, Northern Territory Government (2016).

[7] Payer, Hannah, Brokensha, Huw, Taylor and Dr. Andrew. "Who cares? – Profiling carers in the Northern Territory", *Research Brief Issue 03*, Darwin: Northern Institute, Charles Darwin University (2015).

[8] Australian Bureau of Statistics, *Census of Population and Housing 2011 and 2016,* accessed at www.profile.id.com.au.

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carers is underreported given the difference in cultural understandings of caring responsibilies in kinship relations as well as the broader network of people who share caring responsbilities.

NTCOSS recommends that the Productivity Commission do further consultation with remote Aboriginal communities to determine what supports they need.

Economic Participation in Remote Communities
In rural and remote locations, there are significant challenges for economic participation. The Federal Government's policy of the Community Development Program (CDP) in remote and very remote areas reflects the lack of employment options. There are currently 30,000 people participating in the CDP program, 84% of whom are Aboriginal.[9] The current CDP program is discriminatory for participants as it places significantly more onerous conditions than the mainstream (jobactive) program. CDP participants are expected to start their obligations immediately (compared with after 12 months), work more hours, with stricter hours of work and completing jobs that are ordinarily done by paid workers.[10] As a result, CDP recieves 700,000 more penalities than in a job active which disproportionately affected Aboriginal people.[11]

The CDP program is deterioriating the mental health of participants. Not only do to strigent conditions place unnecessary and discriminatory stress on participants, negatively impacting their mental health, but the rate of penalities also jeopardises people's incomes, leading to income instability and a reduction in income levels. These also place subtantial stress on the family and the individual. Anecdotally, NTCOSS understands that in some regions the harsh conditions and consequent penalties has led to an increase in people without income support.

NTCOSS endorses the Fair Work and Strong Communities Alliance and APONT's call to replace the current CDP with an Aboriginal-led model for economic participation for Aboriginal people in remote communities.

Aboriginal people
For Aboriginal people, the impact of intergenerational trauma on mental health must be recognised. Intergenerational trauma, stemming from the ongoing impacts of colonisation, loss of culture and language and harmful government policies contributes to mental health disorders. Addressing intergenerational trauma, through strong Aboriginal leadership and opportunities to heal, will create safer and stronger families and communities with improved health, education and employment outcomes. There is significant demand for culturally appropriate, trauma-informed healing opportunities and these must play a strong role in supporting people with mental illness for Aboriginal people. It is also critical that services supporting Aboriginal people ahdere to the highest level of cultural competence that reflects their needs and

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[9] Fair Work and Strong Communities, *Aboriginal Peak Organisations NR Proposal for a Remote Development and Employment Scheme Summary Paper* (2018), accessible at: https://docs.wixstatic.com/ugd/f2d5cf_7c6939e219094da78b57f450227a08e7.pdf
[10] Fair Work and Strong Communities Alliance, *Key facts about CDP, accessed at:* https://www.fairworkstrongcommunities.org/key-facts-about-cdp
[11] Ibid.

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circumstances, which may include the consideration of community-specific social issues, embedded language and culture, geographic and demographic characteristics, and the historical impact of government policy. NTCOSS notes that the framework for Social Emotion Wellbeing (SEWB) has been identified as more nuanced and culturally relevant for Aboriginal people and this should be used to inform the Productivity Commission's analysis of mental health for Aboriginal people.[12] NTCOSS endorses the Aboriginal Medical Alliance of the Northern Territory's submission, which details the disproportionate impact of mental health on Aboriginal people and key considerations for the Productivity Commission regarding meeting the needs of Aboriginal people.

Aboriginal Controlled Mental Health Programs and Services

Mainstream mental health services adopt a step model which assumes initial contact with a GP progressing to increasingly more specialised and expensive treatments. NPY Women's Council reports that Aboriginal people rarely seek initial support for mental illness through local health providers. Instead support is sought through peer networks and families where concepts are understood and can be spoken about in language. Often the first connection with mental health services is at a point of crisis through psych wards and prison. Interventions at this point are expensive and take place when a mental illness is already well advanced. The critical gap for Aboriginal people is at the initial point of contact with an Aboriginal controlled service or program that is accessible and can provide initial assessment in language using concepts that are culturally relevant and address the person's needs holistically. These services are rare and require language and specialised mental health interpreters as most regular interpreters are reluctant to participate or feel inadequately trained to provide that support.

The NPY Women's Council's Uti Kulintjaku project has developed ground breaking cross cultural approaches to indigenous mental health through a longterm collaboration with mainstream mental health practitioners in the cross border region of NT, SA and WA. The program develops resources to promote this shared bi-cultural understanding more broadly. Despite international and national recognition and numerous awards this program struggles to gain adequate and consistent funding.

NTCOSS Recommends that the Productivity Commission investigate and recommend long term funding commitments for Indigenous controlled, specialised mental health services and programs that are producing positive results and funding to develop new services and training programs drawing on this expertise.

Inequity of funding

The NT received over $69 million in 2016 – 2017 for mental health services.[13] While this represents a higher than average per capita funding amount, the NT requires a different cost structure to the rest of the country. Funding for mental health services in the NT should be needs-based, rather than per capita, given the high rates of mental ill health. Moreover, the remoteness in the NT and small population results in higher cost of delivery of service compared with other jurisdictions. Therefore, in considering the economic cost of services in the NT, the factors of significant need and greater cost of service need to be considered.

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[12] PHNNT
[13] Australian Institute of Health and Welfare. *Mental health services in Australia*. Canberra: AIHW (2019).

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NTCOSS recommends a needs-based funding model for mental health services in the NT.

Young people and mental health

While young Territorians are over-represented within mental health services compared with other age groups and the national average, it is estimated that approximately 70% of young people do not access mental health services.[14] This indicates that there are high rates of mental illness among young people in the NT and potentially that the availability of services does not meet the need among young people. Aboriginal children and young people experience particularly high rates of mental health disorders.

The NT suicide rate for children aged 5 – 17 years is over three times the national average, with the NT leading the nation in high suicide rates.[15] Aboriginal children are disproportionately affected by suicide with Aboriginal children aged 14 years and under being 8.8 times more likely than their non-Aboriginal peers to take their own life.[16] Childhoods trauma, including abuse and neglect, is linked with the high suicide rates and poor levels of mental health. Often children have not had contact with mental health services before committing suicide.[17]

While the NT Government has recently put in place the *Northern Territory Suicide Prevention Strategic Framework 2018 -2023* following a series of reports into youth suicide in the NT (most recently, the NT Parliamentary inquiry into Indigenous suicde "Gone Too Soon: A Report into Youth Suicide in the Northern Territory", significantly greater investment in youth mental health services and youth development programs is needed to reduce the rates of youth mental ill health and suicide for young people in the NT.

Remote Youth Development Program Funding

While some Aboriginal communities receive adequate funding for youth services, others receive no or inadequate funding. Youth services must be recognised as essential services and the funding gap be closed if the NT is to see an increase in health, wellbeing and participation amongst young people. These positive changes will inevitably have an impact on mental ill health and suicidal behaviour.

Engaging and socialising young people, through development programs which complement the formal education system, is highly effective. Best practice models exist in the NT, such as the Mt Theo program, and their success provides a strong case for developing strong young people and communities.

Fundamentally, youth work is undertaken with a long term approach to working with a young person who generally presents with a complex range of issues (including but not restricted to substance misuse, grief and loss, family and domestic violence) and encompasses crisis intervention, advocacy and access to other services.

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[14] PHNNT
[15] Ibid.
[16] Ibid.
[17] Ibid.

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An outreach youth support worker is uniquely placed to provide the level of support needed for the young person as well as coordinate the timely identification and provision of other interventions that address the positive social, emotional and health requirements of the young person in the context of early intervention school and community based programs

NTCOSS recommends that the NT and Federal Government funding bodies commit to equitable resourcing of community-based remote youth development programs.

Place-based mental health solutions for young people
The current mental health crisis amongst young people must be met with youth-specific, place-based mental health solutions across the Territory. While the financial expense for such a response may appear great, the cost in lives is far greater if this is not made a priority.

NTCOSS recognises the good work of the headspace in urban areas that provide mental health services for young people, and other services, such as the Tamarind Centre, who work in this space. However, there are significant gaps in services across rural and remote locations in the NT.

Many regional and remote communities are without youth services that can fill this complex mental health role. Community-driven initiatives that work with disengaged or at-risk young people, many of whom experience mental health issues, have consistently proven to be most successful at working with this group. These programs must be place-based services; the fly-in fly-out model is consistently found to be insufficient.

Expansion of youth mental health services into regional and remote areas must begin with community-led decision making about what programs and who delivers them would best meet the needs of young people, and from there must be supported to drive implementation. While this may take more time than top-down implementation, without this approach it is likely that services will be ineffective and waste further valuable resources and time.

NTCOSS recommends that resourcing place-based mental health solutions is prioritised, with the capacity to meet the specific needs of young people, in rural and remote areas of the NT.

Youth justice, child protection and mental health
The *Royal Commission into the Protection and Detention of Children in the Northern Territory* (the Royal Commission) recognised the 'clear links between youth justice, child protection and health', and recommended that the NT Government commit to a public health approach to child protection and the prevention of harm to children (Recommendation 39.1). This approach to prevent or minimise illness or social problems requires the identification of early risk indicators and needs of children and their families

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(such as access to housing, education, social support, etc)[18] and then an appropriate investment in responding to these needs. It is widely agreed that the greatest investment should be in primary prevention services[19] that increase protective factors and reduce risk, including health services, early childhood education and care and schools, and community services such as transport, housing, disability and local child, youth and family services provided by councils and community organisations.

However, greater investment is also required in secondary services that provide acute and sub-acute services, for people requiring support to address a particular issue or concern, such as poverty, parental mental health problems, parental relationship conflict and/or breakdown, family violence and parental drug and alcohol misuse. The lack of early support services for children and young people displaying early risk factors can lead to the escalation of these issues. This can result in disengagement from school, a breakdown of family relationships and distancing from positive support networks. Consequently, the justice system is left to respond to the manifestation of mental ill health, which is both costly and often untargeted where behaviour is treated without recognition of the underlying mental ill health and other issues.

Child removal and engagement in out-of-home care can be a contributing factor in the onset of mental health and other profound difficulties, particularly where child placements are unstable, or in other non-nurturing environments. A number of symptoms have been identified as being related to child removal in the past such as *"inconsolable grief and loss, low self-esteem, powerlessness, anger, depression, anxiety, suicide and self-harm, alienation from cultural and kinship ties and personality and attachment disorders, poor relationship skills, lack of cultural identity, substance abuse, violence and guilt"*.[20] It follows that for many the experience of loss has been cumulative during a lifetime, and Post Traumatic Stress Disorder has been identified as a common manifestation of painful past experiences.[21]

In recognition of the harm done the Aboriginal Child Placement Principle was developed by Aboriginal community representatives in the 1980. The principle guides the practice of child protection workers and stipulates that removal of an Aboriginal child should be the last resort and provides priority options should a child need to be placed. This principle has been adopted in all states and Territories and has been embedded in their legislations. The *Royal Commission into the Protection and Detention of Children in the Northern Territory* found that there were deficiencies in the NT Government's application of the Aboriginal Child Placement Principle, which resulted in the breakdown of placements and consequent poorer mental health outcomes of children and young people in care.[22]

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[18] Australian Institute of Family Studies. *The public health approach to preventing child maltreatment.* Canberra; AIFS (2016), accessed at: https://aifs.gov.au/cfca/2016/06/22/public-health-approach-preventing-child-maltreatment

[19] Masters, Rebecca et al. "Return on investment of public health interventions: a systematic review". *Journal of Epidemiology & Community Health* 71(8) (2017): 827-834.

[20] Westermann, T. *Caring Well – Protecting Well: Strategies to prevent child abuse in Indigenous communities*, Indigenous Psychological Services: Perth W.A (2003).

[21] Westermann,T. "Guest editorial, Engagement of Indigenous clients in Mental health services: what role do cultural differences play?", *Australian e Journal for the Advancement of Mental Health* (3) (2004).

[22] Report of Royal Commission into the Protection and Detention of Children in the Northern Territory, Volume 3A (2017).

The Royal Commission found that mental health is the biggest health issue for young people in custody, with 75% of young people having one or more diagnosable psychiatric disorders.[23] The Commission found that the healthcare needs of children and young people in detention were not adequately met, an issue which is yet to be fully addressed by the current NT Government. Therapeutic, non-punitive environments that are culturally appropriate and engage families will help to reduce the severity of mental health issues for young people in custody.[24] Mental health services in custodial environments need to adopt an outreach model to facilitate smooth transition and a guarantee of a continuity of services for young people exiting custody, particularly for young people from remote communities. Youth justice systems that uphold the principle of detention as a last resort, which prevent young people from being incarcerated provide young people with the best prospects for having their mental health needs met as well as preventing further harm through incarceration. Non-custodial and diversion responses to youth offending are also more likely prevent re-offending. Without more investment in screening tools, and the co-location of mental health assessments in Courts, an effective and efficient response to mental ill health by the justice system cannot be achieved.[25]

Domestic and Family Violence and Mental Health

There is also a strong demand for the delivery of services that have sophisticated understandings of domestic and family violence (D/FV). Victims/ survivors of D/FV violence disproportionately experience mental health issues because of the abuse they have experienced. Mental health concerns, such as post-traumatic stress can develop while women are in abusive relationships and after they have left and often co-occur with substance abuse disorders. The Australian Institute of Health and Welfare has stated that D/FV is the most significant health risk factor for women aged 25-44.[26] A study conducted of the D/FV disease burden for Australian women aged 18-44 found that the greatest proportion of burden was due to mental health conditions with anxiety and depressive disorders alone accounting for 70% of the burden.[27] Furthermore, D/FV has a significant cost to the economy. In 2015-2016, this cost was estimated to be $22 billion with nearly half of the cost linked to physical and mental health.[28] It must also be acknowledged that experiences of D/FV are multidimensional and thus often compound other experiences of vulnerability. For example, Aboriginal women are disproportionately experience and are impacted by D/FV. D/FV informed service delivery, which responds to victims/survivor needs and promotes safety for women in D/FV situations will aid victims/ survivors to engage socially and economically in society. Furthermore, by better identifying and responding to women currently experiencing domestic and family violence, the social and economic impact of domestic and family violence can be reduced.

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[23] Report of Royal Commission into the Protection and Detention of Children in the Northern Territory, Volume 2A, (2017), 361.

[24] Report of Royal Commission into the Protection and Detention of Children in the Northern Territory, Volume 2A, (2017).

[25] Ogloff, James et al. "The identification of mental disorders in the criminal justice system". *Trends & issues in crime and criminal justice* No. 334. Canberra: Australian Institute of Criminology (2207).

[26] Australian Institute of Health and Welfare. *Family, domestic and sexual violence in Australia 2018.* Cat. No. FDV 2. Canberra: AIHW (2018).

[27] Webster, Kim. "A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women*: Key Findings and future directions*". *Compass: Research to policy and practice,* Issue 7, Australia's National Research Organisation for Women's Safety, (2016).

[28] KPMG. *The cost of violence against women and their children in Australia: final report May 2016.* Canberra: Department of Social Services (2016).

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To complement this submission, NTCOSS endorses the following submissions: The Aboriginal Medical Services Alliance of the Northern Territory (AMSANT); the Northern Territory Mental Health Coalition; ACOSS; and NT Shelter.

We thank you for receiving our submission and would welcome further opportunity to discuss these issues with you.

Yours Sincerely

Wendy Morton
Executive Director