Submission to the Australian Government Productivity Commission Mental Health Inquiry

by the

Top End Association for Mental Health Incorporated (TeamHEALTH)

2019

About TeamHEALTH

TeamHEALTH is a not for profit organisation that was established in 1987 to deliver supports for people living with mental illness in the Top End region of the Northern Territory. Since its establishment, TeamHEALTH has expanded its scope to deliver a combination of psychosocial disability supports and mental health programs/services assisting recovery and rehabilitation through service outlets in Darwin, Palmerston, Katherine, Nauiyu, Maningrida and Gunbalanya.

TeamHealth employs 75 staff and also manages 80 beds across a range of facilities and levels of support. In the 2017-18 calendar year 750 people were assisted, 34 were housed, 450 people attended tailored wellbeing workshops, 65 people were trained in mental health first aid and NDIS crew training was provided to 100 support workers. Forty Five percent (45%) of TeamHealth clients are Indigenous with an even gender balance. Responses to our annual **" YES"** survey revealed that 70% of residents rated our services as very good to excellent.

TeamHEALTH's services support children, youth, adults, groups and communities across culturally and linguistically diverse contexts including very remote, remote, regional and urban communities. Available support from TeamHEALTH includes:

- assisting <u>adults</u> in their mental health recovery journey by providing supports that are tailored to individual strengths and needs, life goals and aspirations;
- early intervention support to vulnerable <u>families with children and young people</u> (0-18 years) who are showing early signs of, or are at risk of developing mental illness;
- an <u>outreach</u>, mental health recovery program that supports the recovery goals of the individual through focusing on key areas of their life such as managing their mental health, physical health, living skills, relationships and work life;
- a dedicated, <u>short term residential</u>, intensive support service for people who are becoming unwell, or who have recently been unwell;
- a dedicated 24 hour, <u>long-term accommodation</u> program designed to support people with severe psychiatric disability into independent living in the community;
- A special needs mental health Community Housing Program;
- Individually planned and coordinated packages of care tailored to help older Australians, aged 65 years and over, to remain living in their homes; and
- education and training for individuals, groups and organisations about mental illness, mental health concerns and how to provide support to individuals experiencing mental health problems.

TeamHEALTH is the process of building a 16 bed facility in Malak (Darwin), to be know as **Top End House**, for people who have recently been discharged from hospital after a period of mental illness, and people who have a psychosocial disability with an NDIS

package who can't live in a group home and who need to live by themselves in a dwelling. The facility is partly funded by the Australian Government and by TeamHEALTH, with the Northern Territory Government providing the land for the facility. The total value of overall facility exceeds $4m. The Board of Management have a commitment to significantly increase the accommodation options for people who have been hospitalised and need support to rebuild their living skills, and to enable people with a chronic and recurring mental ill health to access suitable accommodation that maximises the quality of their life.

TeamHealth is committed to **expanding the supported accommodation** options for people living with a psychosocial disability, and has recently signed a head lease for a property in Larrakeyah (Darwin) to enable NDIS participants with a psychosocial disability, who have Supported Independent Living in their NDIS Plan, to live in a Group Home in Darwin. As the number of people with a psychosocial disability, who have Supported Independent Living in their NDIS Plan, increases within Darwin, TeamHEALTH is committed to expanding the options for those people to live in a group home. In the next 18 months TeamHEALTH expects that up to 20 NDIS participants will be living in a Group Home supplied by it.

TeamHEALTH is able to undertake this expansion of supported accommodation option for NDIS participants because it can manage the risks associated with this accommodation, due to the significant capital it holds in land and buildings within its balance sheet. Many NGOs in the Top End do not have the same risk appetite as TeamHEALTH, or the same strength in the Non Current Assets they hold, and this is restricting the accommodation choice that NDIS participants with a psychosocial disability have within the Northern Territory.

TeamHEALTH Concerns As a Provider

TeamHEALTH is aware that **the Top End does not have a psychiatrist in private practice who is specialising in adolescent psychiatry**. The Top End is well known for being a thin market for many human services, and under investment in specialist health services for young people with a mental illness, is just one of the workforce problems in the Top End. The Australian Government has not addressed this issue, and its recent announcement that it will reduce the number of overseas trained doctors being recruited worries TeamHEALTH as it may make health service access and availability even more difficult for people experiencing a mental health problems.

TeamHEALTH has been delivering both **Personal Helper and Mentors (PHaMs) and Day to Day Living in the Community (D2DL)** program funding from the Australian Government. The Department of Health PHN Psychosocial Support Guidance document (see attached) provided to TeamHealth in March 2019, illustrates the poorly developed national policy development that has occurred in relation to the Continuity of Supports (CoS) program funding being implemented. The initiative does not allow funded providers to accommodate for people living in areas where there are no Northern Territory funded community based mental health services.

TeamHEALTH is concerned by the number of references in the Department of Health **PHN Psychosocial Support Guidance** document to providers encouraging clients to be "re-test their eligibility for supports under NDIS". The Australian Government policy with regard to Continuity of Supports seems ignorant of the '**perverse incentive**' it is building into the human service system and programs it is delivering. TeamHEALTH is concerned that providers are being actively encouraged to maximise the 'disability' of clients so that they will qualify for NDIS, perhaps because the Australian Government will not need to fund these people through its Continuity of Supports funding.

TeamHEALTH is concerned that the Department of Health PHN Psychosocial Support Guidance document states that "Funded services will provide group psychosocial support activities …". **Many clients may not qualify for NDIS** and yet need ongoing support, that will be unsuitable within a group setting. The guidance provided also ignores the problems associated with thin markets, and instead directs providers in the Top End that "…services should be embedded within or linked to clinical services to support a team approach …". In some remote communities, TeamHEALTH is the only service provider offering any form of human service support to people with a mental health problem who qualify for DSS Psychosocial Support funded services.

The **Continuity of Supports** (CoS) program funding being implemented by the Australian Government does not seem to have been designed to accommodate for those people whose need for support increase over time but who never qualify for NDIS. The guidance refers to "programs aims" being about "Targeted individual support for clients at times of increased need" rather than also encompassing people whose need for support has permanently increased.

There appears to be limited understanding or assumptions built into the model for the Continuity of Supports (CoS) program funding that eligible clients may become more effected by comorbid conditions and therefore require a **continuing increase in the level of supports** provided to them over time. TeamHEALTH is concerned that because the Australian Government is so removed from actual service delivery that it is

ignorant of the major policy deficits within the guidance the Department of Health has issued to providers. There is also the more broader problem, that when the significant promise was made that 'no person would be worse off under NDIS', the propensity for ageing to create increased need associated with **worsening co-morbid conditions**; including for those with a psychiatric disability, was not understood by those making the promise. TeamHEALTH is concerned there may be inadequate care for those ineligible for NDIS.

TeamHEALTH is particularly concerned that the guidance issued has warned that **providers should not be using funding for the "provision of personal care and domestic help** … [and should focus on assisting] clients in learning how to complete household domestic activities …. and help them find assistance to undertake tasks they cannot manage themselves." This is an absurd expectation in thin markets. As already stated, in some remote communities, TeamHEALTH is the only service provider offering any form of human service support to people with a mental health problem. Such a statement fails to understand that some people may have a psychiatric condition that prevents them from learning and/or remembering what they learnt.

Specific Concerns & Response

Mental Health in the NT

"Mental health services have a long history of neglect in the Northern Territory, particularly in the rural and remote regions and specifically for Indigenous persons. The socio-demographic, health and population profile of persons living in the NT, however, indicates that from a mental health perspective it is one of the most at-risk groups in the nation."[1]

Since this report was tabled in 2005, improvements have occurred but the for TeamHEALTH the concern is that overall "neglect" of mental health services continues when its compared with other Australian jurisdictions .

In 2018, the Northern Territory had the highest rate of community mental health service contacts in the nation (30.2 clients per 1,000 population) compared to the lowest in

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[1] *Not for Service- Experiences of Injustice and Despair in Mental Health Care in Australia.* A report of the consultations by the Mental Health Council of Australia and the Brain and Mind Research Institute in association with the Human Rights and Equal Opportunity Commission, Mental Health Council of Australia 2005 ISBN 0-9580363-7-3,

Victoria (10.7). And this "neglect" is reflected in the Northern Territory having the lowest rate of Medicare subsidised mental health services and the lowest number of psychiatrists per head of population (6.8 per 100,000).

In terms of involuntary mental health seclusions, the Northern Territory had the highest rate of seclusion (17.0 events per 1,000 bed days) and the Australian Capital Territory the lowest (2.8 per 1,000). The rate of clients accessing psychiatric disability services was highest in South Australia (537.5 per 100,000 population), and lowest in the Northern Territory (146.9). The national rate was 413.9 per 100,000. The very low rate for the Northern Territory, as a thin market, suggests on-going "neglect".

While Tasmania had the highest percentage of people (21.2% of their total population) receiving mental health-related prescriptions, with each patient receiving an average of 9.3 prescriptions in 2016–17, the Northern Territory had the lowest (8.7% of the population and 7.4 prescriptions per patient). TeamHEALTH is concerned that this may reflect either:
- that culture may influence whether a patient (and their family) believes there is a problem and whether it requires medication,
- the pressure on the hospital and acute mental health facility is creating inefficiencies, the public hospital services are under-funded, and without the dedication of the staff many facilities would not be able to operate at well above a 100% occupancy rate; however some people select not to attend because of overcrowding,
- an inability to gain access to a medical practitioner and/or pharmacist to buy medicines because of poverty or remoteness, or
- that services are avoided because they are culturally inappropriate.

The percentage of patients receiving mental health-related prescriptions in the Northern Territory varied depending on the patient's usual area of residence. The highest proportion of patients and prescriptions were for people living in *Inner regional* areas (21.1% of the population) compared with those living in **very remote areas**, where only 5.8% of people received prescriptions.[2]

A more extensive discussion of the unique issues affecting mental health in **remote Indigenous communities** has been provided by the NT Mental Health Coalition and Queensland Alliance for Mental Health.[3] They identify:

- Extreme difficulties in staff recruitment and retention in remote areas;
- Staff burnout, issues in professional development and isolation;
- Staff turnover is problematic for effective service delivery because it undermines trust and healing relationships; and

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[2] Mental Health Services in Australia: In Brief 2018. https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia-in-brief-2018/formats
[3] Joint Submission to Senate Standing Committee on Community Affairs Accessibility and Quality of Mental Health Services in Rural and Remote Australia, 2018

- Limited levels of support from urban services.

In addition, in the Indigenous context, TeamHEALTH would cite high levels of comorbidity driving rates of mental illness including: family violence, substance misuse, incarceration, poverty, homelessness and migratory patterns that limit service access.

The well publicised rates of Indigenous suicide- especially among young people- is evidence of mental health services that are not coping with an Indigenous population grappling with issues stemming from a cycle of grief, PTSD, violence , substance misuse and incarceration.

Accommodation as a Precursor to Employment

While it is clear that people with mental illness require secure, appropriate accommodation to enhance their prospects for recovery[4], equally it should be understood that the financial pressures involved in private rental can be a major stressor with a causal role in depression, anxiety, relationship breakdown, family violence, substance abuse and other co-morbidities that reinforce severe, long term mental illness and broader social harm[5].

Given that accommodation is an issue that has both a causal role in mental illness as well as a major role in rehabilitation[6] a greater focus on providing appropriate accommodation is required. Employment and housing are crucially linked. Australia must prevent currently employed people with mental illness from losing their jobs because their accommodation is inadequate. The economic benefits for Australia, if more people with mental illness, were able to gain sustainable access to secure housing, because they were in employment, requires quantification. Very few mentally ill people are able to make significant progress toward employment when their accommodation is both inadequate and inappropriate, or is a major source of financial stress in itself.

As noted by the *Australian Housing and Urban Research Institute*:

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[4]   Pathways   of   recovery: preventing   further   episodes   of   mental   illness. **http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-p-mono-toc**

[5]   https://www.ahuri.edu.au/__data/assets/pdf_file/0023/29381/Housing-homelessness-and-mental-health-towards-systems-change.pdf   Housing, homelessness and mental health: towards systems change. Australian Housing and Urban Research Institute, 2018.

[6] National Health Service Briefing. https://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Housing_MH_021211.pdf

"There is a complex bi-directional relationship between housing, homelessness and mental health. Homelessness may act as a trigger for mental health issues and vice versa,

- *Persons with lived experience of mental ill health are more vulnerable to common risk factors for homelessness, such as domestic and family violence, alcohol and other drug addiction, and unemployment.*
- *Secure tenure allows people to focus on mental health treatment and rehabilitation.*
- *Greater choice and control over housing and support contributes to wellbeing and quality of life.*
- *Housing quality positively affects mental functioning, mental health care costs, wellbeing and residential stability.*
- *Neighborhood amenity is a factor for reducing mental health care."* [7]

Inadequate Accommodation Options

At present in the Northern Territory, the accommodation options available for people with mental illness are severely limited. For example, people living with mental health issues are forced to wait up to 8 years for public housing.[8] Recent media reports suggest that there are 4800 public housing dwellings in the Northern Territory with a waiting list of 4200 applicants. Existing public housing shortages force welfare recipients, pensioners and low income earners to seek accommodation in the private sector which places them in financial distress that further undermines their prospects for recovery or adds to the population of mentally ill people as housing and other issues overwhelm their coping skills.

For Indigenous people in remote communities in the NT, chronic housing shortages and overcrowding have been a long standing issue with severe consequences for health and mental health. The Northern Territory Government has now reached an agreement with the Australian Government that completes the National Partnership Agreement on Remote Indigenous Housing. [9] TeamHEALTH is hopeful this will begin to address the extremely long waiting time for housing in the Top End.

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[7] https://www.ahuri.edu.au/__data/assets/pdf_file/0023/29381/Housing-homelessness-and-mental-health-towards-systems-change.pdf Housing, homelessness and mental health: towards systems change. Australian Housing and Urban Research Institute, 2018.

[8] NT News, 1 Match 2019

[9] https://dcm.nt.gov.au/supporting-government/office-of-aboriginal-affairs/national-partnership-agreement-on-remote-indigenous-housing

Below are the estimated waiting times for public housing as of 31 December 2018.[10]

Region	1 bedroom	2 bedroom	3 bedroom
Darwin/ Casuarina	6 to 8 years	2 to 4 years	4 to 6 years
Palmerston	4 to 6 years	Less than 2 years	2 to 4 years
Alice Springs	4 to 6 years	4 to 6 years	4 to 6 years
Katherine	6 to 8 years*	4 to 6 years	4 to 6 years
Nhulunbuy	4 to 6 years	2 to 4 years	2 to 4 years
Tennant Creek	6 to 8 years	More than 8 years*	4 to 6 years

The above table shows that waiting times for public housing are unacceptably long in all parts of the NT.

Research into Accommodation Based Models of Care

Although there is a clear recognition of the importance of employment and other meaningful activities as a component of recovery from episodes of mental ill health, the specific role of accommodation in making and keeping individuals job ready and able to cope with the requirements and demands of work has not been a focus of much research in Australia.

Intuitively, stable accommodation and where justified, different levels and types of support/assistance are essential for adequate sleep, relaxation, entertainment and privacy as well as hygiene and nutrition. However, little is known about the relative importance of these variables and especially about the minimal standards and *duration* of such accommodation required to support gains for people with mental health issues. What is clearly known is that inappropriate and unstable accommodation can be a major life stressor that can increase the chances of suffering from a mental illness and delay recovery for those already undergoing treatment.

At present, TeamHEALTH and other providers clients are housed based on logistical and economic factors and their support is based partly on individual needs and economics rationing, rather than standard packages of care (determined from research and an evidence base) that sets minimal levels and durations that are likely to be of therapeutic significance and create the more effective socioeconomic benefit.

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[10] https://nt.gov.au/property/public-housing/apply-for-housing/apply-for-public-housing/waiting-list

To a large extent, while mental health **services and treatments** are heavily researched in terms of client outcomes, the unique features of housing/accommodation, and their impact on outcomes has not been a clear research focus, independent from treatment types, within a comprehensive evaluation framework.

For those services that are largely involved in providing accommodation and varying levels of client support, filling this gap in the research base has the potential to optimise outcomes against capital and recurrent costs. In effect, appropriate research could help services such as TeamHEALTH and other NGOs to deliver higher Return on Investment (ROI) based on broader evidence, economic impact measurement, and benchmarking of longitudinal impacts.

Indigeneity, Homelessness and Mental Health

Failure of the social system to house an individual or family generally results in homelessness and the Northern Territory has by far the nation's highest rate of homelessness – 17 times the national average.[11]

Of particular concern is the fact that people with mental illness are far more likely to become homeless than others. A 2011 study by the Salvation Army revealed that 15% of homeless people had a mental illness before becoming homeless while a further 16% became mentally ill **after** becoming homeless.[12]

In the Northern Territory, the burden of homelessness and the mental illness that can ensue, is disproportionately evident in Indigenous people. The 2008 Larrakia Nation Research report estimated that 50-75% of Darwin's Long-grass population were symptomatic of Post Traumatic Stress Disorder. In 2012, the Report of the Northern Territory Coordinator General for Remote Service Delivery recommended a study on mobility patterns be undertaken to better understand the full extent and causal factors, to inform appropriate policy responses and service delivery; but to date this study has not been undertaken.

What is evident is that homelessness in the Northern Territory has unique dynamics that are intrinsically bound up with being Aboriginal, remoteness, migration patterns, unemployment, substance misuse, inter-generational trauma, and, the health gap between Indigenous and Non-Indigenous Australians. There is little doubt that mental health issues would be highly represented in this population and that employing the homeless in open employment is not necessarily a practical expectation- even if it is a

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[11] .Office of the Northern Territory Co-Ordinator General for Remote Services Report, 2012.
[12] https://www.sbs.com.au/topics/life/health/article/2017/06/27/surprising-link-between-mental-illness-and-homelessness

worthy goal. Appropriate accommodation is arguably the first step toward recovery for this group and their long term prospects for sustainable open employment.

Issues in Supported Employment

There is widespread agreement that employment or meaningful activities can play a large role in the rehabilitation and progress of people afflicted with a mental illness. [13] Indeed, international evidence shows that most people with a mental illness want to work [14] and that 6 out of 10 can succeed if given the appropriate supports.[15]

However, a more detailed examination of this broad proposition and the processes required to sustain people with mental illness in the employment market, yields additional complexities.

Employing anyone in open employment - regardless of their mental health status - is not simply a case of finding a job vacancy. With the growing complexity of modern workplaces and workforces, much greater attention is placed on the fit between the unique skills and context of the worker and the requirements of the role. It is often assumed that all employment has therapeutic benefit and that any work is better than no work at all. However, ill-suited open employment can be even more damaging than unemployment. [16]

Matching people and jobs is a specialized role, which in the case of people with mental health issues, can require extensive knowledge of the client across many domains of physical tolerance, intellectual functioning, coping ability and strategies, persistence and fatigue levels and the effects of medication. In addition, securing open employment can require the client to attend interviews and testing, as well as assistance with resume preparation.

Clearly, all of these considerations hinge upon the individual client, their level of functioning, motivation, age and marketability. Some may be job ready for supported employment or open employment. These people could be self-directing with minimal assistance in open employment verses others who may require assistance, within supported employment, at the more specialised end of the professional assistance and

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[13] Road to Recovery: Employment and Mental Illness © 2014 by NAMI, the National Alliance on Mental Illness. National Alliance on Mental Illness (NAMI) 3803 N. Fairfax Dr., Suite 100 Arlington, VA 22203. https://www.nami.org/about-nami/publications-reports/public-policy-reports/roadtorecovery.pdf

[14] SAMHSA (2012) Uniform Reporting System, 2012 http://www.samhsa.gov/dataoutcomes/urs/urs2012.aspx

[15] McQuilken M, Zahniser JH, Novak J, Starks RD, Olmos A, Bond GR. (2003) The Work Project Survey: Consumer perspectives on work. Journal of Vocational Rehabilitation; 18:59-68.

[16] Re-employment, job quality, health and allostatic load biomarkers: prospective evidence from the UK Household Longitudinal Study Tarani Chandola Nan Zhang *International Journal of Epidemiology*, Volume 47, Issue 1, February 2018, Pages 47–57,https://doi.org/10.1093/ije/dyx150. https://doi.org/10.1093/ije/dyx150

service cost spectrum. Whatever point people are at within their recovery, supporting them into employment increases their opportunity to remove themselves (and their family) from being trapped relying on welfare, and therefore living in poverty.

If we are to effectively place people with mental illness in different types of employment contexts that benefit them and their employers then we need to accurately match people to jobs, and in open employment to support both workers and employers in their ongoing relationship.

While it may be argued that existing services such as ***Disability Employment Services*** appear to work quite effectively for some disabled Australians, there is very little evidence for its effectiveness for Indigenous people. Indeed Disability Employment Services, employment outcomes, for Indigenous people are the lowest of all subpopulations nationally. As well as this, in the Northern Territory, outcomes for Disability Employment Services, are the lowest in all States and Territories. [17]

Service providers like TeamHEALTH may sometimes find it difficult to refer clients in remote locations to employment services agencies. In most remote communities, there are no agencies operating permanently in those communities that specialise in addressing disability unemployment.

Furthermore, it is very clear that employment opportunities for remote Indigenous people in particular are very low and have historically been subject to confusing policy shifts by successive Federal Governments. A series of changes to the (now) Community Development Program over several decades has altered it from a wage basis to welfare-for-work and in the process removed thousands of effectively unemployed Indigenous people from unemployment statistics.[18] The true picture of unemployment in remote Indigenous communities is therefore unclear but certainly in need of greater focus.

The concern being expressed nationally about the low rates of 'employment' within NDIS is borne out in TeamHEALTH experience with transitioning clients from PHaMs and D2DL to NDIS and CoS. There is no mention or focus within any of the guidance document, towards supporting clients to gain employment as a goal within their NDIS Plan. Whether it is DSS or DoH, neither Australian Government Department is fostering a policy environment within the Continuity of Supports (for people with severe mental illness), that assumes that employment of any form will be the goal) of people receiving an NDIS Plan.

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[17] Employment Services Outcome Report, Disability Employment Services. https://www.jobs.gov.au/employment-services-outcomes-reports

[18] http://www.amsant.org.au/apont/wp-content/uploads/2015/01/120419-APO-NT-Work-not-Welfare-CEEDS-summary-document.pdf

Given the very limited work opportunities available in remote communities, supporting mentally ill people into beneficial work arrangements remains extremely challenging - although not impossible - depending on the unique needs and services of the community itself. In addition, the logistics of remotely supporting employers and employees adds further difficulties and cost to an already culturally and practically complex situation. However, many supported employment providers, and Aboriginal community controlled organisations, are deeply committed to building employment opportunities, and would develop innovative models to improve the employment opportunities in remote communities in the Top End.

Services for Aboriginal and Torres Strait Island people

The Northern Territory's 2019 Mental Health Planning activity highlights the need for more culturally appropriate services and specifically recommends:

Culturally secure, safe and trauma informed care focused on recovery - services and programs planned and delivered in a way that takes into account the unique needs of the population and respects their culture and values. [19]

Cultural appropriateness in the context of mental health services delivery can be considered individually and collectively in terms of three strategies:

(a) Appropriate organizational culture in the way that a service approaches, respects and works with Indigenous people through their culture;

(b) Services with high levels of qualified Indigenous staff who are able to work more effectively with Indigenous clients because of a shared culture; and

(c) culturally appropriate assessment and therapy tools/techniques which provide better understanding of client need and meet the therapeutic expectations of Indigenous people.

Each strategy is considered separately.

Firstly, the above italicised quotation clearly falls into strategy (a) and aligns with the work of professionals and/or researchers who have developed a formal tool for the assessment of support professionals in terms of their cultural competence. [20] In addition, cultural awareness/cultural safety training is a prominent feature of the

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[19] *https://haveyoursay.nt.gov.au/mental-health-planning*

[20] http://indigenouspsychservices.com.au/wp-content/uploads/2017/11/CCP-Report-Example.pdf

induction processes for many organisations working with Indigenous clients across sectors and these efforts also fall squarely into strategy (a).

The core assumption underlying strategy (b) is that there are distinct outcome advantages in building Indigenous workforces for delivering services to Indigenous people. However, it is likely that Indigenous organisations also face similar recruitment, development and retention issues of Indigenous staff as non-Indigenous organisations and levels of demand from Indigenous clients can often exceed service capacity. In such situations, collaboration and cooperation is in the interests of all parties and especially clients. More discussion on this and related issues is provided in the next section.

Strategy (c) recommends the development and application of assessment and therapeutic tools that have greater validity for Indigenous populations. Unfortunately, formal instruments of this kind have not yet been more widely adopted, partly because agencies are strongly encouraged to adopt standardized, well known instruments. Without formal endorsement by professional bodies and funders, it is unlikely that service delivery agencies alone will lead the adoption of such specialised tools. Further, more detailed discussion of strategy (b) and (c) are provided in the final two sections of this submission.

Culturally Appropriate Services Through Employment

As discussed above, a widely accepted approach to cultural appropriateness is to recruit greater numbers of qualified Indigenous staff who are able to work more effectively with Indigenous clients. However, there are numerous barriers to achieving significant gains in Indigenous staff recruitment, development and retention.

To begin with, literacy and numeracy levels among many Northern Territory school students is chronically low [21]and the pool of Indigenous people transitioning into post secondary education is still quite small. Like other employers, service delivery agencies in the mental health sector must compete to attract Indigenous workers. Secondly, worker burnout in the mental health sector is well understood and strategies exist to ameliorate its impact. However Indigenous people face the added burden of working with people to whom they may be closely and distantly related. This places added stress on these workers.

A significant proportion of promising Indigenous young people are also lost to the workforce through substance abuse, early incarceration and early motherhood which further delay their employment prospects in the sector. An additional factor is the very

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[21] https://www.indigenousliteracyfoundation.org.au/what-is-indigenous-literacy

high level of population turnover in the Northern Territory within its broader population as well as the internal migratory patterns that Indigenous people exhibit between remote, regional and urban centers in the Territory[22]. These factors conflict with the requirement for a stable, well qualified Indigenous workforce able to deliver best practice care across urban, regional and remote settings.

Finally, fully integrating Indigenous people into the mental health workforce must recognize and accept cultural differences and practices that sometimes conflict with mainstream values and expectations,[23] Organisations such as NorForce - an Army reserve unit that is one of the largest employers of Indigenous people in the Northern Territory - adapt to this with flexible periods of attendance and modified training.[24] However, given the regulatory requirements for professional registration and skill requirements for workers in non clinical roles, modified training is not an easy solution for mental health workers. At the very least, it may require different training and workforce development strategies than are currently evident.

Assessment of Indigenous Clients

The issue of culturally appropriate assessment and wellbeing therapy has a long standing history in Northern Australia especially where cultural differences are more apparent and confounded with the issue of remote populations and the logistics of service provision.

Considerable effort has been directed at developing and/or converting instruments and therapeutic software for an Indigenous context. Some of this has taken a more conventional psychometric approach applied to Indigenous contexts [25] while more recently, others have harnessed trends toward mobile platforms such as notebook computers and smart phones for their convenience and familiarity. Many of these take a yarning approach to therapy, goal setting and planning which is regarded as more comfortable for many Indigenous people.[26]

Despite these efforts, the adoption of tools/instruments has been slow to occur and is possibly the result of a chicken and egg situation where service delivery agencies are reluctant to adopt tools that are not formally endorsed by the sector whilst simultaneously the sector may be unwilling to endorse such tools until they are widely

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[22] Taylor, A. and Carson, D. (2017). *Synthesising Northern Territory Population Research: A report to the Northern Territory Department of the Chief Minister*. Charles Darwin University: Northern Institute; p.49.

[23] NDIS, January 2017 Northern Territory Market Position Statement

[24] http://www.defence.gov.au/adc/adfj/Documents/issue_202/Waddell_July_2017.pdf

[25] Initial-Validation-of-the-Westerman-Aboriginal-Symptom-Checklist-Adults-WASC-A
https://indigenouspsychservices.com.au/products-tests/wasc-a/

[26] https://www.menzies.edu.au/page/Research/Indigenous_Health/Mental_health_and_prevention/

adopted and recommended by the sector. In this sense, no-one is willing to be the early adopter.

In summary, there has been a long standing implicit goal for better addressing Indigenous mental health needs in the Northern Territory. Namely, developing an Indigenous mental health workforce in the Northern Territory which is both professionally qualified and culturally competent to administer appropriate instruments, make clinically useful assessments and deliver culturally appropriate therapy. Indeed, the ideal solution is for Indigenous mental health workers to apply culturally appropriate tools with Indigenous clients within Indigenous mental health agencies subject to governance by Indigenous community members.

However this pivots around key issues discussed earlier in this submission: the difficulties of recruiting, developing and retaining qualified Indigenous staff, staff turnover and managing cultural differences- especially in remote settings as well as large levels of service demand that require partnership and collaboration between service delivery agencies and stakeholders of all kinds and at all levels.

While the goal sated above is certainly laudable, a host of barriers still exist that impede its realisation.

Recommendations

Mental Health

That Governments address the high rate of mental ill health in the Top End and address the evident gap in mental health services that has existed in the Northern Territory. These gaps stem from inadequate levels of specialist and mainstream service provision, and availability of housing, employment, and addressing needs through culturally appropriate services, within the Top End.

Housing

It is recommended that:
- increased accommodation options are made available for people (and their families) impacted by severe and chronic mental ill health, and/or a psychosocial disability in the Top End.
- research needs to be conducted into the quality and quantity of accommodation in the Top End that can be shown to support therapeutic, sustainable

employment gains for people with mental illness, and that create sustainable improvements in people's quality of life.

Employment

It is recommended that:
- more investment be made in both supported employment and open employment for those affected by mental ill health in the Top End, to increase the level of employment, reduce unemployment, improve people's productive capacity, and to increase their individual and household incomes.
- the fund innovative trials that focus on helping mentally ill people and employers to work together to overcome stigma and other barriers that mitigate against sustainable employment in the Top End; with the aim of utilising the trial performance results to create long term models that can be implemented across the Top End.

Aboriginal and Torres Strait Islander people

It is recommended that:
- A broader range of validated, standardized, cultural competency guides for service delivery agencies as well as appropriate assessment and therapeutic tools for Indigenous people are developed for use across the mental health sector that fit urban, rural and remote settings.
- Conduct research that clarifies viable models, that accommodate for the unique factors that affect the recruitment and retention of Indigenous people in the mental health sector, in the Top End. Strategies need to develop and sustain this specialist workforce, at levels that meets the manifest needs of the Indigenous people living with mental ill health in the Top End .
- The extreme rates of Indigenous homelessness in the Northern Territory as both an outcome and cause of mental illness, and addressing this specialist mental health need requires an integrated response that requires much greater resources. It does not only apply to those who qualify for NDIS but should be applied in terms of accommodation and therapeutic options that best improve the quality of life for Indigenous people living with periodic mental ill health, in urban and remote settings, across the Top End.